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Guide to Super Bill

A superbill is a document made for insurance companies that details the services a therapist or health care provider performed for a client. Essentially, it's a receipt for your visit that contains vital information (like diagnosis and procedure codes) needed for *insurance payers to reimburse you* for the services **after you've paid.** Many insurers agree to cover 50 to 80% of the cost of out-of-network services like therapy through co-insurance payments- so don't throw them away!!

"How To" guide to submit a superbill to your insurance

The term Super Bill may be foreign to you, but it is a widely held practice for most specialty clinics. Here are a few things to do as you start the process:

1. Understand your benefits.
The best way to do this is by viewing your plan details on your insurer's website, or by calling your insurance company using the number on the back of your health insurance card. Questions you may want to explore online or over the phone include:

- Do you have out-of-network benefits? If so, what is your out-of-network deductible?
- Have you met your deductible?
- Does your insurance plan cover the specific services you received? Some plans have exclusions to what is covered.
- What is your coinsurance rate, (the portion of the bill that is your responsibility)?
- What percentage does your insurer cover? This is the amount you may be reimbursed.

2. Review the submission instructions on your insurer's website.
In theory, sending a superbill to insurance is exactly what it sounds like, but because insurers hate making things easy for patients, submission protocols differ from one insurance company to another. Sometimes it's as simple as uploading a claim, but some companies want you to fax or mail them. Review your plan's website carefully to make sure you know how to send a superbill to insurance.

3. Double-check your personal information.
Review the information you input on the claim form, especially your insurance ID numbers. More claims get rejected due to simple data errors than you might think.

4. Review the CPT and ICD codes in your superbill.
To be extra thorough, you can double-check the medical coding in your superbill. Medical coding mistakes are one of the most common reasons insurers reject superbill claims.

5. Prepare to refile.
Even if you handle all of the above steps with care, it's still possible your insurer will reject your claim. After all, insurance companies have an army of employees whose sole job is to save the company money. But rejection is **not** the end of the line! You can correct and refile your claims. In fact, you *should* refile if you think you're entitled to the reimbursement. Try thinking of a rejected insurance

claim as the beginning of the process, rather than the end. It's worth it. Depending on your insurance plan, you might be paying up to 80% more for your superbills than you owe.

FAQs and common misconceptions

Superbills are not really bills.

The name superbill is a little misleading. Superbills are more like itemized receipts, issued **after** a service is paid for. They list the names and costs of your health expenses needed to file out-of-network health insurance claims.

When are superbills used?

When a healthcare provider or facility is in-network, it means they accept your insurance. The provider files an insurance claim and the insurer pays the provider directly. This isn't the case for out-of-network services.

When a provider is out-of-network, they don't accept your insurance. The patient pays for the services up front. The patient needs detailed information to submit information to their insurance to file a claim. The insurer then reimburses the patient, not the provider.

Out-of-network providers record the services they provide and the patient's payment into a superbill. This helps the patient submit a claim and get reimbursed. Again, the insurer can only reimburse a patient for services they have **already paid for**.

Can I Still Get Reimbursed for Out-of-Network Care?

Yes! Many patients think that because a provider is listed as OON, they have to pay 100% of the cost themselves. But that's not true—insurance companies just want you to believe it is. Many insurers agree to cover 50 to 80% of the cost of out-of-network services like therapy through co-insurance payments. Check your EOB; your out-of-network benefits might surprise you.

When you factor in the quality and expediency of the care you can get from an out-of-network provider, it might be worth going that route rather than staying in-network with someone who's a bad fit.