Rochelle Community Hospital

Registration & Patient Accounts

Clarifying Questions and Answers Related to Registration and Billing

Question 1:
Why do I need to show my insurance card upon each registration?
Answer 1:
Identity theft is a common problem in the U.S. today. When a patient presents for services with identification, we can help ensure someone else is not stealing your identity. This process also assists us in properly filing your insurance claim for you.

Question 2:
Can I receive medically necessary services at Rochelle Community Hospital if I do not have insurance?
Answer 2:
The hospital will not turn away a patient seeking medically necessary treatment for their inability to pay for services. We have staff that can help identify different programs you may qualify for to assist you in payment resolution.

Question 3:
I've heard of something called Financial Aid, what is that program and how would I apply for it?
Answer 3:
Financial Aid is a program the hospital offers patients who do not have the ability to pay for their services. There is an application process to be completed. Your application is then reviewed against hospital policy and a determination is made. You may qualify for a percent discount or possibly a 100% writeoff of charges. It is a program of last resort. We will work with the patient to see if he/she may qualify for other payment resources first. The application can be downloaded from our website or you may pick one up at the registration or cashier stations.

Question 4:
Do you accept all insurances?
Answer 4:
The hospital will bill all insurances. It is possible that your insurance will not pay benefits or pay a reduced benefit if you seek services out of network. It is the patient's obligation to check with his insurance prior to scheduling a procedure to verify the hospital's in network status.

Question 5:
Why do I continue to receive statements when my insurance has not paid the claim yet?
Answer 5:
We will bill your insurance for you. You will not receive a statement for approximately 60 days after your services. If your insurance has not paid at that time, monthly statements will be generated to you to inform you the claim is not paid. This will assist you when you call your insurance to see why they have not paid. Oftentimes, your insurance is waiting on the patient to answer coordination of benefit questions prior to paying. These are things the patient must supply to his insurance himself.

Question 6:

Who is Health Care Billing Services? When I receive their notice does this mean I have been sent to a collection agency?

Answer 6:

No, they are not a collection agency. Health Care Billing Services (HCBS) is an extension of our patient accounts department. They handle our patient accounts with amounts due from the patient after all insurance monies have been collected. Your subsequent payments can be made directly to their office or ours.

Question 7:

I am a Medicare patient and occasionally when I have lab work, I have to sign something called an ABN. What is this and why do I have to sign it?

Answer 7:

An ABN (Advanced Beneficiary Notice) is a form Medicare requires hospitals to have signed if there is a possibility Medicare will not pay for your services. Generally the services you are receiving are a covered Medicare service, but due to frequency or the diagnosis your physician provided, the hospital may have reasonable doubt that Medicare will pay. Federal regulations require the hospital to inform you that Medicare may not pay and the amount of charges for the services. This allows you to make an informed decision about whether you want to continue with the testing. You may choose not to receive services on the scheduled date and have a further discussion with your physician as to other alternatives.

Question 8:

Some insurance plans require a prior authorization before having tests or procedures performed. How do I know if prior authorization is needed for what the physician wants me to have done?

Answer 8:

Each insurance differs on their prior authorization policies. In fact, the same insurance policy will have different policies for different procedures. The insurance companies require prior authorization to help you make an informed decision. Insurances want to help manage your care. It's possible the insurance's case management team feels there is a less expensive procedure to obtain the results the physician needs to continue your plan of care. It is always best to work with your physician team and contact your insurance prior to having hospital tests or procedures performed.

Question 9:

Who do I call if I have questions about my bills?

Answer 9:

You may call the hospital at 815-562-2181 and ask for the patient accounts department. We employ a team of people who have healthcare billing expertise and can help you get your claim paid.

Question 10:

When I have a procedure done at the hospital, will I also get bills from other providers besides the hospital?

Answer 10:

Depending on what kind of services you receive, you may get bills from other physicians. For example: if you have a diagnostic imaging service (X-Ray, CT, MRI, Mammogram or Ultrasound), you will also receive a bill from the Radiologists. If you have surgery while at the hospital, you will receive a bill from the surgeon and anesthesiologist if one was included in your care. The physician you see in the emergency room will also bill separately for their service. If you are hospitalized on the Medical/Surgical floor for an inpatient, observation or swing bed stay the physician overseeing your care while you are here will also bill separately.