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Medical Bills: Everything You Need to Know About Your Rights

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Acknowledgements

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Your one-stop guide to understand and fight your medical bills

As the cost of health care has grown ever higher, you may find your personal budget strained.

Health care prices are at an all-time high and continue to grow. That means — even if you have health insurance — more medical bills become your financial responsibility. You may find yourself paying for a monthly health insurance premium in addition to an annual deductible, copays, and coinsurance for each visit to the doctor's office or hospital. If you are one of the millions of people in the United States who do not have health insurance, you are forced to pay the full amount of every single doctor's visit, blood draw, or E.R. trip — which is no small thing, considering the average price of a routine doctor's visit is between $300 to $600 alone.

These costs can be devastating to your financial security. In fact, nearly one in 10 people in the U.S. have medical debt. This includes nearly 11 million people who owe more than $2,000 and 3 million people who owe more than $10,000. Black adults (16 percent) report a disproportionate amount of medical debt compared to white adults (9 percent).

Medical debt can lead to home foreclosures, personal bankruptcies, and reduced credit scores. It also has health-related consequences, like delaying a medically necessary treatment due to the cost.

That's why it's so important to learn how to handle your medical bills and use your rights to avoid unnecessary billing charges. In some cases, you may even need to fight an illegal medical bill.

This guide is meant to help you navigate medical bills and other common charges in health care settings — like when you need emergency care, are scheduling care at a hospital, or are faced with unaffordable medical bills. Simply select the subject that applies to you to learn more.

Guides

Guide 1: I Have Health Insurance and Need Emergency Care

Guide 2: I Have Health Insurance and Need to Schedule Hospital Care

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Know Your Rights

If you believe your rights have been violated, or if you are unsure — contact a legal aid organization[1] in your area.

If English is not your primary language, you have the right to request and receive language assistance when receiving health care. You may ask for an interpreter and/or translation of all documents related to your medical services, including medical bills, financial assistance application, and consent forms.

[1] https://www.lawhelp.org/

Guide 1

I Have Health Insurance and Need Emergency Care

In emergency situations, you often don't choose the ambulance or the hospital. That means you may end up receiving care from a provider who is not part of your health insurance plan's network. This is called "out-of-network care."

- Out-of-network care often costs more in copays and coinsurance, and sometimes results in a "surprise medical bill."
- "Surprise medical bills" occur when a patient is billed for the difference between what their health insurer covers and what an out-of-network provider charges. (This is sometimes called "balance billing.")

You have legal protections against emergency room, out-of-network "surprise medical bills" — which are described below.

What if I need emergency transportation?

In an emergency, you may find yourself transported to a hospital in one of two ways:

- An "air ambulance" is a helicopter or airplane equipped with medical equipment and staffed with trained paramedics.
- A "ground ambulance" travels by road.

When you call 911, an emergency dispatcher will send the closest available ambulance, which may or may not be part of your insurance network. Because you don't get to choose the ambulance company — and because requesting an ambulance often means you're preoccupied with your actual emergency — you may be surprised to later receive an out-of-network ambulance bill.

The No Surprises Act[2] is a national law that protects you from out-of-network "surprise medical bills" from air ambulances, *but not from ground ambulances*.

Out-of-network air ambulance transportation

The No Surprises Act protects you from out-of-network "surprise medical bills" for emergency air ambulance transportation. You will only be responsible for paying the total

[2] https://www.cms.gov/nosurprises

amount that would have been charged if that air ambulance was in your health insurance plan's network.

Remember

The air ambulance company cannot send you an out-of-network "surprise medical bill."

Out-of-network ground ambulance transportation

The No Surprises Act does not protect you from out-of-network "surprise medical bills" from ground ambulances. However, as shown in this map, 14 states offer some limited protections from ground ambulance "surprise medical bills."

