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The Complete Guide for Patients on Using Private Medical Insurance

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This guide is provided for general information only and does not replace advice from your insurer or healthcare professional. Coverage under private medical insurance varies between providers and individual policies. Patients should always consult their policy documents and contact their insurer directly for confirmation before undergoing treatment.

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Sponsored by TouchPoints.health – practice management software for private doctors.

Introduction: This guide will walk you through every step of using private medical insurance (PMI) in the UK, from understanding what your insurance might cover to getting treatment. We explain how to choose a private doctor or clinic, confirm your insurer will cover it, use your policy details, obtain the necessary approval (pre-authorisation) from your insurer, manage any excess payments, and handle claims and bills. The language is clear and jargon-free, with examples from major UK insurers like WPA, Bupa, AXA Health, Aviva, and VitalityHealth. Always remember that every insurance policy is different – **check your own policy documents** for the details of your cover, and contact your insurer if in doubt. This guide is general and **not a substitute for advice from your insurer.**

Understanding Private Medical Insurance (PMI)

Private medical insurance (also called private health insurance) is a policy you pay for (monthly or annually) that covers the cost of private healthcare for new medical conditions that arise after your policy starts. In practical terms, this means if you become ill or need treatment, you can access private doctors, specialists, and hospitals without worrying about big medical bills – your insurer will pay some or all of the costs as long as the treatment is eligible under your policy.

PMI typically gives you faster access to consultants and procedures than the NHS waiting list, and more choice over where and when you are treated. For example, you might be able to choose from a range of approved private hospitals or clinics, and pick a convenient appointment with a specialist of your choice. Some policies even offer extras like virtual GP appointments or therapies to speed up your care. Each policy has its own list of exactly what is covered and excluded, as explained in your policy documents and Key Features summary (always read these to know the limits of your cover. In short, PMI gives peace of mind that if you need non-NHS treatment, you can get it done privately and the insurer will handle the costs within the scope of your policy.

*(**Tip:** Many people get PMI through their employer's benefits. If you're covered by a company or group scheme, the process of using it is usually the same as for individual policyholders. Just be sure you know the insurer's name and your membership details from your employer's HR or benefits team)*

Choosing a Private Doctor or Clinic

When you have a health concern and want to use your insurance, the journey often starts with **seeing your GP (general practitioner)**. In the UK, most insurers require or at least recommend that you get a GP referral before seeing a private specialist. So, book an appointment with your GP (this can be your NHS GP or sometimes a GP provided through your insurer's app or digital service) and tell **them** you have private health insurance.

The GP will assess your condition and, if you need to see a specialist or get treatment, they will write you a referral letter. **Ask your GP for an "open referral"** if possible – this means the letter will state what kind of specialist or treatment you need, without naming a specific consultant or clinic. An open referral gives you more flexibility to choose where to go, and **insurers often prefer it** because it allows them to help you find a suitable consultant within your cover. (Some insurers will accept a named consultant referral too, but they reserve the right to suggest alternatives in line with your policy terms.)

Finding a private specialist or hospital: With referral in hand, you can select a private consultant or clinic. You might already have someone in mind, or your GP may have suggested an appropriate specialist. You should **check that the doctor or hospital is recognised by your insurance** – we cover how to do this in the next section. You can also use your insurer's resources to find a doctor. For example, Bupa offers an online **"Finder" directory** of approved consultants and hospitals where they have direct billing arrangements. Many insurers have similar directories or helplines. If you're unsure how to choose, your insurer can often **recommend specialists** in the relevant field. The idea is to ensure you see a qualified expert and that the treatment will be covered by your plan.

A free independent government mandated resource is the Private Healthcare Information Networked (PHIN). They have some useful information as well as a helpful search tool, found here - www.phin.org.uk

Do I need an NHS GP referral? In most cases yes, but there are some exceptions. Certain insurers offer **direct access** for specific conditions – meaning you might not need a GP referral for things like physiotherapy, mental health, or minor consultations. When in doubt, start with a GP visit. It's always safe to get a referral letter, which you can then show to your insurer as proof that the treatment is medically advised.

Checking If Your Provider Is Covered by Your Insurer

One crucial step is to **confirm that your chosen specialist and hospital are covered by your insurance**. Just because you have PMI doesn't guarantee it will pay at any private facility – most insurers have networks or approved lists of hospitals and doctors. Before booking any appointment, **call your insurer or use their online tool to check** that the consultant and clinic you plan to use are recognised under your policy. Usually, this is done when you contact the insurer for authorisation (next step), but you can also check in advance.

