



Sagicor Life

# Frequently Asked Questions

by providers



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## WHAT IS THE TURN-AROUND TIME FOR CLAIMS PAYMENT?

Our standard turn-around times are:

5-7 business days for electronic claims

10-15 business days for manual claims.

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## WHAT CAN CAUSE A DELAY IN THE SETTLEMENT OF MY CLAIMS?

There are several factors that may impact the timely processing of claims submitted. These include:

Incomplete claim submission (e.g. Missing diagnosis, tooth numbers, alteration to charges, co-payment not stated, etc.)

Missing client information (e.g. Name & Card Number)

Additional information required (e.g. Explanation about medical procedure done)

Accuracy of banking information provided

For manual provider claims – poor handwriting

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## HOW DO I IDENTIFY THE PRIMARY CARDHOLDER

The primary card is the card where the cardholder number ends in '00'. This is the card where the patient is the employee of the company. However, where persons are covered under the N.I. Gold plan this will always be the Primary plan.

The secondary card ends with numbers other than '00' which denotes that the patient is a dependent. In the case of children, the father's card is the primary.

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## WHAT ARE THE REQUIREMENTS IF I HAVE A NEW DOCTOR WORKING AT THE MEDICAL CENTRE/ DOCTORS OFFICE?

Whenever new doctors are employed to your facility, we ask that you notify us and provide certified copies of his/her qualifications and registration



along with the days and hours he/she will work at the facility.

If the doctor is already a participating provider on our network, we need a notice stating that the doctor is now employed to the facility along with a certified copy of the most recent registration and the days and hours he/she will work at the facility. This information can be sent to [slj\\_providerqueries@sagikor.com](mailto:slj_providerqueries@sagikor.com)

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### **CAN A DOCTOR DISBURSE PRESCRIPTION ITEMS AT HIS/HER OFFICE AT A CHARGE TO THE PATIENTS?**

Sagikor does not pay for oral medications dispensed in a doctor's office as only registered pharmacies should dispense these drugs on a retail basis. We will pay for stat (urgent) dosages.

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### **WHERE CAN I FIND VARIOUS CODES ON THE SWIPE SYSTEM?**

The swipe system is a “codes-driven” system. As such, all procedures and diagnoses are coded into the system. It is formatted with the International Classification of Diseases, Ninth Edition codes (ICD-9).

To find same, position the cursor in the ‘Diagnosis field” hold both the [Shift+?] keys in the same order. A ‘Diagnosis Search Text’ box should be displayed. Type the description of the diagnosis and select the description that best suits the claimant’s condition.

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### **CAN I WAIVE THE OUT OF POCKET COST FOR MY PATIENTS?**

Insurance is a cost-sharing benefit. As such, patients are required to pay their copayment/coinsurance amounts where applicable.



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## **WHAT IS THE DIFFERENCE BETWEEN WAIVING THE OUT OF POCKET COST FOR MY PATIENTS AND GIVING A DISCOUNT?**

A waiver is the decision to not accept payment from the client; while a discount is a reduction in the cost of the service. Our policy states that discounts are to be applied in the same way that it is done commercially. That is, discounts are taken from the total cost. The net amount should then be submitted as the “new” charge. When discounts are applied, the patient may still be required to pay a portion of the cost. However, waiving out of pocket costs will result in the client not making a copayment.

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## **WHY ARE CLAIMS SHORT PAID WHEN PRE-AUTHORIZED?**

The pre-authorization letter has several listed conditions under which the amounts specified will be paid.