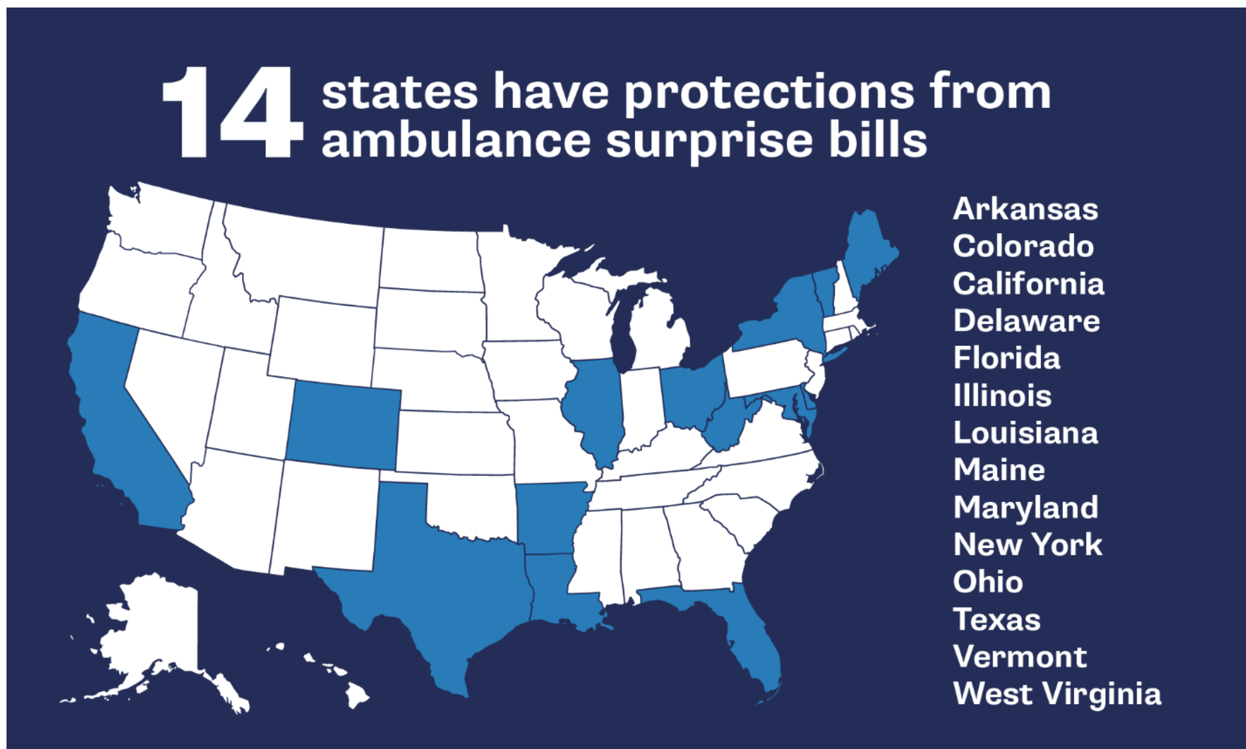

Image courtesy of U.S. PIRG Education Fund

Know the limits of your state's protections

Even if you live in one of these 14 states, the protections are only available for people who are insured by their state-regulated health insurance plans. Call the number on your health plan's insurance card to find out if your plan is regulated under your state's law.

What's more, each of these states offer different types of protections from ground ambulance "surprise medical bills." To learn more about your state's protections, contact your state insurance department[3].

[3] https://content.naic.org/state-insurance-departments

If you do not live in one of these 14 states, you could receive a bill directly from a ground ambulance service if that ambulance is not in your health plan's provider network.

If you receive an out-of-network bill for a ground ambulance service and you can't afford it, you can work with your health insurance plan and the ambulance company — or contact a legal aid organization in your area — to negotiate the cost of these additional charges. Need more help? **Learn how to negotiate to lower your hospital bill.**

What if I need emergency room care?

Emergency care is expensive. This is especially true if you end up in an emergency room that is not in your health insurance plan's network.

- If you are experiencing a medical emergency, visit the nearest E.R. as quickly as possible — regardless of whether it is in your health insurance plan's in-network hospital system.
- When patients are transported by any type of ambulance, they cannot choose which emergency room the ambulance brings them to.
- Your health is the priority, and you have rights that will help to protect you against potential out-of-network costs.

Avoid urgent care centers

Urgent care centers, which are prevalent across the U.S., are not included in No Surprises Act's list of eligible emergency care facilities — even if they are located near a hospital. That means if you visit an urgent care center, you are not protected against "surprise medical bills."

Protections from out-of-network emergency room visits

The No Surprises Act protects you from "surprise medical bills" when you receive treatment for an emergency in an out-of-network emergency room and/or from out-of-network emergency room doctors. These protections apply to emergency rooms that are either: part of a hospital; independent, free-standing emergency departments; or behavioral health crisis facilities that are licensed to provide emergency care.

- Through No Surprises Act's protections, you will only owe the out-of-pocket costs that *would have been* charged if that emergency room and its physicians were in your health insurance plan's network. These costs also count toward your annual deductible.

- The emergency room and its physicians cannot send you a balance bill. Furthermore, no one can ask you to sign a consent form to waive your out-of-network "surprise medical bill" protections in an emergency room.
- Health insurance plans cannot deny coverage for emergency care if you are deemed reasonable in thinking that you need immediate attention from health professionals.

How long does the No Surprises Act protect me against "surprise medical bills"?

If you are treated for an emergency at an out-of-network hospital, you are protected from "surprise medical bills" under the No Surprises Act.

However, after the medical emergency is over, those billing protections end. This can even occur WHILE you are still in the hospital. In this circumstance, you will be asked to either consent to out-of-network billing, or you will be asked to leave the hospital and seek further services at an in-network health care facility.

Consenting to out-of-network care

You cannot be asked to leave the out-of-network hospital or to consent to the additional out-of-network charges UNLESS your doctors determine that:

- You do not need emergency medical transportation to get to an in-network health care facility.
- The in-network facility is within a reasonable travel distance, considering your medical condition.
- The in-network facility has an available bed for you to use after they admit you.
- You are well enough to understand the reasons why you must transfer to a new hospital and are able to give consent.

You will be given a consent form that looks like this one: sample notice and consent form (PDF).[4] Do you have questions about consent forms? Use this explainer[5].

[4] https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf
[5] https://www.cms.gov/files/document/nosurpriseactfactsheet-health-care-notice-consent-form508c.pdf

What do I do if I receive an illegal "surprise medical bill"?

If you receive an out-of-network "surprise medical bill" from an air ambulance company, emergency room or emergency doctors, follow these steps:

STEP ONE: Contact both your health insurance plan and the health care provider (such as the out-of-network hospital or the air ambulance company) immediately to say: "I believe I have received an out-of-network bill that is illegal under the No Surprises Act. I do not owe more than my in-network amount on this bill." Then ask the health care provider or the insurer to send you a written or emailed confirmation that you do not owe the amount of the out-of-network "surprise medical bill."

STEP TWO: File a complaint online or call 1-800-985-3059. Even if you have gotten the company to stop its collection efforts on an illegal bill, it is important to notify the government of companies that are violating the law. After you file a complaint, you will receive information about when to expect a response.

Guide 2

I Have Health Insurance and Need to Schedule Hospital Care

Health care can be expensive. When you have health insurance and need to schedule hospital care, there are some things you can do to lower the amount that you will have to pay out-of-pocket.

What do I have to pay for if I have health insurance?

When you have health insurance, charges fall into different categories. Here are the terms to know.

Monthly Premium

This is the amount that must be paid every month to maintain your health insurance. Some employers pay all or part of your monthly premium.

