



Creating a Web Quote Using AllPayor's Price Quote Portal


Introduction

The AllPayor Price Quote portal is designed to be integrated into any Hospital's Web Page. The following screen shots show the steps a user will take to generate an estimate.

Step #1

Start by selecting your Facility.

Web Price Quote




Facility: 

Insurance: 

Patient Type:

Quote Type: Quick Detail


Select Item or Service: By Code By Description


 Create Quote  Clear Form  Exit

Step #2

Click on the magnifying glass to search for your Insurance.

Web Price Quote




Facility: 

Insurance: 

Patient Type:

Quote Type: Quick Detail

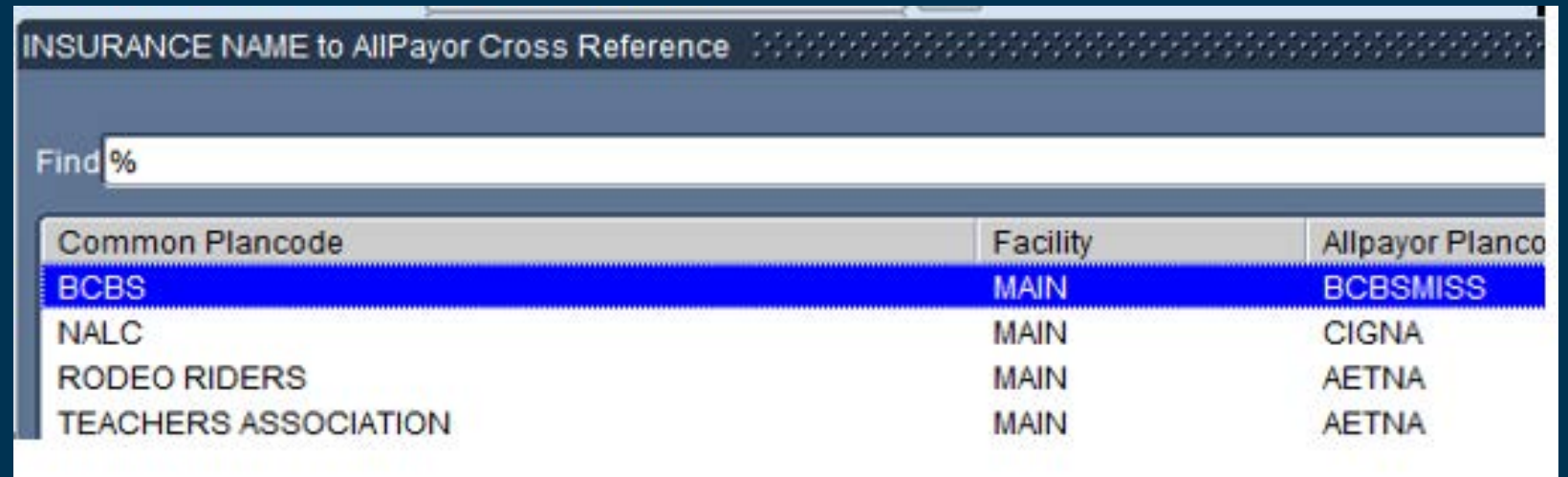
Select Item or Service: By Code By Description

Create Quote Clear Form Exit

Step #3

Select your Insurance.



INSURANCE NAME to AllPayor Cross Reference


Find %


Common Plancode	Facility	Allpayor Plancode
BCBS	MAIN	BCBSMISS
NALC	MAIN	CIGNA
RODEO RIDERS	MAIN	AETNA
TEACHERS ASSOCIATION	MAIN	AETNA


Step #4

From the drop down select either Outpatient or Inpatient. The program defaults to Outpatient.

Web Price Quote


Facility: YOUR HOSPITAL 


Insurance: 


Patient Type: OUTPATIENT 

Quote Type: Quick Detail

Select Item or Service: By Code By Description

 Create Quote


 Clear Form


 Exit

Step #5

You have the option of creating a Quick quote or a Detail quote.

