Understanding Your Cleveland Clinic Estimate

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An estimate is an approximate calculation of what will be the total cost incurred for your medical visit. However, an estimate is not a guarantee of your final bill as this is an estimate and it is subject to change. Many variables may impact your amount due. These include, but are not limited to the circumstances noted below:

- · Payer denies your service due to medical necessity, frequency of service or benefit exclusion
- Benefits change since the time of the estimate creation
- If services are cosmetic, elective or non-covered services
- Change in your treatment plan service ordered as a screening but becomes diagnostic during the procedure (often happens with colonoscopy or mammogram). Visit <u>clevelandclinic.org/diagnosticscreening</u> for additional information.
- Complications during your service/care, including pathology, additional procedures, extended OR time or additional days in the hospital
- Self-administered drugs Medicare does not pay for self-administered drugs as an observation patient. Visit <u>medicare.gov</u> for more information.
- Change in insurance coverage prior to service
- Providers, not contracted or employed with Cleveland Clinic, who provide care for you (your surgeon, radiologist, anesthesiologist, or pathologist)
- Cleveland Clinic physicians who utilize third party billers for specific services (eg. radiology and laboratory) therefore, you may receive separate bills for these physicians
- · Additional specialty doctors needed for your care who are unanticipated at the time of order
- Error in the estimate creation

There are many reasons an estimate may differ from the statement you will receive. Above is a list of circumstances that may affect the actual cost of your visit.

This <u>guide</u> may help with common questions related to insurance, billing, and financial assistance.

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