Medical Billing Remedy

Complete Step-by-Step Bill Audit and Dispute Guide

THE FAST VERSION

• Get the itemized bill.

• Get the matching EOB and payment history.

• Reconcile what the provider says you owe with what the insurer says you owe.

• Screen surprise out-of-network situations before paying a disputed balance.

• Ask for financial assistance before borrowing money to pay the bill.

THE COMPLETE STEP-BY-STEP PROCESS

STEP 1 - Do not treat the first bill as final

A summary statement may not contain enough detail to audit. Do not ignore due dates, but ask for a billing hold or extension while a documented review is pending.

STEP 2 - Request the most detailed itemized bill available

Ask for codes, quantities, dates of service, billing entities, medications, supplies, and procedure lines. The goal is reconciliation, not an accusation.

Use this wording: "Please send me the most detailed itemized bill available, including codes, quantities, dates, and billing entities."

STEP 3 - Get the matching Explanation of Benefits

For insured care, obtain the EOB for the same date of service. It shows what was billed, allowed, paid, adjusted, and assigned to you.

STEP 4 - Add your payment history

List every payment, refund, adjustment, and credit already posted. The current provider balance should reconcile to the EOB and payment history after timing differences are accounted for.

STEP 5 - Reconcile the provider balance against patient responsibility

Compare the provider's current balance with the EOB patient-responsibility amount minus payments already made. A difference is a review item, not automatic proof of overbilling.

STEP 6 - Check apparent duplicate lines

Flag same-code or same-description charges that appear repeated. Confirm dates, units, and modifiers before calling anything a duplicate.

STEP 7 - Check quantities and services

Ask about medications, supplies, room charges, time units, and procedures that do not match what you remember or what the medical record supports.

STEP 8 - Ask neutral coding questions

A code alone cannot prove upcoding or unbundling. Ask what the code means, what documentation supports it, and whether a coding review is needed.

STEP 9 - Screen emergency and out-of-network care

If the care involved an emergency, or an out-of-network clinician at an in-network facility, collect the plan, facility, provider, and date facts needed for a No Surprises Act screen.

STEP 10 - Treat ground ambulance separately

Do not assume federal No Surprises Act protection applies to ground ambulance charges. State law and plan rules can differ.

STEP 11 - If uninsured or self-pay, compare the Good Faith Estimate

If a Good Faith Estimate applies, compare the estimate with the final bill and confirm whether the services actually match before treating a $400 or greater difference as a potential dispute trigger.

STEP 12 - Ask for the actual self-pay or cash rate

A chargemaster or gross charge is not automatically the amount a self-pay patient should accept as final. Ask what cash/self-pay pricing and assistance options apply.

STEP 13 - Request the financial-assistance policy

If the bill involves a qualifying tax-exempt hospital facility, obtain the actual written financial-assistance policy. Eligibility and covered providers vary by facility.

Use this wording: "Please send me your current financial-assistance/charity-care policy and application."

STEP 14 - Do not finance the bill before the audit is finished

A medical credit card or deferred-interest product can turn a disputed bill into consumer debt. Resolve the supported balance and assistance options first.

STEP 15 - Document every call and letter

Record date, time, department, representative, reference number, amount discussed, and what the provider or insurer promised to do.

STEP 16 - Escalate the correct problem to the correct party

Billing reconciliation usually starts with the provider and insurer. No Surprises issues, state insurance issues, and credit/billing disputes require different routes. Do not send every complaint everywhere.

STEP 17 - Resolve only the supported balance

After corrections, insurance adjudication, assistance, and documented rights issues are resolved, pay or arrange a plan for the amount the evidence supports.

HARD STOPS / MAJOR RED FLAGS

• Provider will not explain or itemize a disputed balance.

• Provider balance materially exceeds the EOB patient responsibility with no documented explanation.

• A possible protected balance bill is being collected before the coverage facts are resolved.

• A self-pay final bill materially exceeds an applicable Good Faith Estimate and the service differences are not reconciled.

• Pressure to finance or pay immediately while the bill is still under documented review.

• A tax-exempt hospital facility will not provide access to its actual financial-assistance policy.

• Coding or quantity discrepancies are dismissed without explanation or review.

BUYER / CONSUMER WORKSHEET

A. Core bill numbers

Field	Your entry
Provider current balance	
EOB patient responsibility	
Payments already made	
Credits/adjustments	
Difference requiring review	

B. Documents

Field	Your entry
Summary bill received	
Itemized bill received	
EOB received	
Payment history	
Good Faith Estimate if applicable	
Financial-assistance policy	

C. Review items

Field	Your entry
Apparent duplicate lines	
Quantity/service mismatch	
Coding question	

Out-of-network issue	
Emergency-care issue	
Ground ambulance	
Collections/credit issue	

D. Contact log

Field	Your entry
Provider billing contact/date	
Insurer contact/date	
Reference/case number	
Hold/extension obtained	
Next follow-up date	

SOURCE AND SCOPE

Built from the canonical Medical Billing Remedy v1.1 master. The canonical defines the product as a bill-reconciliation assistant, No Surprises Act fact screener, and financial-assistance router. The quick worksheet intentionally uses evidence and reconciliation rather than an assumed medical-bill error rate.

Educational reference only. Medical billing, insurance, financial-assistance, and legal rights depend on the actual documents, plan, provider, date, and jurisdiction. This guide does not diagnose fraud, guarantee a dispute result, or replace professional coding, legal, insurance, or financial advice.