Deductible

This is an annual amount that you must pay for health care services that occur *before* your insurance starts to cover your costs. The amount that you pay in copays and coinsurance (see below) do not count toward your deductible.

For example: Your annual deductible is $2,000. The first time you visit a doctor that year costs $1,500. You are responsible for the full amount of that bill: $1,500. If you need additional medical care that same year, you still have to reach the deductible amount — in this case, $500 more to hit $2,000 total — before your insurance starts to pay its share. Once you've paid $2,000 in medical bills that year, you have "met your deductible." Now insurance starts to cover your health care bills — except for copays or coinsurance (see below).

Copay

This is a set amount ($10, $25, etc.) that you must pay for certain appointments and services, such as a doctor's check-up or bloodwork.

Coinsurance

This is an *additional* out-of-pocket cost that some insurers require you to pay (for particular appointments and services) *after* you have met your annual deductible. The amount of coinsurance you pay is based on a percentage of the amount billed for the provider.

For example: If your bloodwork cost $400 and you have 10% coinsurance, you will be asked to pay $40 — in addition to your copay.

Out-of-Pocket Maximum

Most plans have an out-of-pocket maximum, which is the most you have to pay in medical costs during your insurance policy's year. Deductibles, copays, and coinsurance count toward your out-of-pocket maximum. Note that your monthly premium payments do not count toward your out-of-pocket maximum.

For example: If your plan has a $5,000 out-of-pocket maximum, you can add up all the amounts you paid in copays, coinsurance, and deductibles. If those expenses add up to $5,000, your insurance will begin to pay 100% of any additional medical care covered by your insurance until it is time to renew your insurance for the next 12 months.

Essential care coverage

Most plans fully cover the cost of preventive care, meaning you won't even owe a copay. Check with your health insurance plan to be clear what kind of care, screenings, and vaccines it covers with no out-of-pocket cost to you.

How do I lower my out-of-pocket costs?

Get your care from in-network providers

You will pay less out-of-pocket if you choose a doctor and hospital that are part of your health insurance plan's network. Most health insurance plans have a list of in-network doctors and hospitals on their website. You can also call the number on the back of your insurance card to get help finding an in-network provider.

- When you choose a doctor and hospital in your health insurance plan's network (also known as an in-network provider), you only have to pay your in-network copay, coinsurance, and any remaining amount of your deductible.
- If you choose a doctor or hospital that is NOT part of your health insurance plan's network, you end up paying more:
    - Your copay is often higher. For example, if you normally pay a $10 copay, you may have a $25 copay for an out-of-network provider.

    - Your coinsurance percentage is higher. For example, if you normally pay 20% of your health care charges for an in-network doctor, you may have to pay 40% for an out-of-network doctor.
    - You may receive a “balance bill.” This is the difference between what your health plan’s insurer covers and what an out-of-network provider charges. (Also known as “balance billing.”) Some out-of-network providers are allowed to send you a balance bill — any amount of their bill that your health insurance plan did not pay. (You may have some protections from balance bills[6].)
    - Any amount paid to an out-of-network provider *does not count* toward your deductible.
- In certain cases, you may have a health insurance plan (like an HMO) that will not cover ANY out-of-network care. If you have this type of health insurance plan and receive out-of-network care, you will have to pay the FULL amount of an out-of-network provider’s bill. If you are unsure about your plan’s out-of-network policies, call the number on the back of your health insurance plan’s card for more information.

Sometimes, it is hard to find an in-network provider. Here are some tips:
Health insurance companies have an extensive list of doctors and providers who are in their network. However, if a doctor — or even an entire hospital — *leaves* an insurance network, the health insurer’s network directory may not be updated immediately. That’s why it’s essential to double check to make sure you have chosen a doctor, laboratory, imaging service, or hospital in your health insurance plan’s network.

- If you use your insurer’s online network directory to choose a doctor, take a screenshot of the page that lists your doctor as in-network. Keep this image as a record so you can prove that you relied on information on your health insurance plan’s website.
- When scheduling your appointment, ask to make sure the doctor or hospital is still part of your insurance network.

  ASK
  “Are you part of my insurance network?”

  DO NOT ASK
  “Do you take my insurance?” Some providers who are out-of-network will say they “take” your insurance — but what they mean is that they will bill your insurance. This isn’t the same thing as being “in network.”

[6] https://pirg.org/edfund/articles/patient-guide-surprise-medical-billing-protections-you-can-use-now/

What if I get a bill from an out-of-network provider?

Sometimes, even if you carefully choose an in-network doctor and hospital, you may still receive care from an out-of-network health care professional. The No Surprises Act[7] is a federal law that protects you from out-of-network "surprise medical bills" — even in non-emergency situations at an in-network hospital.

Be careful with forms

Some out-of-network doctors are allowed to ask you to sign a "Surprise Billing Protection Form,"[8] which allows them to bill you for out-of-network services that aren't covered by your health insurance plan. This form might be in the stack of paperwork you are given when scheduling your care. The form *must include an estimate* of what that treatment will cost for that out-of-network doctor or service. **Do not sign** this form unless you agree to the terms and are willing to pay more for out-of-network services.

Keep in mind

- You always have the right to ask for an in-network doctor if you are at an in-network health care facility. You should never be pressured to sign a "Surprise Billing Protection Form." If you felt pressured to sign this form, file a complaint[9] or call 1-800-985-3059.
- You should NEVER be given a "Surprise Billing Protection Form" if you're being treated for an emergency.
- If you sign this form, you're giving up your No Surprises Act protections[10] from expensive "surprise medical bills." Your signature means that you agree to allow your out-of-network provider to bill you for any services your health insurance plan won't cover.

Who can ask me to sign a "Surprise Billing Protection Form"?