- **Contact your insurer with the referral details:** Provide the name of the consultant and hospital to your insurance company and ask if that provider is covered by your plan. The insurer will look up if the doctor is within their network, and if the hospital is on your allowed list. **Not all doctors work with all insurers,** so it is always best to confirm with your insurer first if you want to see a particular doctor. This prevents any surprises later.

- **What if my chosen doctor isn't covered?** If the specialist you were referred to is not covered by your insurance, don't panic. You have options: your insurer can usually suggest an alternative consultant who *is* covered. You could also choose to see the original doctor privately and pay yourself, but then your insurance likely won't reimburse much or at all. In general, it's better to stay within the insurer's network to

maximize coverage. Always get confirmation from your insurer *before* proceeding with any appointment or treatment that it will be covered – otherwise you risk facing the bill yourself.

Using Your Policy Number and Insurance Details

When arranging private care, you'll need to **provide your insurance details** to both your insurer and the healthcare provider. Chief among these details is your **policy or membership number**. This is the unique number given to you by your insurer (often found on your insurance certificate or membership card).

- **Have your policy number handy:** Your insurer will ask for this whenever you call to make a claim or pre-authorise treatment. Likewise, the hospital or clinic will record your insurance membership number to liaise with the insurer and bill them directly. You can usually find this number on any letters or emails from your insurer, on your insurance card, or by logging into your insurer's online portal/app. If you can't find it, contact your insurer's customer service before your appointment.
- **Other details to prepare:** In addition to your policy number, you should know the **policyholder's name** (if it's a company scheme, for instance, the policy might be under your employer's name or a group number) and your **scheme details** (such as whether you have individual or family cover, and any group or employer scheme ID). The doctor/hospital may ask for the **insurance company name** and perhaps your policy's level of cover. For example, private hospitals will typically ask for: *your insurer's name, your membership/registration number, your level of cover, and your company scheme name (if applicable)*. They will also want the **pre-authorisation code** from your insurer once you have it, but we'll come to that next.
- **Bring your insurance card or documents to appointments:** It's good practice to bring a copy of your insurance card and a photo ID when you go for a private consultation. While not always required, having proof of insurance can smooth the administrative process. As one hospital group notes, *before your first appointment, gather your policy documentation, your insurer's details, your membership number, and any confirmation of eligibility like a pre-authorisation number.* This ensures that the hospital can quickly verify coverage and arrange billing with your insurer. If you've

been given a claim form or approval letter by your insurer, bring those along too.

Getting Pre-Authorisation from Your Insurer

Pre-authorisation (also called pre-approval) is the process of getting your insurer's agreement to cover the proposed treatment *before* you have it. In almost all cases, you **must obtain pre-authorisation from your insurer before going ahead with private treatment**. This step is crucial – without it, the insurer might refuse to pay for your treatment. Pre-authorisation typically results in an **authorisation code or reference number**, which you then give to the hospital or consultant as proof of cover.

Here's how to get pre-authorisation, step by step:

1. **Contact your insurer as soon as you have a referral and have chosen a specialist/hospital.** You can usually do this by phone, and many insurers also offer online or in-app claim requests. Have your referral details and policy information ready. Tell the insurer what specialist you've been referred to (or that you need help finding one) and what treatment or consultation is planned. The insurer will check your policy to confirm that the condition and proposed treatment are included in your cover. They may ask some questions about your symptoms and how the referral came about.
2. **Provide the information the insurer needs.** Typically, you'll be asked for:
    - Your **membership/policy number**.
    - Details of your medical issue – e.g. the symptoms or diagnosis and when they started.
    - The name of the specialist and hospital (if you have one) or the type of specialist you need.
    - What treatment or test has been recommended by the GP (for example, an MRI scan, a surgery, etc.).
    - The date of your upcoming appointment, if already booked (or you can say you are planning to book once authorised).

Each insurer's process is a bit different so it's best to check with them first.