Web Price Quote


Facility: 


Insurance: 


Patient Type:

Quote Type: Quick Detail

Select Item or Service: By Code By Description


Create Quote



Clear Form



Exit

Quick Quote

The Quick quote will generate a generic price quote without the patient's name or other demographic data.

Web Price Quote




Facility: 

Insurance: 

Patient Type:

Quote Type: Quick Detail

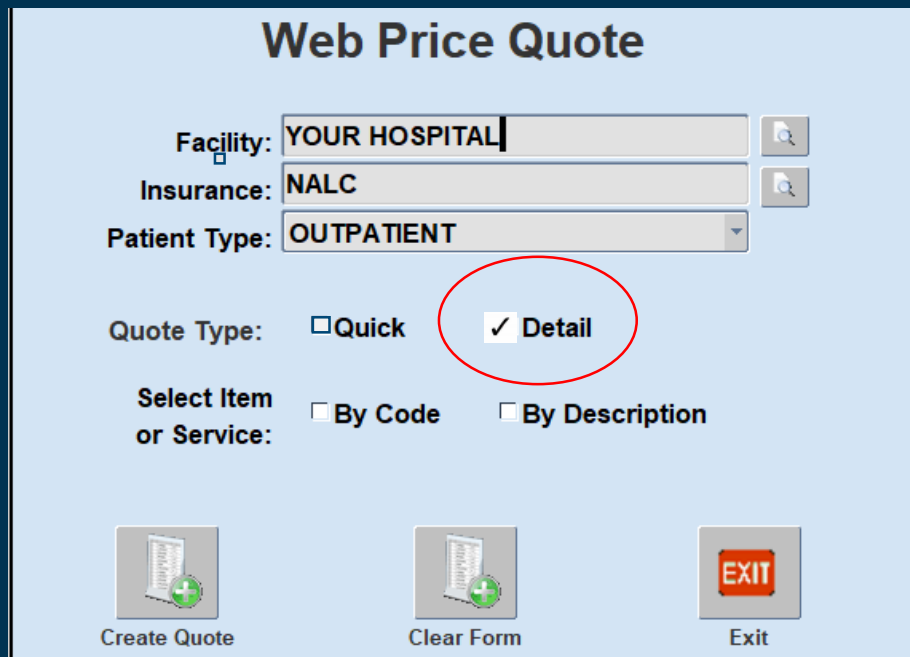
Select Item or Service: By Code By Description

 Create Quote  Clear Form  Exit

Detail Quote

The Detail quote allows the patient to enter their name and other identifying information for a specific price quote.