There are two common scenarios where you may be asked to sign a "Surprise Billing Protection Form": 1) when you are scheduling hospital care, such as a surgery, or 2) when you're already in the hospital and you need some type of unexpected care.

- For care that is scheduled for the same day, the form should be provided *at least 3 hours* before a procedure.
- For all other scheduled care, you must be given the form *at least 72 hours* before a scheduled procedure.

[7] https://pirg.org/articles/patient-guide-surprise-medical-billing-protections-you-can-use-now/
[8] https://www.cms.gov/files/document/notice-and-consent-form-example.pdf
[9] https://www.cms.gov/nosurprises
[10] https://pirg.org/articles/patient-guide-surprise-medical-billing-protections-you-can-use-now/

For example: You are scheduling surgery for a hip replacement with your specialist who operates at a nearby hospital. That specialist — in this case, a surgeon in charge of your procedure — may be an out-of-network provider. That surgeon may ask you to sign a "Surprise Billing Protection Form" in advance of the surgery. The form must include a cost-estimate of what you will owe. It must also be provided at least 72 hours before your hip replacement surgery. If you sign the form, you are consenting to paying the out-of-network balance bill. If you do not consent to care from an out-of-network surgeon, request to be treated by an in-network surgeon and do not sign the "Surprise Billing Protection Form."

These providers are *not allowed* to ask you to sign this form:

- Emergency rooms or E.R. physicians (because E.R. care is protected against "surprise medical bills")
- Assistant surgeons
- Anesthesiologists
- Radiologists or imaging services at an in-network hospital
- Hospitalists
- Intensivists
- Pathologists
- Neonatologists

If you are asked to sign the form by any of these providers or their staff while you are receiving emergency care, **DO NOT SIGN** the form. Report this violation immediately: Call the No Surprises complaint line at 1-800-985-3059 (8 a.m. to 8 p.m. ET) or file a complaint online[11].

Are there other fees I should ask about?

Be aware of "facility fees"

Some health care facilities charge "facility fees," in addition to regular bills for medical services. Facility fees are often charged at hospitals — including emergency rooms and outpatient centers — or at clinics and doctor's offices that are owned by a local hospital. These offices may look like a regular doctor's office, so be on alert.

Sometimes health insurance plans don't cover facility fees, or they only cover part of a facility fee. Call the location where you plan to receive care and ask if you will be charged a facility fee. If the answer is "yes," call your insurance company to see if they will fully cover this expense. If your insurer will not fully cover a facility fee, ask your doctor or your insurer to help you to find an alternative location that won't charge these added fees.

[11] https://www.cms.gov/medical-bill-rights

Ask about equipment costs and any follow-up care
Sometimes you need additional care or medical equipment after your treatment. Make sure to ask your provider about medical equipment you may need after your treatment, such as crutches or a wheelchair. If you do not need the equipment, you do not have to take it, even if it's offered by your provider.

If you are unsure of whether or not you either need medical equipment — or if that equipment is covered by your insurance — ask the health care worker who is discharging you to verify if medical equipment and/or follow-up care is necessary as well as its associated out-of-pocket costs. Remember, your provider or caretakers are there to help YOU. Lean on them to help you navigate the system.

If your insurance coverage is insufficient, ask your health insurance company for ways you can keep equipment or follow-up care costs at a minimum.

Can I know my health care costs before I receive care?

Yes! Ask for an "advance explanation of benefits"
For any care that is scheduled in advance — like a colonoscopy or non-emergency surgery — you may ask your health insurance plan to provide an estimate of what you will owe. This is referred to as an "advance explanation of benefits." The plan may provide this estimate in writing, but they are not required to.

If you get an estimate, be sure to compare it with the Explanation of Benefits (EOB) that you receive *after* you receive your scheduled care. Ask your health insurance plan to explain anything that does not match up.

Guide 3

I Am Uninsured and Need Medical Care

If you are uninsured or "self-pay" (or not planning to submit your medical bills to a health insurance company), it can be helpful to know what you will be charged for your medical care.

- The No Surprises Act[12] gives patients important tools to know what their medical costs will be, *before* they get treatment.
- You may also ask to be screened for hospital financial assistance programs or public health insurance coverage.

Can I know my health care costs before I receive care?

Ask for a "good faith estimate" and keep it in a safe place

Providers must use a form similar to this one[13] and provide expected costs for treatment in writing. The form must include the provider's name and list the services included in the estimate — including the billing codes for each treatment, medication, laboratory test, or medical services. It must list a total amount and an itemized breakdown of what you will owe for each expected service and/or medical treatment.

For example: Request a "good faith estimate" for things like a pre-surgery checkup or post-surgery physical therapy. Also ask if the surgeon's estimate includes the cost of the anesthesia and the anesthesiologist.

Quick tip

You will likely need to ask for a *separate* "good faith estimate" from each doctor and each health care facility to better understand the entirety of expenses related to your care. A "good faith estimate" is *not* a contract and does not obligate you to use those doctors and/or hospitals.

[12] https://www.cms.gov/medical-bill-rights
[13] https://www.cms.gov/files/document/good-faith-estimate-example.pdf

Providers must provide a "good faith estimate" within a certain amount of time
If you do not have insurance or are "self-pay," you can ask your doctors and hospitals for a "good faith estimate" at any time — even if you aren't ready to schedule your treatment.

If you request a "good faith estimate," your provider must provide one, in writing, within three business days after your request. Getting a "good faith estimate" is one way to shop around for costs from different providers. If you delay your care for more than a month, check back in with that provider to make sure the "good faith estimate" is still accurate.

When you are ready to schedule care, doctors and hospitals must provide a "good faith estimate" in writing:

- Within one business day: if the care scheduled is within the next three to nine days.
- Within three business days: if the care scheduled is at least 10 days in advance.

