Understanding
Patient Access

4 Easy Steps to Successful Patient Access

A prior authorization is required by health insurance companies to determine if they will cover a prescribed procedure, service, or medication. The process is intended to act as a safety and cost-saving measure, although they can delay patient treatment and negatively affect outcomes.

Step 1: Collecting Demographic and Insurance Information

Collect accurate information about the patient and their insurance coverage:

- Name, Address, DOB, Contact Information
- Insurance Details, Group and Plan #'s, Coverage Dates, Secondary Coverage
- Double check that information is entered correctly into EMR/Billing Software to create a strong foundation for later billing

Step 2: Verifying Insurance and Benefits Eligibility

Using an automated solution, verify the insurance information electronically prior to each visit, including:

- Insurance Eligibility Dates
- Co-Pays and Co-Insurance Amounts
- Deductibles
- Annual Out-of-Pocket Limits
- In-Network vs Out-of-Network Benefits

Step 3: Obtain Prior Authorizations Through a Real-Time Solution

With only 13% of prior authorizations done electronically, an AI-driven Prior Authorization Software would allow real-time execution, including:

- Determine Necessity
- Collect Relevant Information and Process Request
- Submit to Appropriate Insurance Payer
- Facilitate Efficient Scheduling

Step 4: Use Patient Pay Estimation to Determine Amounts Owed

With an electronic estimation tool, patients can be notified and pay up-to-date amounts owed, including:

- Current Amounts Due
- Any Co-pays and Co-insurance Due
- Deductibles
- Past Balances

With today's advanced automation, the patient access process should be:

- Seamless and Smooth
- Fewer claim denials
- Improved bottom line

Contact Infinx to learn more about a streamlined patient access workflow.

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Source: 2018 AMA Prior Authorization Physician Survey