This is where the patient's basic insurance information is entered



Web Price Quote

Facility: YOUR HOSPITAL

Insurance: NALC

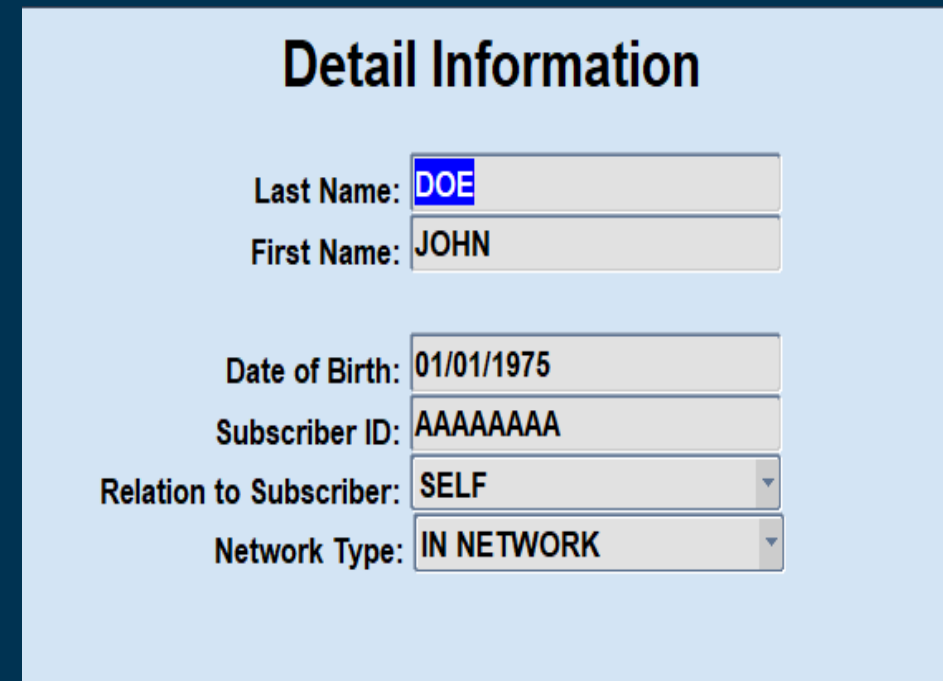
Patient Type: OUTPATIENT

Quote Type: Quick Detail

Select Item or Service: By Code By Description

Create Quote Clear Form Exit

The 'Detail' radio button is circled in red.



Detail Information

Last Name: DOE

First Name: JOHN

Date of Birth: 01/01/1975

Subscriber ID: AAAAAAAA


Relation to Subscriber: SELF


Network Type: IN NETWORK

Step #6

Selecting the service by CPT Code or CPT Description.

Web Price Quote




Facility: 

Insurance: 

Patient Type:

Quote Type: Quick Detail

Select Item or Service: By Code By Description

 Create Quote  Clear Form  Exit

Example of the list by CPT Code.

Items and Services by Billing Code

Find

Billing Code	Template Description
19120	REMOVAL OF BREAST LESION
23350	INJECTION FOR SHOULDER X-RAY
29826	SURGICAL ARTHROSCOPY SHO W/CORACOACRM LIGM RLS
29881	KNEE ARTHROSCOPY/SURGERY
36415	ROUTINE VENIPUNCTURE
36430	BLOOD TRANSFUSION SERVICE
36561	INSJ TUNNELED CTR VAD W/SUBQ PORT AGE 5 YR/>
36600	WITHDRAWAL OF ARTERIAL BLOOD
42820	REMOVE TONSILS AND ADENOIDS<AGE 12
43235	EGD DIAGNOSTIC BRUSH WASH
43239	EGD TRANSORAL BIOPSY SINGLE/MULTIPLE
43999	*NOT PROVIDED* STOMACH SURGERY PROCEDURE
44970	LAPAROSCOPIC APPENDECTOMY
45378	DIAGNOSTIC COLONOSCOPY
45380	COLONOSCOPY AND BIOPSY
45384	COLONOSCOPY W/LESION REMOVAL
45385	COLONOSCOPY W/LESION REMOVAL

Example of the list by CPT Description

Items and Services by Template Description	
Find %	
Template Description	Billing Code
ANTIBODY TREPONEMA PALLIDUM	86780
ANTINUCLEAR ANTIBODIES	86038
APPL MODALITY 1/> AREAS VASOPNEUMATIC DEVICES	97016
ASSAY GLUCOSE BLOOD QUANT	82947
ASSAY OF AMMONIA	82140
ASSAY OF AMYLASE	82150
ASSAY OF BLOOD/URIC ACID	84550
ASSAY OF FERRITIN	82728
ASSAY OF FOLIC ACID SERUM	82746
ASSAY OF FREE THYROXINE	84439
ASSAY OF GGT	82977
ASSAY OF GONADOTROPIN (LH)	83002
ASSAY OF IGE	82785
ASSAY OF INSULIN TOTAL	83525
ASSAY OF IRON	83540
ASSAY OF LACTIC ACID	83605
ASSAY OF LEAD	83655

Step #7

Once all your selections have been made, click on the Create Quote Button

Web Price Quote

Facility: YOUR HOSPITAL




Insurance: NALC

Patient Type: OUTPATIENT

Quote Type: Quick Detail

Select Item or Service: By Code By Description

DIAGNOSTIC COLONOSCOPY

Create Quote Clear Form Exit




Your Quote is Created

At this point, the quote can be printed by clicking on the Print button.