Make sure your "good faith estimate" contains your name and address, your provider's name and address, billing codes, and a plain-language explanation of the treatment and estimated price you are expected to pay.

Were you denied a "good faith estimate"?
If you do not receive the "good faith estimate" that you are entitled to by law, contact the No Surprises Help Desk[14] online or call 1-800-985-3059.

What should I do after I receive a medical bill?

- Open your bill(s) immediately.
- Be sure you understand the charges. If you don't, call the facility's billing department for an explanation of anything that is confusing. Billing departments and insurance companies can make mistakes — so if something doesn't look right, it's good to check. Keep notes of your conversation: include the date, time, name of the person you're speaking with, and what they tell you.
- Save all bills and documents from your provider and health insurance company, and keep them together in the same, easy-to-find place.
- Mark the due date for your first payment on your calendar to help you remember to send your payment on time. (Late fees may be charged otherwise.)
- Compare each "good faith estimate" with your final bills. If the bill is $400 or more than the "good faith estimate," you can dispute your bill. (**Learn how to dispute your bill.)**

[14] https://www.cms.gov/medical-bill-rights

Are you unsure about a bill?
If you think you've been sent a bill you should not have to pay, file a complaint with your state attorney general's office[15] or consult your local legal aid office.[16]

How do I dispute bills that are $400 or more than the "good faith estimate"?

Start by contacting the doctor or hospital to notify them that they have sent you a bill that is $400 or more than the "good faith estimate." Then ask them to adjust the bill to the amount in the "good faith estimate."

If the provider does not lower the bill, you have a right to use the Patient-Provider Dispute Resolution[17] system. Here are some additional tips[18] to understand whether you can dispute your bill.

If you officially dispute a bill:

- You must file within 120 days (about 4 months) of the date of your first medical bill.
- You must submit a copy of the bill and the "good faith estimate."
- You must pay $25 to dispute the bill. If you win the dispute, this fee will be returned to you as a $25 credit toward your medical bill.

How do I "officially" dispute my bill?
You may start a dispute online[19] or by mail or fax[20]. Once you do so, you have entered what's called the "Patient-Provider Dispute Resolution" period.

Under the No Surprises Act, your doctor or hospital is prohibited from sending your medical bills to collection agencies during the Patient-Provider Dispute Resolution period. During this time, check your credit report[21]. If you see the medical bills from an ongoing Patient-Provider Dispute Resolution listed on your credit report, submit a complaint online[22] to the Consumer Financial Protection Bureau or call 855-411-2372.

At the end of the Patient-Provider Dispute Resolution, if you still have an unaffordable medical bill, ask to be screened for the hospital's financial assistance program. **DO NOT**

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[15] https://www.naag.org/find-my-ag/
[16] https://www.lawhelp.org/
[17] https://www.cms.gov/medical-bill-rights
[18] https://www.cms.gov/files/document/nsa-provider-dispute-examples.pdf
[19] https://nsa-idr.cms.gov/billdisputes/s/
[20] https://www.cms.gov/files/document/billing-dispute-initiation-form.pdf
[21] https://pirg.org/articles/how-make-sure-your-credit-reports-dont-include-paid-medical-debt-0/
[22] https://www.consumerfinance.gov/complaint/

sign up for a medical credit card or medical loan. (**See Guide 5: I Am Unable to Pay for My Care Up Front.**)

For a deeper dive
Learn more about your rights to dispute a bill[23].

[23] https://www.cms.gov/medical-bill-rights

Guide 4

I Received a Medical Bill I Cannot Afford to Pay

What can I do about my expensive medical bill?

First, check your bill to make sure it is correct:

- Verify the name and address on the bill. Is this your bill? If it is, review the bill carefully.
- Be sure your bill lists the details of *all* charges. If not, request an "itemized bill" from the health care facility and/or the providers who treated you.
- Check the list of charges and make sure you recognize all the types of care on the bill. Billing departments and insurance companies can make mistakes, so follow up if something does not look right.
- If you do not understand your bill, call the billing office or your health insurance plan to ask questions.

If you call your health insurance plan or a billing office
Keep notes of your conversation: include the date, time, name of the person you're speaking with, and what they tell you. Save all bills and documents from your provider and health insurance plan, and keep them together in the same, easy-to-find place.

Did you know?
Many hospitals provide financial assistance to patients who cannot afford to pay for their care. Before you pay for anything, ask if you are eligible for a free or discounted care program. **DO NOT** sign up for a medical credit card or a medical loan.

If you have insurance
Make sure you are looking at the bill, not the "Explanation of Benefits" (EOB). Usually, an EOB arrives *before* the medical bill itself. An EOB is *not* a bill. An EOB is a summary of the care that you received and shows the amount your insurer is billed, how much your insurance will pay for that care, and the amount that you will owe.

If you do not have insurance
If the bill is $400 or more than the "good faith estimate," ask your provider to adjust the bill to the amount in the "good faith estimate." (**See Guide 3: I Am Uninsured and Need Medical Care to learn more.**)

What should I do if the medical bill looks incorrect?

Providers and insurance companies can make mistakes when billing patients. That means you could get billed more than you should. Here are some common types of mistakes on medical bills.

Improper charges for services or medicines you did not receive

This error can happen to anyone. Call the billing office to tell them and report the errors to your health insurance plan. Make sure to call the phone number on the back of your health plan's insurance card and ask to speak with their "fraud department" to dispute the charges included in your bill.

Insured patients may encounter other common errors — including, but not limited, to billing errors, improper claim denials, and illegal "surprise medical bills"

Billing errors

Compare your bill with your Explanation of Benefits (EOB). If they don't match up, call your health insurance plan to find out why.

