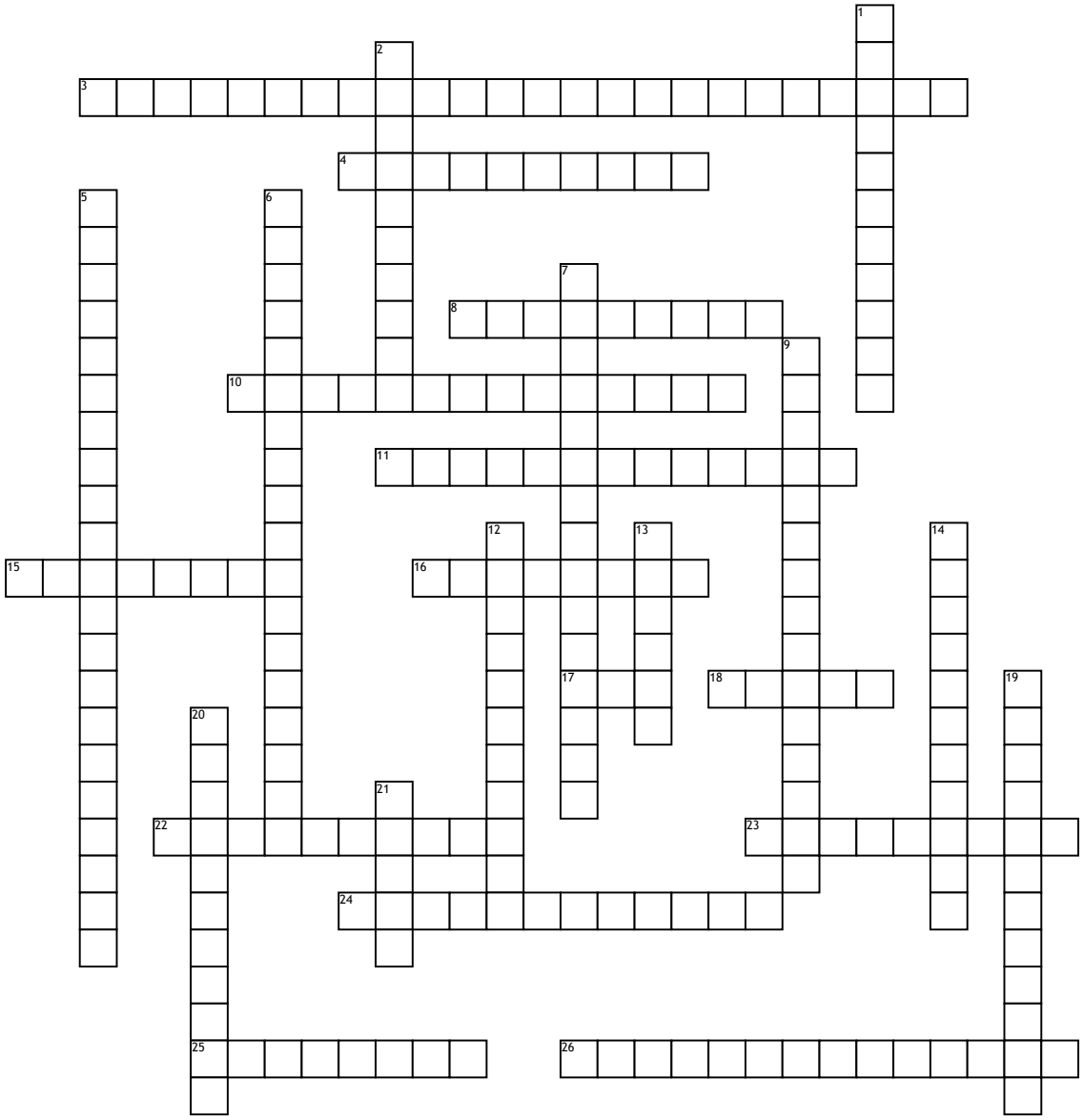
Name: _____ Date: _____

Healthcare Terminology Crossword



Across

3. A facility other than a hospital, medical or dental office, whose main function is performing surgical procedures on an outpatient basis.

4. An amount the insured person must pay before insurance payments for covered services begin.

8. An immediate family member of a subscriber by marriage, birth or legal acquisition and who is legally dependent upon the subscriber to the Intern Revenue Service.

10. Dollar amount over the negotiated rate to be written off by a participating provider for services to a participating provider member. This dollar amount if the difference between the total charge and the allowed amount.

11. The period of time which must elapse before benefits are payable under an insurance contract.

15. Medical services rendered to a member that are covered in the plan, i.e. office visits and in return paid by health insurance

16. An individual or institution that render medical care.

17. Equipment and supplies such as wheelchairs, hospital beds, crutches, nebulizers, etc., and must be prescribed due to a medical condition of injury.

18. Itemized bill for services rendered to a member

22. The person with whom an insurance contracts to provide health benefits for that person and enrolled dependents.

23. A subscriber or covered dependent who occupies a hospital bed while receiving hospital care, including room, board and general nursing care.

24. Termination of membership for a subscriber's contract.

25. Benefits, as stated in the policy, for which an insured is eligible.

26. Coding system used to identify services rendered.

Down

1. Medical expenses not covered under a benefit agreement that an insured is required to pay.

2. Services received for a sudden, serious, or unexpected illness, injury or condition, emergency other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such conditions.

5. A form sent to the subscriber after a claim for payment has been processed by the insurance company explaining the action taken on that claim.

6. Medical services that have been authorized and approved as medically necessary by the primary care giver.

7. The date that the member' policy/coverage is no longer active (in effect).

9. Maximum dollar amount that an insurance company will reimburse a provider for a given service.

12. The amount a physician or other provider of care actually bills for a particular medical service or procedure. The actual charge may differ from the customary and/or reasonable charges under insurance programs.

13. Any person covered under an insurance policy.

14. Satisfaction of requirements for membership as stated in the policy; the state of being qualified or eligible to receive coverage.

19. Three-digit codes used in the billing of hospital claims.

20. An insurance policy purchased by an organization or association as a benefit to its employees or members.

21. Aims to protect privacy of all the members.