



Insurance and Billing Basics

A parent and caregiver guide to therapy coverage

The Openshaw Spot

A spot to belong. A place to grow.

Insurance can feel confusing, especially when you are starting therapy. This guide explains common terms, questions to ask, and ways to help avoid unexpected bills.

Your costs and coverage depend on your individual plan. Our office can help with questions about our billing process. Your insurance company can explain your specific benefits and coverage requirements.

Before your first appointment

Please provide:

- Your child's current insurance card, including the front and back.
- Information about any additional insurance coverage.
- Accurate patient and policyholder information.
- Any requested referral or other documents.

Ask about coverage for both the **evaluation and ongoing treatment**. Insurance may handle them differently.

A therapist's recommendation for services does not automatically mean insurance will cover them.



Common insurance terms

Premium

The amount paid to maintain insurance coverage, often monthly. Paying a premium does not necessarily cover the full cost of appointments.

Deductible

The amount you may need to pay for covered services before your plan begins paying its share. Some services may have different rules.

Copay

A fixed amount you may owe for a covered appointment.

Coinsurance

A percentage of the plan's allowed cost that you may owe. For example, if the allowed amount is \$100 and your coinsurance is 20%, your share would generally be \$20 after any applicable deductible.

Allowed amount

The amount your insurance plan recognizes for a service. This may differ from the amount billed.

Out-of-pocket maximum

The most you generally pay for covered, in-network services during your plan year. Premiums, noncovered services, and some other charges generally do not count toward this amount. Ask your plan what applies.

In-network and out-of-network

In-network providers have an agreement with your insurance plan. Coverage and costs may be different for out-of-network care. Confirm the specific provider, location, and service with your plan.

Referrals and prior authorizations

A referral is a request or recommendation from a healthcare provider for your child to receive services.

Prior authorization is approval from an insurance plan that may be required before certain services are provided.

These are different requirements. Your child's plan may require one, both, or neither.



An authorization may apply only to certain services, dates, providers, or numbers of visits.

An authorization is not a guarantee of payment. Other coverage requirements still apply when the claim is processed.

Visit limits and coverage rules

Some plans limit therapy visits or require additional review for continued treatment.

Ask whether:

- The evaluation counts toward the visit limit.
- Occupational, speech, and physical therapy share a limit.
- Visits at other clinics count toward the same limit.
- The limit follows a calendar year or another plan year.
- Additional visits can be requested.
- Teletherapy has different coverage requirements.

Coverage for one type of therapy does not necessarily mean another type is covered.

Questions to ask your insurance company

The member services number is usually on your insurance card. You can ask:

- Is outpatient occupational therapy or speech therapy covered for my child?
- Is The Openshaw Spot in-network for our specific plan and location?
- Are the evaluation and treatment covered differently?
- Do we need a referral or prior authorization?
- What deductible, copay, or coinsurance applies?
- Are there visit limits or exclusions?
- Does another insurance plan need to be billed first?
- Are teletherapy services covered?

Write down the date, representative's name, and call reference number. Keep any written benefit information you receive. Benefit estimates can change after a claim is reviewed.



What happens after an appointment

The clinic submits a claim describing the services provided. Your insurance company reviews the claim and determines how it will be processed under your plan.

You may receive an **Explanation of Benefits**, often called an EOB. It may show:

- The amount billed.
- The amount allowed by the plan.
- What insurance paid.
- Adjustments or reasons a service was not paid.
- Any amount identified as your responsibility.

An EOB is not a bill. A clinic statement shows any payment the clinic is requesting from you. Contact the office if you do not understand a charge or if your statement appears different from your EOB.

Why a claim may be delayed or denied

A claim may need further review because of:

- Incorrect or outdated insurance information.
- Questions about which insurance pays first.
- Missing referral or authorization information.
- A visit limit or coverage exclusion.
- A request for additional documentation.
- A processing error.

A denial does not always mean the family owes the full billed amount. Contact the office before assuming what you need to pay. Depending on the reason, a claim may need correction, additional information, or an appeal.



Tell us immediately when insurance changes

Contact the office if:

- Your child receives a new insurance card.
- Your plan, member ID, or policyholder changes.
- Coverage starts or ends.
- Your child gains or loses a second insurance plan.
- Your insurance company asks you to update other coverage information.

Even if the insurance company's name stays the same, your benefits or billing information may change.

If front office staff are unavailable, let your team lead know that you need help updating insurance information. Ask how to submit your documents securely.

If you have more than one insurance plan

Tell the office about every active plan. Insurance companies use **coordination of benefits** rules to determine which plan pays first.

Having two plans does not automatically mean every service will be covered in full. Respond promptly if either insurer requests information about other coverage.

If you are worried about costs

Please ask questions early. You can request an explanation of a statement, ask about estimated costs, or discuss available payment arrangements with the office.

Before choosing self-pay, ask whether it is available for your situation and what terms apply.

You do not need to understand every insurance term. Start with: “Can you help me understand what this means and what I need to do next?”

This guide provides general information. Your plan documents, coverage rules, and applicable requirements determine your individual benefits and financial responsibility.