If the patient wants a customized quote, click on the Patient Responsibility button.

Quote Date:	11/12/2021	Billing Code:	45378
Quote Number:	QUOTE_936	Description:	DIAGNOSTIC COLONOSCOPY
Patient Name:	LASTNAME, FIRSTNAME	Shoppable Category::	OP MED SURG
Facility Code:		Insurance:	NALC
Patient Type:	OUTPATIENT	Insurance Negotiated Amount:	1,720.85
Network:	IN NETWORK		

Rev Code	Rev Code Description	Service Date	HCPCS	Total Charges
250	PHARMACY	11/12/2021		\$10.49
258	IV SOLUTIONS	11/12/2021		\$11.61
272	MED / SUR - STERILE SUPPLY	11/12/2021		\$51.25
278	MED / SUR - OTHER IMPLANTS	11/12/2021		\$17.08
301	LAB - CHEMISTRY	11/12/2021	82948	\$48.00
360	OR SERVICES	11/12/2021	45378	\$3,856.50
370	ANESTHESIA	11/12/2021		\$521.00
636	DRUGS - REQUIRING DETAIL CODING	11/12/2021	J7120	\$10.80
001	Total			\$5,435.48

 Print	 Patient Responsibility	 Exit
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Customizing, Printing and Saving Your Quote




Co-insurance percent, deductible, out of pocket, co-pay amount etc. can be added to provide a specific patient estimated amount due.

Once the customized quote information is entered, the quote can be printed or saved from this screen by clicking on the Print button.

Quote Date: 11/12/2021	Billing Code: 45378
Quote Number: QUOTE_936	Description: DIAGNOSTIC COLONOSCOPY
Patient Name: LASTNAME, FIRSTNAME	Shoppable Category: OP MED SURG

Enter your Insurance Coverage Information. This can be obtained from your Insurance Company.	
Co-Insurance Percent: 20.0000	Insurance Code: CIGNA
Individual Deductible: 1,000.00	Estimated Total Charges: \$5,435.48
Remaining Deductible: 250.00	Negotiated Amount Due: \$1,720.85
Max Out of Pocket: .00	Your Co-Pay Amount: \$0.00
Remaining Out of Pocket: .00	Remaining Deductible Amount: \$250.00
Co-Pay Amount: .00	Coinsurance Amount: 20.00 % \$294.17
	Remaining Out-of-Pocket Amount: \$0.00
	Total Estimated Due from Patient: \$544.17

 Disclaimer	 Print	 Exit
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 Print	 Patient Responsibility	 Exit
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Saving and Printing Your Quote

The quote downloads into a PDF format, so it can be saved or printed.

If a printed copy of the quote is wanted, the patient has the option of printing a summary or a detail of the quote in either English or Spanish.

Quote Date: 11/15/2021

Quote Number: QUOTE_938

Patient Name: LASTNAME, FIRSTNAME

Facility Code:

Patient Type:

Network:

Billing Code: 45378

Description: DIAGNOSTIC COLONOSCOPY


Shoppable Category: OP MED SURG


Price: NALC


Estimated Amount: 1,720.85

Report Language Options


English Spanish



 Print Summary



 Print Detail


 Exit

Rev Code	Rev C	HCPCS	Total Charges
250	PHARMACY	11/15/2021	\$10.49
258	IV SOLUTIONS	11/15/2021	\$11.61
272	MED / SUR - STERILE SUPPLY	11/15/2021	\$51.25
278	MED / SUR - OTHER IMPLANTS	11/15/2021	\$17.08
301	LAB - CHEMISTRY	11/15/2021 82948	\$48.00
360	OR SERVICES	11/15/2021 45378	\$3,856.50
370	ANESTHESIA	11/15/2021	\$521.00
636	DRUGS - REQUIRING DETAIL CODING	11/15/2021 J7120	\$10.80
001	Total		\$5,435.48


 Print


 Patient Responsibility


 Exit

Patient Print Summary Price Quote

The print summary price quote provides the detail of the quote along with the total charge and the patient's estimated amount due at time of service.