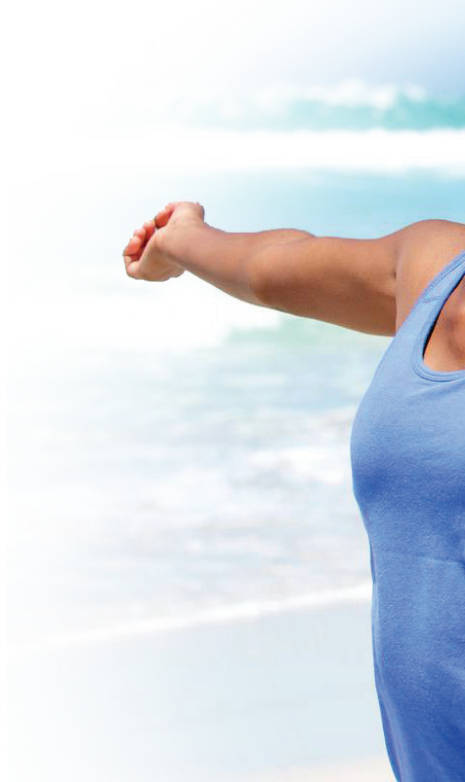
There may be instances where the Life Time Maximum (LTM) or major medical benefits are depleted after the pre-authorization

letter was prepared and prior to your claim submission.

There may be changes in the benefit amount subsequent to the pre-authorization letter being done, this may be due to changes in the plan.

A claim may be incurred at the start of a new plan year and a deductible is now required.

We urge you to submit your claims (along with a copy of the pre-authorization approval letter) at your earliest convenience as well as pay attention to the conditions listed to avoid any adverse situations.



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## **WHY SHOULD THE AMOUNT PAID BY PATIENT BE STATED ON THE CLAIM FORM?**

This will facilitate the correct adjudication of your claim.

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## **WHY SHOULD THE DIAGNOSIS AND PROCEDURE BE STATED ON THE CLAIM FORM WHEN THEY ARE ALREADY IN THE PRE-AUTHORIZATION LETTER?**

All relevant information, including diagnosis and procedure, must be indicated on the Claim Form. While a pre-authorization letter is a “proposal” based on the anticipated procedure to be done, the claim form is the legal document that should be completed and signed by the insured and the provider when submitting the claim.

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## **WHY SHOULD WE SUBMIT A BREAKDOWN OF CHARGES?**

Various plans pay different amounts for specific services. Listing each service along with its charge will facilitate the correct adjudication of the claim.

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### WHY ARE PROVIDER AUDITS DONE?

Claims are paid from the funds provided by clients in the form of premium payments. Sagicor has a responsibility to manage these funds carefully and to ensure that claim payment is made for valid services and procedures.

An Audit is simply a verification that the information submitted in the claim is an accurate reflection of the services rendered. Audits are done for all categories of Providers. It is also important to ensure that Sagicor's standards and procedures are being upheld. In addition, Audits provide a means of highlighting training needs.

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### HOW DO I REQUEST TRAINING?

Our officers are available to provide initial and refresher training to all Providers and/or their teams. Training can be requested by sending an email to **[slj\\_providerqueries@sagicor.com](mailto:slj_providerqueries@sagicor.com)**

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### WHAT ARE THE PAYMENT CYCLE DATES?

Provider payments are done twice weekly, on Tuesdays and Fridays, and you will receive "bulk" payments. Your explanation of benefits (EOB) statements provide payment information that will assist with your reconciliation.

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### WHO CAN I CONTACT WHEN I HAVE A PROVIDER QUERY?

Provider queries are made through our Client Contact Centre at **876-929-8920-9** or **888-724-4267** or by email at **[slj\\_providerqueries@sagicor.com](mailto:slj_providerqueries@sagicor.com)**



**17****WHY SHOULD THE PROVIDER VALIDATE THE PATIENT'S IDENTITY?**

We ask our Providers to assist with our fraud/abuse prevention campaign by requesting an ID from the patients. This will ensure that the person receiving the service is the cardholder. In cases where provider renders services without identity validation, we will investigate and ask for a refund of all monies paid if warranted.

**18****WHOM SHOULD I CONTACT WHEN I HAVE A CLAIMS QUERY?**

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