3. **Receive your pre-authorisation code.** If the treatment is covered and everything is in order, the insurer will issue a code or an authorisation number. This code is very important – it's essentially the insurer's stamp of approval for payment. The code might be given over the phone, sent by email, or available in your online account. **Write it down and keep it safe**, and be prepared to give it to the hospital admissions staff or the consultant's secretary.
4. **Check any conditions or limits of the authorisation.** Sometimes authorisation is given with a limit – for example, the insurer might approve an initial consultation and one diagnostic scan, but if you end up needing more tests or a surgery, those might need separate approval. Make sure you understand what exactly has been authorised. The insurer's advisor will usually explain this. They might say, for example, "We've authorised an initial consultation with Dr X and an MRI. If further treatment is needed, please contact us again." Always **contact the insurer again if the specialist recommends additional tests or a procedure that wasn't originally approved** – it's usually just a quick call quoting your claim number to extend the authorisation. This ensures continuous cover.

By obtaining pre-authorisation, you have peace of mind that your insurer agrees the treatment is covered. It also means the provider (hospital/clinic) can typically invoice the insurer directly for the costs, since they have the approval on record. *Skipping this step can be very risky*: as one industry guide warns, it's essential to authorise your claim before incurring costs, because like any insurance, there are exclusions and limits – you don't want to end up liable for a bill because you didn't get the upfront okay. The good news is that getting pre-authorisation is usually straightforward and quick – often just a phone call or an online form, and you'll have your code within minutes if all is well.

Understanding Your Cover: Limits and Exclusions

Every health insurance policy is a little different in what it covers. It's really important to **know the scope of your own cover – both what is included and what isn't**. Here are some general points, but remember to refer to your **policy schedule and handbook** for the specifics of your plan.

What is typically covered: Most private medical insurance policies cover the cost of acute (short-term, treatable) medical conditions that arise after you've taken out the insurance. Core areas usually include:

- **In-patient and day-patient treatment** – if you need an operation or procedure that requires a hospital stay (even just for the day), the policy will pay for the hospital charges, surgeons, anaesthetists, etc, as long as it's an eligible condition.
- **Consultations with specialists** – you can see private consultants (e.g. cardiologist, orthopaedic surgeon, etc.) for assessments and the insurance covers their fees.
- **Diagnostic tests and scans** – such as blood tests, X-rays, MRI or CT scans, and other investigations needed to diagnose your condition.
- **Out-patient treatment** – this varies by policy; if you have out-patient cover, it can pay for things like specialist consultations, physiotherapy, and follow-up tests that don't require a hospital stay. Some basic policies might limit this or exclude out-patient cover entirely, whereas comprehensive ones include it.
- **Hospital accommodation and nursing** – if admitted, the room and care you receive are covered.
- **Cancer treatment** – many leading insurers provide extensive cover for cancer, including chemotherapy, radiotherapy, and surgeries. Some insurers will cover cancer treatments even if the illness becomes long-term, which is an exception to the "acute only" rule (check your policy; insurers often highlight their cancer cover separately).
- **Therapies and aftercare** – e.g. post-surgery physiotherapy, maybe mental health therapy sessions, depending on your plan.

Common limitations or things *not* covered: Private medical insurance is not all-inclusive. **It does not replace the NHS for every health need.** Generally, PMI will **not cover** costs related to the following, among others:

- **Chronic conditions** – A chronic illness is one that is long-term and ongoing (like diabetes, hypertension, or multiple sclerosis). PMI is meant for acute conditions that can be cured or managed in the short term. Long-term management of chronic diseases is usually excluded (though acute flare-ups might be covered in some cases). For example, an

insurer might pay to diagnose a condition, but once it's deemed chronic, they won't cover routine monitoring or maintenance.

- **Pre-existing conditions** – Health issues you already had before your policy started are typically excluded. When you first took the policy, you would have declared your medical history, and any pre-existing problems are listed as exclusions or subject to a waiting period. (Some company schemes cover pre-existing conditions on a "medical history disregarded" basis, but that's an exception.)
- **Normal pregnancy and childbirth** – Insurance won't cover routine maternity care or childbirth costs in a normal situation. Complications of pregnancy might be covered, but having a baby privately is usually self-funded unless you have a specific maternity rider (rare in UK policies).
- **Fertility treatment** – IVF or other fertility procedures are generally not covered.
- **Cosmetic surgery** – Procedures that are not medically necessary (e.g. purely cosmetic plastic surgery) are excluded. If something is reconstructive and medically advised (like reconstruction after cancer surgery), that can be covered.
- **Preventive or routine care** – Things like routine health checks, vaccinations, screening tests, and normal dental/optical care are not covered by PMI (unless you have a separate cash plan or add-on).
- **Accident & Emergency (A&E) admissions** – Emergencies are usually handled by the NHS. If you have an emergency (like a car accident or heart attack), you would typically go to an NHS A&E. PMI might cover you *after* you are stabilised if you then choose to have follow-up or elective surgery privately.

