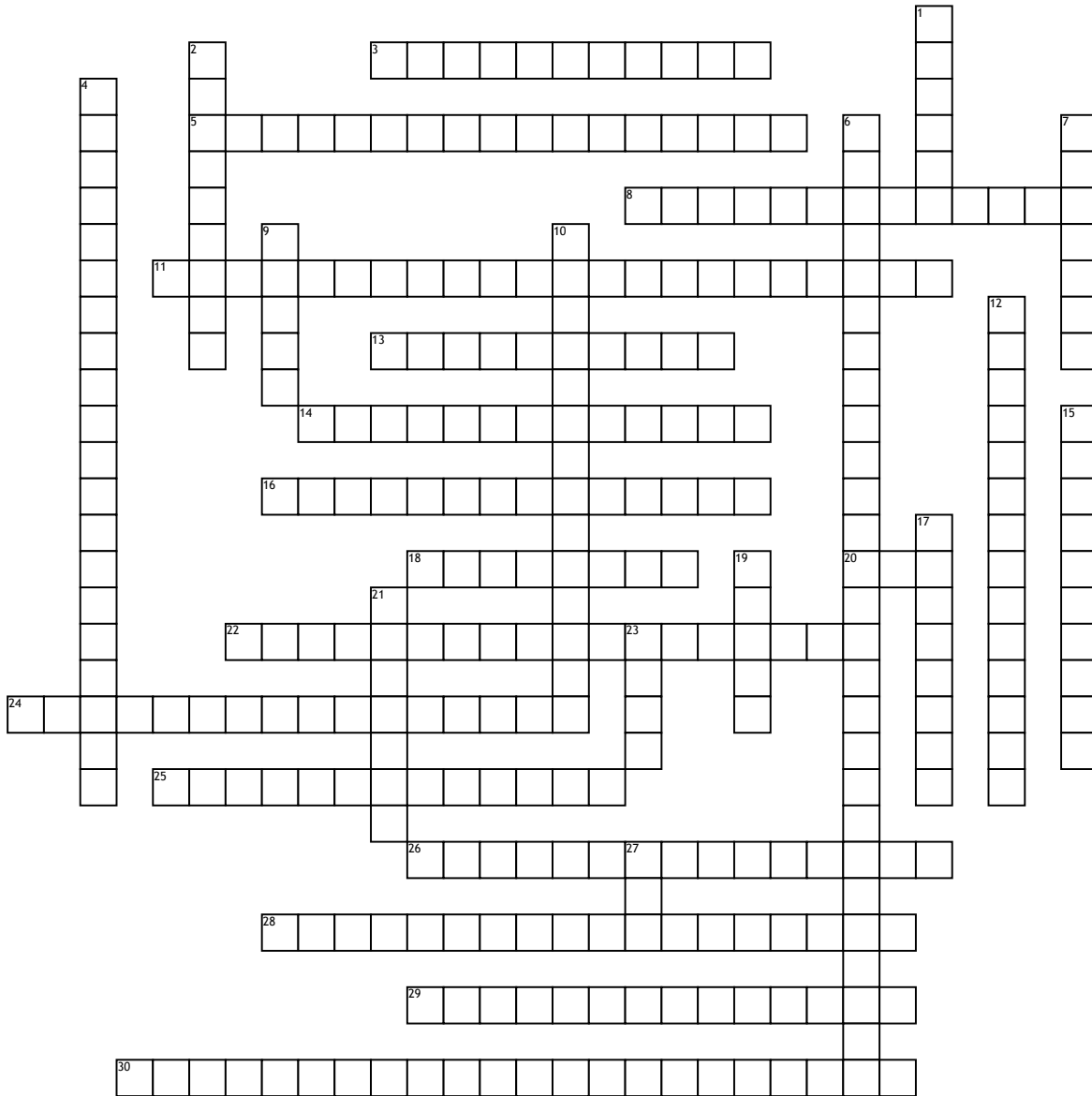


# Billing Terms Crossword



**Across**

- 3. the number assigned to a HIPAA 270 electronic transaction
- 5. Changed a code from the accurate one to one that you know the insurance company will pay for.
- 8. Form used to summarize the treatments and services patients received during visits.
- 11. Form completed by patients that summarizes their demographics and insurance information.
- 13. Coding each individual procedure if there is a code that includes all of those procedures in ONE code.
- 14. effects of a condition
- 16. A payment made during checkout based on an estimate
- 18. Choosing a higher level code than what was actually done just to get more money from the insurance company.
- 20. A set of 5 digit codes used to describe all medical services which are performed.
- 22. the insurance plan that pays benefits after payment by the primary payer when a patient is covered by the more than one medical insurance plan.

- 24. The insurance plan that pays benefits first when a patient is covered by the two medical insurance plans.
  - 25. The encounter form is a source of \_\_\_\_\_ information for the medical insurance specialist
  - 26. A practice's rules for payments for medical services are found in its \_\_\_\_\_
  - 28. A patient who has received professional services from a provider or another provider in the same practice with the same speciality in the past three years
  - 29. Assignment of benefits
  - 30. A clause in an insurance policy that explains how the policy will pay if more than one insurance policy applies to the claim.
- Down**
- 1. If a health plan member receives medical services from a provider who does not participate in the plan cost to the member is \_\_\_\_\_
  - 2. If a husband has an insurance policy but is also eligible for benefits as a dependent under his wife's insurance policy, the wife's policy is considered \_\_\_\_\_ for him.
  - 4. Authorization by the policyholder that allows a payer to pay benefits directly to a provider.

- 6. Under Medicare, what must a provider receive before it is permitted to collect a deductible or any other payment ?
- 7. subjective, as related by the patient
- 9. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
- 10. a policy retaining patients credit card information
- 12. the document a patient signs to guarantee payment when a referral authorization is pending.
- 15. A patient who has not received professional services from a provider or another provider in the same practice with the same speciality in the past three years.
- 17. cause or underlying condition
- 19. Billing for something that was not documented in the patient's chart.
- 21. policyholder, guarantor, or subscriber
- 23. objective evidence of a disease or condition
- 27. A set of codes used to identify what is wrong with a patient -their diagnosis-or why the patient received medical services.