What Is a Superbill?

A Superbill is a receipt for a session with an out-of-network provider allowing the patient to submit to their health insurance for reimbursement. A Superbill may be requested by a patient when the patient pays out-of-pocket for the qualified medical expense. Reimbursement will be determined by the individual healthcare policy at the time the claim is received. Understanding your healthcare benefits on the front end is the best way to optimize your chances of a successful Superbill submission.

As most insurance companies are passing more of the out-of-pocket expenses to their members, understanding your healthcare insurance is part of financial well-being. Each time you use your healthcare insurance there is a financial responsibility—as a paying member to healthcare insurance, you can call for an explanation of benefits (EOB). Especially when submitting a Superbill for an out-of-network provider, the benefits can be dramatically different from your in-network benefits.

How Do I Submit a Superbill?

Each insurance company has unique policies. Therefore, it's best to call your individual insurance company to obtain your plan benefits. The call to insurance will take 10-20 minutes to verify benefits and submit a Superbill. This time is well spent on the front-end to realize the benefits and expectations of submitting a Superbill to your insurance.

On the back of your healthcare insurance card, call the phone number for "Members" or "Members Services" with your insurance card in hand and the ability to take notes.

1. **Verify out-of-network benefits:**

   - Ask the representative, "What are my out-of-network healthcare benefits for behavioral health in an out-patient setting?" Take notes of the answers to the following questions:

   - Co-payment? (if applicable)
   - Deductible? (if applicable)
   - Today's accumulation for deductible? (if applicable)
   - Co-insurance? (if applicable)
   - Timely filing (Timely filing is the time limit that an insurance company allows for a claim to be submitted)

2. **Is pre-authorization required? (if applicable)** If pre-authorization is required, ask the representative to get this started. The authorization will provide a time frame for services, and/or a total number of visits allowed during the time frame.

3. **Verify how to submit a Superbill.** Each healthcare company has various ways to submit a Superbill.

4. **Make sure they have your correct address (especially if a check will be issued)**

Your Insurance Will Determine How Your Superbill Is Processed & Paid

The information received when verifying your healthcare benefits will determine how the Superbill will be processed and any subsequent reimbursement. The primary factors are whether the policyholder has a copayment, or a deductible, along with timely filing.

What Can I Expect After Submitting My Superbill?

When a claim is received by insurance, most insurance companies will make a determination in two weeks. If reimbursement is due after the claim is processed, most insurances have a specific day of the week when checks are mailed. When the claim is processed accurately and applied to the deductible, no payment is forthcoming.