All policies differ, so again, **read your policy documents** which will clearly list the exclusions and any limits or caps. For instance, your policy might cap outpatient therapy at a certain amount per year, or limit mental health cover to a certain number of sessions. It will also detail any **financial limits** – for example, some policies have an annual maximum or specific limits like £500 for home nursing, etc. The insurer provides a Key Features or Benefit Table that **"makes it clear what's covered, what isn't, and the financial limits for any claim."** Keep that document handy and don't hesitate to call your insurer's helpline for clarification on cover *before* you proceed with treatment.

*(**Remember:** When in doubt about whether something is covered, check with your insurer. A quick call can save a lot of trouble – they can confirm eligibility of a treatment and any limits. Never assume "it'll be fine"; always verify, especially for major treatments.)*

Managing Excess Payments

Many UK health insurance policies include an **excess**. An excess is the **amount of money you agree to pay towards a claim directly to your treating doctor(s) / hospital** whilst your insurance pays the rest. In other words, it's your share of the cost. It works similarly to car insurance excess: if you have a £200 excess and you make a claim, you are responsible for £200 of the costs, and the insurer covers the remainder (up to policy limits).

Key points about excesses:

- **Excess amount and type:** Your excess amount is set when you take out the policy (common options might be £100, £250, £500, etc.). Some policies apply the excess **per claim** or per condition – meaning you pay it each time you claim for a new unrelated issue in the year. Others apply it **per policy year** – meaning you pay it only once in any insurance year, no matter how many claims you make. Check your policy to know which type you have. This will affect how often you might have to pay it.
- **When and how to pay your excess:** The insurer will deduct the excess from the claims they settle, and **you will be asked to pay the remaining portion**. In practice, if your hospital is billing the insurer directly, the insurer will tell the hospital (or the consultant) that you have, say, a £200 excess. The hospital or Consultant might then invoice you for that £200 as well as billing the rest to the insurer. Insurers handle this in different ways. Some **ask you to pay the excess directly to the hospital/clinic at the time of treatment**, others may **bill you afterward**. In many cases, you'll simply receive a letter or invoice informing you of the excess due after the insurer has processed the claim. Be prepared to pay your excess by debit/credit card or bank transfer when you're billed for it.
- **Excess vs. shortfalls:** An *excess* is agreed in your policy. A *shortfall* is different – that would be if the treatment cost exceeds what the insurer is willing to pay (e.g., if a specialist charges more than the insurer's fee

schedule, or if you exceed a benefit limit). Shortfalls are less common, but they can happen. If there's any shortfall in addition to your excess, the insurer or hospital will let you know.

Managing payment: When you set up your treatment with the hospital, they often take a credit card imprint (like a security) to cover any excess or costs not covered by insurance. This doesn't mean you're paying up front; it's just to facilitate payment of your excess later if needed. The hospital will only charge your card if the insurer confirms an excess or disallowed amount. They usually notify you first. For example, you might get a letter saying your insurer has settled £1,000 of a £1,250 bill and £250 was excess, so £250 will be charged to your card (or you need to pay it). This system is in place *"to cover any insurance excess or shortfall your insurer is not liable to pay"*, and you'll be informed before any charge is made.

Where it can get confusing is the fact that many doctors will bill for their work directly to the insurers separately from the hospital or clinic where you are seen or treated. So you may receive an excess payment request directly from the doctor as well. This will need to be settled with the doctor directly.

(In summary: Know your excess amount. When you make a claim, expect to pay that amount of the costs. The insurer or provider will let you know how and when – often after treatment. Always budget for your excess in case you need to use the insurance.)