The disclaimer is specific to your hospital.

The AllPayor system auto-saves each template, which can be accessed later.

Your
Hospital
Logo Here

Procedure Estimate - Summary
IN NETWORK
 Generated November 05, 2021
10005 - FINE NEEDLE ASPIRATION BX W/US GDN 1ST LESION

Patient Name: DOE, JOHN
Patient Date of Birth: 01/01/1970
Quote Number: DOE_1924
Primary Insurance: AETNA
Patient Type:
Network Type: IN NETWORK
Subscriber ID: 12332456
Relationship to Subscriber: SELF
Facility: /
Admit Date: 11/05/2021
Discharge Date: 11/06/2021
DRG: .00
DRG Description: UNKNOWN

Your Insurance Carrier: AETNA
Estimated Total Charges: \$ 3,677.37
Plan Benefit: \$ 2,704.52
Your Co-Pay is: \$.00
Your Remaining Deductible is: \$.00
Your Coinsurance is: \$ 540.90 20.0000%
Your Remaining Out-of-Pocket: \$.00
Your Total Estimated Due: \$ 540.90

Payment Estimate Disclaimer:
This is only an ESTIMATE for the services listed.
This estimate only includes Your Health facility charges. This estimate may not reflect the final bill. It does not include other fees such as physician fees, anesthesiologist fees or radiologist fees. The estimate is based on contracted rates with the insurance company. If additional procedures are performed, they will be billed and ARE NOT INCLUDED IN THIS ESTIMATE. If you cannot pay this estimate in full, you can set up a payment plan and you can also request a charity care application. Individual family income must be less than 200% of the current Federal Poverty Income Guideline published by Health and Human Services.

Patient/Guardian Signature
Date

Patient Print Detail Price Quote

The print detail price quote provides the charge description, service date, CPT/HCPC's code and charge amount for each line item.

It also includes the total charge and the patient's estimated amount due at time of service.

Your
Hospital
Logo Here

Procedure Estimate - Detail

Generated November 05, 2021

IN NETWORK

10005 - FINE NEEDLE ASPIRATION BX W/US GDN 1ST LESION

Last Name: DOE	Account Number: DOE_1924
First Name: JOHN	Master Plan Code: AETNA
Subscriber ID: 12332456	
Relationship: SELF	Facility Code:
Date of Birth: 01/01/1970	DRG: 0
Admit Date: 11/05/2021	
Discharge Date: 11/06/2021	
Bill Type: OUT	

Revenue Code	Description	Service Date	Rate/HCPCS	Total Charges
270	MED / SUR SUPPLIES & DEVICES	11/05/2021		518.99
311	LAB - PATHOLOGY / CYTOLOGY	11/05/2021	88185	950.06
311	LAB - PATHOLOGY / CYTOLOGY	11/05/2021	88184	369.40
311	LAB - PATHOLOGY / CYTOLOGY	11/05/2021	88173	100.92
361	OR - MINOR SURGERY	11/05/2021	10005	1,738.00
TOTAL				\$ 3,677.37

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Your insurance carrier is:	AETNA
Plan Benefit:	\$ 2,704.52
Estimated Total Charges:	\$ 3,677.37
Your remaining deductible is:	\$.00
Your estimated coinsurance is:	20.0000% \$ 540.90
Remaining out-of-pocket is:	\$.00
Your total estimated due:	\$ 540.90

Payment Estimate Disclaimer:
 This is only an ESTIMATE for the services listed.
 This estimate only includes Your Health facility charges. This estimate may not reflect the final bill. It does not include other fees such as physician fees, anesthesiologist fees or radiologist fees. The estimate is based on contracted rates with the insurance company. If additional procedures are performed, they will be billed and ARE NOT INCLUDED IN THIS ESTIMATE. If you cannot pay this estimate in full, you can set up a payment plan and you can also request a charity care application. Individual family income must be less than 200% of the current Federal Poverty Income Guideline published by Health and Human Services.

Patient/Guardian Signature

Date

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For questions and/or issues, please contact your hospital.