# Balance Bill Kit

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866.861.9227
advancedpricing.com
info@advancedpricing.com

AMPS
Healthcare Cost Management

## Information and Instructions regarding your Balance Bill Kit

Please review, sign, date and return the following:

- The Authorization Letter
- The Notice of Billing Errors & Dispute of Charges
  ***If the patient is a minor, the parent or guardian may sign.***

If you receive a phone call or voice message from your provider, please fill out the Telephone Information Form we have provided in this packet and send a copy to AMPS immediately.

In spite of our efforts you may still be contacted by your provider or their agent. If this should happen, know your rights.

## *Know Your Rights*

Bill collectors are not legally allowed to do any of the following:

- Contact you at work if you tell them not to or your employer indicates that they disapprove of the calls.
- Call before 8 am or after 9 pm.
- Contact you after you have told them in writing to stop.
- Contact anyone else about your Bill or tell anyone about your medical treatment or history. [Note: A collection agent can contact someone else to attempt to find out how to reach you, but they are not permitted to contact the same person more than once.]
- Harass or threaten you, use obscene or abusive language, etc.
- Publish your name on a list indicating that you owe debt.
- Make false statements concerning your debt.
- Threaten a lawsuit, arrest, wage garnishment, or property seizure unless your state's laws allow them to take such steps, if they legitimately intend to do so.

If you have any questions, please feel free to contact us via phone or email so that we may assist.

Thank you,

AMPS Patient Advocacy Department
e: info@advancedpricing.com
p: 800.425.9373

@Insert CurrentDate_LongDate@

# Authorization to Contact Medical Provider

**AMPS ID:** TEST CLAIM ID
**Employee Plan Participant**: TEST EMPLOYEE NAME
**Patient**: TEST PATIENT NAME
**DOB**: TEST DATE OF BIRTH
**Date(s) of Service**: TEST DATE OF SERVICE
**Provider**: @Prompt TEST PROVIDER NAME
**Provider Account #:** TEST PROVIDER ACCOUNT NUMBER

Attention: TEST PATIENT NAME

I, TEST PATIENT NAME, a covered individual under TEST PLAN NAME (the "plan") hereby request, authorize and grant authority to Advanced Medical Pricing Solutions ("AMPS") as the appointed Claims Delegate for the Plan to contact and act on my behalf as my representative and agent in dealing with TEST PROVIDER NAME (the "Provider") and any other interested party in reference to charges for treatment, care and services provided in connection with the above-referenced claim and bill (the "Medical Bill"), including, without limitation, charges that the Plan has determined exceed the Allowable Claim Limits under the terms of the Plan. I have advised the provider of this authorization and have directed them to direct any future correspondence or communication pertaining to this matter to:

AMPS
Attn: Patient Advocacy Department
35 Technology Parkway S, Suite 100
Peachtree Corners, GA 30092

Phone: 800.425.9373
Fax: 866.861.9227
Email: info@advancedpricing.com

Additionally, by my signature below, I acknowledge that I have authorized the provider to release any records and information related to the Medical Bill, including Protected Health Information (PHI), to AMPS. I am requesting that such Protected Health Information be disclosed under this authorization, as permitted by 164.508(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I have retained a copy of this authorization for my records. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written statement for the revocation to the provider and AMPS. Unless I so revoke it, this release will remain valid and effective for as long as any portion of the Medical Bill remains unsettled.

Patient Signature: _____

Guardian Signature:
(if the patient is a minor) _____

Relationship to minor: _____

Date: _____

@Insert CurrentDate_LongDate@

TEST PROVIDER NAME
Attn: Billing and Inquiries
TEST PROVIDER STREET ADDRESS
TEST PROVIDER CITY STATE & POSTAL CODE

## Notice of Billing Errors and Disputed Charges

**AMPS ID**: TEST CLAIM ID
**Employee Plan Participant**: TEST EMPLOYEE NAME
**Patient**: TEST PATIENT NAME
**Date(s) of Service**: TEST DATE OF SERVICE
**Provider**: TEST PROVIDER NAME
**Provider Account No.**: TEST PROVIDER ACCOUNT NUMBER
**Total Billed Amount**: $TEST TOTAL BILLED CHARGES
**Total Plan Payment Amount**: $TEST TOTAL AMOUNT PAID BY PLAN ACCORDING TO EOB
**Undisputed Aggregate Co-Pay/Deductible/Co-Insurance Amount**: $TEST TOTAL AMOUNT OWED BY PATIENT ACCORDING TO EOB
**Disputed Amount**: $TEST SAVINGS MINUS PATIENT RESPONSIBILITY AND ADJUSTMENTS

Attention: TEST PROVIDER NAME

I am in receipt of the above-referenced billing statement (the "Bill") from TEST PROVIDER NAME (the "Provider"). Your office has already been notified by my benefit Plan that certain charges on the Bill in the amount of $DISPUTED AMOUNT have been determined to be inaccurate, invalid, excessive or otherwise outside of the Permitted Payment Levels or scope of benefits available under the Plan (the "Disputed Charges"). To date, the provider has not submitted additional information to the Plan sufficient to support or justify those charges. Details regarding the Disputed Charges are also attached.