Denied claims

A denied claim happens when your health insurance plan refuses to pay for a service that you received, so the provider charges you for the full amount of that service. If you believe that your health insurance plan has mistakenly denied a claim, you can appeal that denial of coverage[24] with your health insurance plan. Instructions on how to start an appeal should be listed on your Explanation of Benefits (EOB). Otherwise, call the phone number on your health insurance plan's card.

Surprise medical bills

Your bill may include illegal "surprise medical bills" [25]from an out-of-network provider. Under the No Surprises Act, many providers who are not in your insurance network are not allowed to bill you. You may only have to pay your normal in-network costs (deductible, copay, coinsurance).

For more information, see **Guide 1: I Have health insurance and Need Emergency Care** and **Guide 2: I Have Insurance and Need to Schedule Hospital Care.** Learn how to dispute illegal bills under the No Surprises Act below.

Not billing insurance first

Sometimes your health care provider sends a medical bill to you *before* the insurance

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[24] https://www.healthcare.gov/appeal-insurance-company-decision/
[25] https://www.cms.gov/medical-bill-rights

company has made its portion of the payment. If happens to you, call your insurer to see if it has made payments to the provider. Then, ask your provider to send you an updated bill that reflects the amount due *after* your insurer has paid.

Are you unsure about a bill?
If you think you've been sent a bill you should not have to pay, and can't get your health insurance plan or the health care provider to fix it, file a complaint with your state attorney general's office. [26]Your local legal aid office[27] may be able to help as well.

How do I fight an illegal, out-of-network "surprise medical bill"?

For detailed information on how to fight an out-of-network "surprise medical bill," see **Guides 1 and 2**.

The No Surprises Act[28] protects people with health care insurance from extra charges from certain out-of-network providers in particular situations.

You should **never** receive a surprise out-of-network bill if:

- You receive medical care at an emergency room (E.R.)
- You are transported by air ambulance (airplane or helicopter)
- You receive scheduled care at health care facilities in your health insurance plan's network.

In these situations, you should only pay what you would normally pay as a copay, coinsurance, or toward your deductible. The out-of-network provider cannot send an additional bill.

If you have received an illegal, "surprise medical bill" from an out-of-network provider, follow these steps:

STEP ONE: If you have received an illegal, "surprise medical bill" from an out-of-network provider, immediately notify your health insurance plan. If your health insurance plan does not resolve the situation for you, contact the provider who sent the bill and tell them they have sent you an illegal, "surprise medical bill."

[26] https://www.naag.org/find-my-ag/
[27] https://www.lawhelp.org/
[28] https://pirg.org/articles/patient-guide-surprise-medical-billing-protections-you-can-use-now/

STEP TWO: If the provider still demands payment, file a complaint[29] at the government's No Surprises Help Desk or call 1-800-985-3059. Language support is available if you need help filing your complaint.

STEP THREE: Check your credit report to make sure your bill was not sent to collections. It should NOT be listed on your credit report. Here is how[30] to check.

What if I already owe my hospital money? Can I still get care?

If you need emergency care, any hospital must accept you as a patient and treat you[31] for that emergency — even if you have a bill that you haven't paid.

However, if you do not need emergency care, a provider may refuse to treat you if you have an outstanding bill with them.

[29] https://www.cms.gov/medical-bill-rights
[30] https://pirg.org/edfund/articles/how-make-sure-your-credit-reports-dont-include-paid-medical-debt-0/
[31] https://www.cms.gov/files/document/emtala-know-your-rights.pdf

Guide 5

I Am Unable to Pay for My Care Up Front

You may have done everything right — working to get a "good faith estimate" or making sure your care is in-network — but your health care provider still requests you to pay for your bill, or a portion of it, up front. Increasingly, this may occur even before you are able to receive care.

Even so, you can try to negotiate with your provider to lower the amount you have to pay up front and/or in total. Some hospitals or community organizations have patient advocate departments to help you negotiate to apply for hospital financial assistance program, set up a no-interest repayment plan, or lower your bill.

Apply for a hospital financial assistance program

It is never too late to see if you're eligible for financial assistance. Many hospitals, especially non-profit hospitals, provide financial assistance programs in the form of free care (also called "charity care") or discounted care to uninsured and insured people. Hospital financial assistance policies are usually posted on the hospital's website. You may also call the billing office to ask for more information.

Explain your financial situation and ask if you can speak to someone about whether you are eligible for financial assistance. Be respectful and patient, but ask clearly for the help you need. Don't take "no" for an answer.

If you need help applying for financial assistance, contact Dollar For[32]. You may also contact a legal aid organization in your area[33] for assistance.

Work out a payment plan

If you don't qualify for financial assistance, work *directly* with your doctor or hospital on a repayment plan. Sometimes, if you offer to pay a portion of your bill right away, they will offer you a discount. Many health care providers offer low- or no-interest repayment plans over several years.

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[32] https://dollarfor.org/
[33] https://www.lawhelp.org/

Get it in writing
Make sure to get these payment agreements in writing. In some states, certain health care providers may be *required* to develop reasonable payment plans to ensure affordability for patients.

For example: In Colorado, hospitals are banned from billing low-income patients more than 4% of their monthly income each month and, if the patient has made 36 payments, the hospital has to forgive the remaining amount and consider the bill paid in full.

Negotiate to lower your bill

You may be able to negotiate to get a discount. For example, tell the hospital that you cannot afford the full cost and ask what they normally bill insurance companies or what Medicare pays. Ask if you can pay that lower amount. Don't take "no" for an answer. Be polite but persistent. If you need to, ask if there is someone else you can talk to. Express your willingness to pay, but explain what your limits are. *If they agree on a discounted price, get the agreed-upon price in writing.*

Tips for repayment plans
After you have settled on a price, ask if you can set up a no-interest repayment plan over 24-30 months. If the provider agrees to a payment plan, get it in writing and make sure it includes language stating that you *will not* be charged interest, late fees, or other penalties. Sometimes, the provider may pressure you to sign up for a medical credit card or medical loan to pay your bill. DO NOT give in.