Submitting Claims and the Billing Process

One big advantage of private medical insurance is that **in many cases, you won't have to submit complicated claim forms or pay upfront for major treatments** – the insurer and hospital will handle payment directly between them. However, the exact process can vary, and there are times you may need to pay and claim back. Let's break down what to expect after you've had your treatment authorised:

- **Direct billing:** If you have followed the steps above – got your treatment pre-authorised and given your insurance details to the hospital – then usually the hospital and doctors will send their bills straight to your

insurer. You won't be asked to pay the main bills yourself. **Most major insurers have direct settlement arrangements** with the private hospitals, clinics and doctors. This means after your appointment or surgery, the hospital's finance office or doctors office sends the invoice to Bupa, AXA, Aviva or whichever insurer is covering you, and they pay according to the policy coverage. **You should not be billed for covered costs except for your excess or items not included in your cover.**

- **If you receive an invoice or bill after treatment or a consultation:** Sometimes, due to timing or communication issues, you might get a bill from the hospital or doctor that you think should have gone to the insurer. If this happens, **don't panic**. First, call the doctor or hospital's billing department or your insurer to check. If it's a covered expense, you can forward the invoice to your insurer and they will take care of it. However if the invoice states "**Excess/shortfall payment**" this usually means the insurer has not covered this portion of the claim and you need to settle the amount directly. **You may well receive a request for an excess payment months after your treatment or consultation**. This is normal as it takes the doctor/hospital time to invoice your insurer, your insurer then settles the amount minus any excess and then informs the doctor/hospital an excess is due. This whole process can take several weeks/months.

- **Claim forms and paperwork:** The process nowadays is often paperless. Many insurers no longer require you to fill out a claim form for each treatment, especially if pre-authorised by phone or online. However, a few insurers or specific circumstances might require a form – for instance, some might ask your GP to fill out a brief section confirming the need for treatment (this was more common in the past or for certain policies). If your insurer does issue a claim form, they will usually send it to you or direct you to download it. **Follow your insurer's instructions carefully.** Typically, if a form is needed, you might need to:
    - Have your GP or specialist fill in the medical information section (they may charge a small fee for this paperwork).
    - Complete your part (personal and policy details, and sign it).
    - Take the form with you to the hospital or send it to the insurer. Some hospitals will help collect the form and send it off. For example, some advise: if your insurer requires a claim form, *bring it*

to your first appointment, inform the hospital staff, and they can help get the medical sections completed by the consultant. Make sure you've signed the patient section yourself.

In summary, the claim form is basically a document that triggers the insurer to pay the claim. Increasingly, this is done electronically or via phone, but check your **"Claims" section of your policy pack** – it will state if a form is needed for certain claims.

- **After treatment – follow-ups:** If your treatment involves multiple stages (say an initial consultation, then an MRI, then a surgery, then physiotherapy), you might have multiple claims as part of the same "episode." As mentioned earlier, keep your insurer in the loop at each stage. Once the initial consultation is done, and suppose the consultant says you need an injection or operation, you would contact the insurer again with the new referral/recommendation to get that operation authorised. It will often fall under the same claim reference number. The insurer will then pay the hospital for the surgery. After surgery, if you need physio, again, check if it requires separate authorisation or if it's included in a package.
- **What if I have to pay and claim back?** In certain scenarios, you might pay upfront and then claim reimbursement. This could happen if you use a small clinic that doesn't bill insurers directly, or if you didn't get authorisation in time for an appointment. It can also occur for things like buying medications. For instance, some policies allow you to claim back the cost of seeing a private GP or a counsellor up to a limit – usually you pay the provider and then submit the receipt to the insurer for refund. If you find yourself needing to claim back, you will need to **submit a claim to your insurer after paying**. This typically involves filling a claim form or an online submission, and attaching the receipts/invoices. The insurer will then process it and pay you back according to your cover (often via bank transfer or cheque). Always notify the insurer as soon as possible if you plan to do this; some require claims to be submitted within a certain time (e.g. within 3-6 months of treatment).
- **Employer schemes:** If your insurance is through your employer, the claims process is fundamentally the same, but you might have a different point of contact (some big companies have a corporate scheme hotline). Follow the instructions given in your employee insurance handbook. It might also mean any claims payments for reimbursements go via the

company, but usually for medical insurance, the insurer deals with you directly once you're a member. Just ensure you mention you're a corporate scheme member when calling the insurer if asked.

Bottom line: The claims process might sound complex, but it usually works smoothly behind the scenes once you've got that pre-authorisation. It can be summarised in **five simple steps:**

1) get a GP referral,
2) start the claim with your insurer (online or phone) and get approval,
3) choose a doctor and get treatment,
4) insurers pay the bills directly minus any excess.
5) pay any outstanding excess to the doctor/hospital.