This letter is formal notice that I am disputing the accuracy and validity of the Disputed Charges under the federal Fair Credit Billing Act, 15 U.S.C. § 1666 (the "FCBA"), as well as other applicable federal and state laws regarding, without limitation: unfair billing or collection practices or credit reporting; unfair and deceptive trade practices; and accord and satisfaction and the implied covenant of good faith, fair dealing and reasonability (collectively "Applicable Law"). I am requesting that this matter be investigated, that the Bill be appropriately adjusted, that any finance and other fees related to the disputed amount be credited to my account, and that I receive an accurate billing statement as soon as possible. Until this matter is addressed and resolved in accordance with Applicable Law, no payments will be made on the Disputed Charges.

Pursuant to the FCBA, the provider is required to acknowledge this notice of dispute within thirty (30) days and, within ninety (90) days, must investigate the Disputed Charges and either adjust the charges on the account and send a corrected Bill or provide a written explanation as to why the charges at issue are appropriately included in the Bill. Unless the provider appropriately follows the required procedures, Applicable Law prohibits any legal or other action to collect the Disputed Charges or related amounts. In addition, protections and procedures under other Applicable Law must also be followed. Please be aware that I have appointed and authorized Advanced Medical Pricing Solutions ("AMPS") to be my authorized representative and agent to act on my behalf in addressing Disputed Charges and any and all other matters relating to the Bill.

If, subsequent to your investigation of this matter, you wish to explain or validate the Disputed Charges, please send any relevant information and documentation to the following address:

TEST PATIENT NAME
c/o Advanced Medical Pricing Solutions
Attention: Patient Advocacy Department
35 Technology Pkwy S., Ste. 100
Peachtree Corners, GA 30092

Even in the absence of the billing inaccuracies and invalidities referred to above, I am not legally responsible for paying the Disputed Charges for a number of reasons. First, as plainly noted on the medical benefits card I presented to the provider prior to receiving treatment, and as further specifically stated on the explanation of payment sent to you with the claim reimbursement from the Plan, **an assignment of benefits under the Plan is only permitted if accepted as consideration in full for services and treatment rendered.** The provider accepted my assignment of benefits under the Plan, billed the Plan directly for payment, and then accepted payment from the Plan. By choosing that option rather than billing me directly under an admissions contract, the provider agreed to be bound by all of the rules and provisions of the Plan. Per the rules and provisions of the Plan, the provider waived the right to balance bill and recover payment from me for those services in an amount in excess of any required deductibles and co-payments or co-insurance on accurate and valid charges. Please note that I am not disputing or refusing to pay the amount of any such deductible, co-payment or co-insurance for which I am responsible under my Plan.

Further, we trust that you have complied, and will comply, with all parts of IRS Regulation 501(r) (26 C.F.R. § 1.501(r)). With respect to eligible patients, the IRS prohibits the use of gross billed charges and limits billing to "not more than the amounts generally billed to individuals with insurance covering that care" (AGB). Providers must calculate their AGB percentages no less than annually. The IRS permits one of two acceptable practices for determining the applicable AGB. The first approved method is the "look-back" method "based on actual past claims paid to the provider by either Medicare fee-for-service only or Medicare fee-for-service together with all private health insurers paying claims to the provider (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals)." In other words, you may only bill the average of Medicare payments or the average of Medicare payments and private insurance payments, not what the provider ***charges*** any patient. The second approved method is the "prospective" method requiring the provider to estimate the amount it would be paid by Medicare and a Medicare beneficiary for the medically necessary care at issue.

Using either method, your calculated AGB will likely be less than what the Plan has already determined to be a fair and reasonable payment for the services rendered. In no case will you be able to collect gross billed charges. Moreover, you will not be able to engage in extraordinary collection actions unless you have made reasonable efforts to determine whether the individual is eligible for financial assistance. Until you provide proof that the provider has complied with these requirements you may not begin extraordinary collection efforts even for the limited AGB.

Please do not contact me again regarding this matter either by phone, email or in writing. If you do not provide a specific explanation supporting and justifying the Disputed Charges, please confirm in writing that you have removed these charges from my account.

Sincerely,

TEST PATIENT NAME

Patient/Guardian Signature _____ Date_____

By my signature above, I acknowledge that I approve and authorize the release of any Protected Health Information (PHI) to Advanced Medical Pricing Solutions. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508(c)(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I have retained a copy of this release authorization in my records and I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to the provider and Advanced Medical Pricing Solutions. Unless so revoked by me, this release will remain in effect and valid for 365 days from date first set forth above.

# Telephone Call Information Form

**Patient**: TEST PATIENT NAME
**AMPS ID:** TEST CLAIM ID
**Date(s) of Service**: TEST DATE OF SERVICE
**Provider:** TEST PROVIDER NAME

**If you receive a call about a provider bill, collect/write down the following information**

Date of call: / / Time of call: : AM☐ PM☐

Who received the call:

Persons relation to you:

☐Self ☐Family Member ☐Friend ☐Employer ☐Co-Worker ☐Other:

Location of received call:

☐Home ☐Work ☐Cell ☐Other:

Have they contacted anyone else prior to calling you: Yes☐ No☐ Not Sure☐

(If "Yes" when and how many times?):

Name, ID#, and Title of Caller:

Who the caller works for:

Who the caller represents:

Callers phone number: (including area code):

Callers mailing address:

Did the call refer to or mention any medical information of any kind: Yes☐ No☐

If "Yes, " please explain:

Did the caller make any threats, harass you, or use obscene language: Yes☐ No☐ Not Sure☐

If "Yes," please explain:

What did the caller say? (Please be as specific as possible):