If you are late in paying your medical bill, offer to make a payment today — and ask if they can waive the late charges and any interest accrued.

Avoid using a credit card to pay for your medical bills

Some doctors and hospitals ask for a credit card up front. You do not have to provide your credit card number, but be aware that the provider may not agree to treat you. Instead, find another provider willing to treat you without taking your credit card information in advance.

Three reasons why should not use a credit card to pay for your medical bills

1. You lose the ability to negotiate
As soon as you pay with a credit card, the doctor or hospital has no reason to negotiate the amount of the bill because they have already been fully paid. If something happens that makes it difficult to pay off your credit card debt, you won't be able to work out a no-interest payment plan with the hospital or doctor.

Instead, you will be stuck paying late charges and high interest to your credit card company.

2. Late fees and high interest rates can make your medical bill even more expensive
If you don't have enough money to pay off your medical bill in full right away, setting up a no-interest payment plan with your provider will be less expensive than the potential interest and late charges associated with your credit card.

3. You could lose your medical debt protection rights
Some federal and state laws offer stronger consumer protections for medical debt than for credit card debt. However, if you pay your medical bill with a credit card, you lose those medical debt protections.

For example: Federal law prohibits credit bureaus from adding medical debt to your credit report until payments are past due for one year. But that protection does not apply if you paid for the medical bill with a credit card.

Avoid signing up for medical credit cards or medical loans

Some health care providers, including dentists and eye doctors, offer medical credit cards or medical loans to patients who don't have insurance coverage or can't afford to pay for treatments.

These medical financing schemes are marketed toward patients, and are increasingly being used to finance the payment of medical coinsurance and copayments. Many of these products contain introductory or deferred-interest features during a promotional period, which may seem very appealing. However, if you cannot afford to pay off entire balance in full by the end of the promotional period, these financing products can become a debt time bomb, as you may be subjected to significant and unexpected interest expenses, which are calculated at extremely high rates.

What's the difference between medical credit cards and medical loans?

Medical credit cards
Many medical and dental providers offer medical credit cards for patients to finance care. Once a patient signs up for a medical credit card, the patient can use the card repeatedly until reaching the credit limit.

- Medical credit cards are primarily offered through three financial companies: CareCredit, a subsidiary of Synchrony Financial; Wells Fargo; and Comenity, a subsidiary of Bread Financial.
- Many medical credit cards are "deferred interest" credit cards, which often harm the most financially vulnerable patients.
- Deferred interest credit cards are often advertised as "no interest" or "0% interest" for a specified time period, such as 12 or 18 months. If the patient pays off the full balance before the end of the promotional period, the patient will pay no interest on the purchase.
- However, if any portion of the balance remains after the promotional period, interest is assessed on the entire purchase, going back to the original purchase date. This includes interest on amounts that have already been paid.
- Patients who pay deferred interest pay significantly *more* interest than they would have paid if they had used another credit card. This is because the interest rate on deferred interest credit cards is much higher than the interest rate on most general-purpose credit cards.
- Between 2015 and 2020, about one in five health care purchases with a deferred interest product were *not* paid off by the end of the promotional period. Deferred interest was assessed on these purchases.
- On average, patients who are not able to pay off their purchases by the end of the promotional period pay an additional 23 percent of the purchase price in interest charges.

For example: A patient pays for a $2,500 medical bill using a one-year deferred interest plan and pays off all but $100 by the end of the year. The next bill will include interest on the entire $2,500, dating back one year. If the interest rate is 25%, patient will owe nearly $400 in interest fees.

Medical Installment Loans (also called Care-Now-Pay-Later Loans)

- Some medical providers offer installment loans, which allow the patient to split the cost of treatment into separate payments over time.
- Medical installment loans are offered through companies such as AccessOne, Prosper, PayZen, and Walnut.
- Medical installment loans differ from medical credit cards in that they are typically offered *before* a treatment, and they are only authorized to cover the cost of that treatment.
- Some medical installment loans have zero interest or low interest. Other medical installment loans have interest at the market rate or higher, depending on the patient's credit risk.
- Some medical installment loans have deferred interest terms. As noted above, deferred interest financing often harms the most financially vulnerable patients.

Guide 6

My Unpaid Medical Bill Was Sent to a Collection Agency

What happens if I don't pay my medical bill?

If you don't pay your medical bill, the provider can sue you for payment or sell your debt to a collection company. If you fail to pay your bills, it can also hurt your credit score. However, some states have laws that prohibit health care providers from using certain collection practices against patients to collect unpaid medical bills.

People with a low credit score can have difficulty renting an apartment, or buying a car or house. In some cases, it can even keep you from getting a job.

If you have done everything you can to lower your medical bills (**see Guide 4**), you should seek out trustworthy debt counseling[34] to help you sort out your debt issues. Be wary of scams. You can also use Dollar For's debt forgiveness tool[35] to see if you can qualify to get a medical bill reduced, or eliminate it entirely.

A note of caution about credit cards

If you charge your medical bills to your credit card, it will be tagged as a credit card debt. As a result, you will lose any protections you may have from collecting on medical bills. Try to avoid this!

Dive deeper

Learn more about existing medical debt protection laws[36] in your state. You may also reach out to a legal aid organization[37] in your area for assistance.

What should I do if a debt collector contacts me about an unpaid medical bill?

