



Insurance Terms

Key insurance terms to help you get started with insurance billing!

Billing Provider: The individual or organization legally responsible for submitting claims and receiving payment for healthcare services. The billing provider's information (such as name, NPI, and address) appears on the claim form and may differ from the rendering provider who performed the service.

Clearinghouse: a third-party service that acts as an intermediary between healthcare providers and insurance payers. It checks medical claims for errors, formats them correctly, and securely transmits them to the appropriate insurance companies for processing and payment.

- Office Ally, Change Healthcare, and Jopari are the clearinghouses integrated with OptiMantra.

Clearinghouse Rejection: occurs when a medical claim is not accepted by the clearinghouse due to errors or missing information. This means the claim never reached the insurance payer and must be corrected and resubmitted.

Coding: In insurance billing, *coding* refers to the process of translating healthcare services, procedures, diagnoses, and supplies provided to a patient into standardized medical codes. This includes CPT codes (Current Procedural Terminology) for procedures and services, diagnosis codes (typically ICD-10) for the patient's condition, service units to indicate the quantity of services provided, and modifiers to give additional context or specify variations in the service performed. Accurate coding ensures proper claim processing and reimbursement by insurance companies.

Electronic Data Interchange (EDI): in medical billing this refers to the electronic transfer of healthcare data, such as claims, eligibility requests, remittance advice, and authorizations, between healthcare providers and insurance payers in a standardized format. EDI streamlines communication, reduces paperwork, and speeds up claim processing.

- Common EDI transaction types include:
 - 837: Claim submission
 - 270/271: Eligibility inquiry and response
 - 835: Electronic Remittance Advice (ERA)

Electronic Remittance Advice (ERA): a digital version of a paper Explanation of Benefits (EOB) that provides detailed information about how a medical claim was processed by a payer, including payments, adjustments, and denials. It corresponds to the standard HIPAA transaction code 835, so it's often referred to as the **835 ERA**.

Explanation of Benefits (EOB): a statement sent by a health insurance company to a patient after a claim has been processed. It explains what services were billed, how much was covered by insurance, what the insurance paid, and what the patient may still owe.

Place of Service (POS): a two-digit code used on medical claims to indicate the location where healthcare services were provided, such as a physician's office, outpatient facility, or patient's home. The POS code helps payers determine appropriate reimbursement rates and coverage policies based on the setting of care.

For a comprehensive list of all insurance billing terms, visit our [Glossary](#)