As the patient it's best to *communicate as much as possible*: make sure your insurer is informed and has authorised everything, and make sure the hospital has your correct insurance details and authorisation code. After that, the billing is mostly insurer-to-provider. If any issues arise (like a bill you think should be covered or a delay in payment), both the hospital's private patient team and the insurer's claims team are there to help you sort it out – don't hesitate to give them a call for updates.

Important Reminders and Disclaimers

- **Always double-check your coverage:** Every policy has its quirks. Read your policy handbook or summary to understand what's covered, what's excluded, and any limits or excesses. This document is your go-to reference and will clarify things like whether you need a GP referral, which hospitals you can use, and how much you might need to contribute. *"Your policy will come with a full document and key features summary... what's covered, what isn't, and the financial limits..."* – this tells you everything. When in doubt, call your insurer's helpline – they can look at your specific policy and answer questions.
- **Get approval first:** We've said it multiple times, but it bears repeating: don't incur private treatment costs on the assumption your insurer will

cover it later. With few exceptions, **you need the insurer's authorisation in advance**. A quick phone call can save you from an expensive surprise.

- **Keep records:** Maintain a file (even just an email folder or notebook) with your insurance info, policy number, and any correspondence. Jot down the authorisation codes you receive and the names of anyone you speak to at the insurer. This can be useful if any clarification is needed later.

- **Know key contacts:** Here are some useful contacts for major insurers:
  - **Bupa** – Claims/pre-authorisation helpline for existing members: 0345 609 0111 (Mon-Fri 8am-8pm).
  - **AXA Health (formerly AXA PPP)** – Customer service/claims: 0800 454 080 for members.
  - **Aviva** – Health claims line: 0800 158 3333 for existing customers or use MyAviva online.
  - **VitalityHealth** – Member helpline: 0345 602 3523 for claims (existing members).
  - **WPA** – Helpline for members: 01823 625000.

(These numbers are subject to change; you can also find contact info on your insurer's membership card or website)

- **This guide is not personal insurance advice:** It's a general overview to help you understand and navigate the process. It doesn't override anything your insurer has told you or what your specific policy says. Always follow the guidance provided by **your insurer** and healthcare professionals. TouchPoints.health (the sponsor of this guide) and the authors have compiled this information to assist you, but your insurer's rules and your policy terms are the final word on what you should do in your situation.

- **Use your insurance when you need it:** Finally, remember that if you have private medical insurance, it's there to be used to your benefit. Many people pay premiums for years and forget to use their insurance when a health need arises. As long as you follow the steps – GP referral, authorisation, etc. – you should find that using your PMI is not daunting and can provide you with speedy treatment and comfort. If you need

help at any point, both your insurer and the private healthcare provider will be happy to assist; after all, they deal with these processes every day.

Always check your policy documents and consult your insurer for advice specific to your plan – this guide provides a comprehensive pathway, but your individual circumstances or policy may have particular requirements. With that said, we hope this guide has demystified the journey and will help you confidently make the most of your private medical insurance cover when you need treatment. Stay informed, and we wish you the best of health!

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Using Your Private Medical Insurance

A QUICK PATIENT GUIDE

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01. See your GP*

Start with your NHS or a private GP or a GP arranged via your insurer.

Ask for an "open referral letter" (e.g. "to orthopaedic surgeon").

*Some insurance policies include GP cover that will undertake referrals to specialists. If so, it's best to speak to your insurer first.

Research which specialist you want to see by looking at your insurers website or other resources.

It's important you check your insurer works with that specialist before proceeding.

02. Contact your insurer

After going through some details, if you're covered, your insurer should then issue you a **Pre-authorization code**.

Ask them about any excess payments YOU might need to pay yourself.

If you have no preference or are unsure your insurer will guide you.

Excess fees are the difference between what your doctor/hospital charges and what your insurer pays. You are liable for the difference.

03. Contact the doctor/clinic

Many specialists will have a website with ways to book listed. There's usually a phone number to call if you need more information.
You'll need to give your insurance details and authorization code to your doctors office to book an appointment.

Need further treatment

Always contact your insurer if you need any further treatment or referrals to ensure you're covered.

Discharged

Settle any excess fees if applicable.

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