Debt collectors are allowed to contact you to collect on the bills you owe and are allowed to sue you to recover the money. If they win the lawsuit, they can garnish your wages

[34] https://www.consumerfinance.gov/ask-cfpb/what-are-debt-settlementdebt-relief-services-and-should-i-use-them-en-1457/
[35] https://dollarfor.org/debt-forgiveness/
[36] https://staging-i4j.theoryandprinciple.com/
[37] https://www.lawhelp.org/

(taking some of your paycheck every pay period until the debt is paid) or put a lien on your home.

But debt collectors must follow certain rules. For example, they must verify that the debt belongs to you. And if you are disputing an illegal surprise medical bill, they cannot ask you to pay until your dispute is finalized. They are limited in how often they can contact you. Know more about your rights against debt collectors.[38]

If you feel your rights are being violated, seek help from the Consumer Financial Protection Board:

- Problems with debt collectors[39]
- Problems with credit reporting agencies[40]

What to ask debt collectors

Debt collectors cannot harass you to pay a debt that is not yours. Ask debt collectors to give you details about exactly what bill is being collected — including the name of the business that says you owe them money and the amount that you owe. Be careful of debt collection scams.

If you believe you received an illegal surprise medical bill for out-of-network services, contact the No Surprises Help Desk online or call 1-800-985-3059 (8 a.m. to 8 p.m. ET).

If you feel your rights are being violated, seek help from the Consumer Financial Protection Board:

- Problems with debt collectors[41]
- Problems with credit reporting agencies[42]

How does medical debt impact my credit score?

Owed medical debt can be reported to credit bureaus one year after you first miss a payment. Medical debt can lower your credit score, which can hurt your ability to get loans. Unpaid medical debt stays on your credit report for seven years.

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[38] https://www.consumerfinance.gov/about-us/blog/know-your-rights-and-protections-when-it-comes-to-medical-bills-and-collections/
[39] https://www.consumerfinance.gov/complaint/
[40] https://www.consumerfinance.gov/ask-cfpb/how-do-i-dispute-an-error-on-my-credit-report-en-314/
[41] https://www.consumerfinance.gov/complaint/
[42] https://www.consumerfinance.gov/ask-cfpb/how-do-i-dispute-an-error-on-my-credit-report-en-314/

In 2022, a voluntary policy was announced by the three major credit bureaus (Equifax, Experian, and TransUnion) to prevent some medical debt from being listed on your credit report and factored into your credit score:

- Paid medical bills should no longer be included on credit reports.
- Unpaid medical bills cannot be listed until the bill has not been paid for at least 12 months.
- Medical bills for $500 or less should no longer be included on credit reports.

If your credit report contains any these forms of medical debt, follow these instructions[43] to dispute any errors.

If you feel your rights are being violated, seek help from the Consumer Financial Protection Board:

- Problems with debt collectors[44]
- Problems with credit reporting agencies[45]

How can I check my credit report?

Request a free copy of your credit report from annualcreditreport.com[46] or by calling 1-877-322-8228. You are allowed to request a free report from each of the three major credit bureaus (Equifax, Experian, and TransUnion) once per year.

Look closely at your report to make sure the information is correct. Medical debt will generally appear in one of two places:

- Check the "Account Information" or "Collections" section of the report.
- Check the section that "flags" new debt.

The following types medical debt should not be listed on your credit report or factored into your credit score:

- Paid medical bills.
- Unpaid medical bills unless the bill has not been paid for at least 12 months.
- Medical bills for $500 or less.

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[43] https://pirg.org/articles/how-make-sure-your-credit-reports-dont-include-paid-medical-debt-0/
[44] https://www.consumerfinance.gov/complaint/
[45] https://www.consumerfinance.gov/ask-cfpb/how-do-i-dispute-an-error-on-my-credit-report-en-314/
[46] https://www.annualcreditreport.com/index.action

If your credit report contains any these forms of medical debt, follow these instructions[47] to dispute any errors.

Watch out for scams
Other sites may offer a credit report, but they may ask for a fee, show you ads, or could be an outright scam to steal your personal information[48].

If you feel your rights are being violated, seek help from the Consumer Financial Protection Board:

- Problems with debt collectors[49]
- Problems with credit reporting agencies[50]

How can I improve my credit score?

It's not easy to improve your credit score on your own. However, some non-profits can help you repair your credit score. Use a reliable source such as the National Foundation for Credit Counseling[51] to find good credit counselors. As always, be wary of scams[52].

If you feel your rights are being violated, seek help from the Consumer Financial Protection Board:

- Problems with debt collectors[53]
- Problems with credit reporting agencies[54]

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[47] https://pirg.org/articles/how-make-sure-your-credit-reports-dont-include-paid-medical-debt-0/
[48] https://pirg.org/resources/protecting-yourself-identity-theft/
[49] https://www.consumerfinance.gov/complaint/
[50] https://www.consumerfinance.gov/ask-cfpb/how-do-i-dispute-an-error-on-my-credit-report-en-314/
[51] https://www.nfcc.org/
[52] https://www.consumerfinance.gov/ask-cfpb/how-can-i-tell-a-credit-repair-scam-from-a-reputable-credit-counselor-en-1343/
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[54] https://www.consumerfinance.gov/ask-cfpb/how-do-i-dispute-an-error-on-my-credit-report-en-314/

Can I file a complaint against a debt collection company?

If you are having trouble with a debt collector, you may wish to file a complaint[55] with the Consumer Financial Protection Board (CFPB). The collection company has two weeks to respond to your complaint before it is made public in the CFPB's database.

Filing a complaint with the CFPB helps in two ways:

- It may lead to a swift solution. Collection companies don't want public complaints on file with the government, so they have a greater incentive to work with you to solve your complaint.
- It builds up a record of the type of abuse and the specific companies prone to behave badly. This helps the government know how to better help and protect people against these practices and businesses.

[55] https://www.consumerfinance.gov/complaint/

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