



Non-Covered Services Financial Disclosure Form

Frequently Asked Questions

Q1. What benefit does this process offer me?

A1. Fulcrum wants to help providers collect all appropriate reimbursement, however, not all plans with chiropractic benefits cover all chiropractic services. State and federal laws, as well as the policies of our health plan customers, prohibit providers from seeking financial reimbursement from patients for any services unless appropriate communication has taken place and is documented sufficiently. ChiroCare's Non-Covered Services: Financial Disclosure Form has been developed to support the providers' ability to collect funds for care that is not eligible for insurance coverage due to the patient's phase of care or other benefit exclusions.

Q2. Which patients do we need to have complete a form?

A2. Please use the form to document a patient's agreement to financial liability when rendering services that are not covered by the patient's benefit plan, but will be billed to the patient since you believe they are likely to offer clinical value.

This form may be used when patients have coverage through Commercial, Medicaid, and Medicare Advantage/Cost plans. This would include all patients for whom Fulcrum has clinical oversight, however, it would likely be accepted by other managed care organizations as well. Please review the policies of other Payors to confirm that all their documentation requirements are met prior to implementation for those patients.

Important Note: Fulcrum's form may not be used when treating patients with traditional Medicare coverage.

Q3. I'd prefer to use one form for all patients. Why can't Fulcrum's form be used for original/traditional Medicare patients?

A3. When treating patients with traditional Medicare coverage, the standard CMS Advance Beneficiary Notice (ABN) of Noncoverage (ABN) form must be utilized to document a patient's agreement to pay for non-covered services when such documentation is required.

Q4. What information is required on this form?

A4. Bullets below:

- The provider's demographics at the top (you may use a mailing label if you find that easier)
- Treatment plan start date and treatment plan end date (**Note:** end date cannot be greater than 12 weeks beyond the start date)
- Completion of the Non-Covered Service Table:
 - Populate the cost per visit for all services that you expect will not be covered
 - When populating the Therapies/Modalities and/or DME section, be sure the specific service(s) is either circled or identified in the "Other" space.
 - Calculate the TOTAL cost per visit
 - Have the member initial and date each line, including the TOTAL cost per visit
- The anticipated reason for non-coverage (e.g. phase of care or benefit exclusion)
- A signature of the Provider or authorized health care representative who reviewed the form with the patient.
- The patient's name, signature and date of signature (**Note:** the document must be signed prior to the service being rendered but no more than 12 weeks prior to the billed date of service).

Note: Failure to execute the Form properly, and in its entirety, will result in charges being assigned to provider liability (i.e. the non-covered services rendered cannot be billed to the member).

Q5. Once I've collected a valid Financial Disclosure Form, how long can I use it?

A5. An executed Form is valid for the duration of one treatment plan, up to a maximum of 12 weeks. When completing the Form, it is essential that the Treatment Plan dates be completed and that all services billed to the member be documented on the Form and within the dates specified.