Insurance and emtala act

Question Before a person goes to admit himself in the emergency department, it is important to verify his insurance by considering the insurance information that he has provided (Select Specialty Hospital, 2010). It is important to complete all notification requirements that the patient's insurance company asks for before he gets admitted in the emergency department because by doing so, the insurance company knows what condition the patient is in and what might be his circumstances in the near future. More importantly, doing so helps the hospital authorities to claim and bill the insurance company on the patient's behalf. Thus, all services that are rendered to the patient are billed directly to the insurance company. The patient himself may not be well enough to provide the insurance coverage and know his responsibilities later on during his stay, so doing so prior to admission is very fruitful. Many hospitals these days require the patient to provide his financial information or if he is insured, then he is required to complete his insurance notifications prior to admission. There are certain departments in hospitals that tend to verify the patient's insurance benefits and contact him in case any forms are incomplete. These departments then obtain access to the insurance company in order to let it know that the individual has been admitted to the emergency department. It is also important to follow the insurance company's notifications and requirements about the managed care. Hence, the purpose of completing notifications of the insurance plan is to provide financial assistance to the patient and also to keep the insurance company informed about his medical condition. Question 2 Under EMTALA Act, the hospital is required to provide services to all patients that are admitted to the emergency department irrespective of their financial position. No reimbursement is provided. This Act requires

hospitals to provide emergency services to patients “ including active labor, regardless of an individual's ability to pay” (Centers for Medicare and Medicaid Services, 2010). Patients may also be transferred to another hospital if he is not satisfied with the treatment process or if the hospital is unable to provide necessary stabilizing treatment. The patient may also get discharged if he provides his informed consent. This enables those patients, who are not able to provide enough finances for the expensive diagnoses and treatments in emergency medical conditions, to get them held liable for emergency services. The hospital is required to execute a medical screening examination for the patient; treat the patient; or, have him transferred. However, if a patient comes to the hospital in an ambulance that is not owned by the hospital, this means that he is not presented to the hospital’s emergency department. In that case, he does not hold entitled to EMTALA provisions. Another of the hospital’s requirements is sufficient staff and services. If a patient is presented to the emergency department and the hospital does not have sufficient staffing or services to provide, then it may deny access to emergency services. In short, if a patient is not able to pay for the emergency treatment or is not insured, then he is not asked for reimbursement even if there are no federal funds available for the treatment process. References Centers for Medicare and Medicaid Services. (2010). EMTALA. Retrieved June 21, 2011, from http://www. cms. gov/EMTALA/ Select Specialty Hospital. (2010). Insurance and Billing. Retrieved June 21, 2011, from http://www. selectspecialtyhospitals. com/admissions/Insurance-Billing. aspx