

Medical Billing Glossary

A through Z

Every term you'll ever encounter — explained in plain, everyday English

Whether you are brand new to medical billing or just need a quick refresher, this glossary covers every important term — clearly and simply. No confusing jargon. No medical school required. Just real definitions you can actually use.

A

Adjudication	The process an insurance company uses to review a claim and decide how much to pay. Think of it as the insurer's final decision on your claim.
Allowed Amount	The maximum dollar amount an insurance plan will pay for a specific service. If a doctor charges more, the extra cost may fall on the patient.
Appeal	A formal request asking an insurer to reconsider a denied or underpaid claim. You always have the right to appeal a denial.
Assignment of Benefits (AOB)	When a patient signs a form allowing insurance payment to go directly to the provider instead of to the patient first.
Authorization / Prior Auth	Approval from the insurance company that must be obtained BEFORE certain procedures are done. Without it, the claim may be automatically denied.

B

Balance Billing	When a provider charges the patient for the difference between what the provider billed and what the insurer paid. Not always legal, depending on the contract.
Beneficiary	The person covered by a health insurance plan — usually the patient.
Birthday Rule	When a child is on two parents' plans, the parent whose birthday falls first in the calendar year has the primary insurance.
Blue Cross Blue Shield (BCBS)	A large group of independent insurance companies. A very common payer that billers work with regularly.

C

Capitation	A payment model where a provider receives a flat monthly fee per patient, regardless of how many times that patient is seen.
Claim	A formal request submitted to an insurance company asking them to pay for medical services provided to a patient.
Clean Claim	A claim submitted with no errors, missing information, or inconsistencies. Clean claims are processed faster and result in fewer denials.
CMS-1500	The standard paper claim form used by non-institutional providers (doctors, clinics) to bill Medicare, Medicaid, and most insurers.
Coinsurance	The percentage of the bill the patient pays AFTER their deductible is met. Example: 80/20 means insurance pays 80%, patient pays 20%.
Coordination of Benefits (COB)	Rules that determine which plan pays first (primary) and which pays second (secondary) when a patient has two insurance plans.

Copay (Copayment)	A fixed dollar amount the patient pays at the time of service — for example, \$25 per office visit.
CPT Code	Current Procedural Terminology. A 5-digit number that describes exactly what medical service or procedure was performed.
Crossover Claim	A claim where Medicare pays first, then automatically forwards the remaining balance to Medicaid as the secondary payer.

D

Days in AR	Average number of days it takes a practice to collect money owed. Fewer days means healthier cash flow.
Deductible	The amount a patient must pay out-of-pocket each year before their insurance starts paying. Example: a \$1,000 deductible means the patient covers the first \$1,000.
Denial	When an insurer refuses to pay a claim or pays less than expected. Always check the denial reason — many can be corrected and resubmitted.
Date of Service (DOS)	The specific date the medical service was provided. Critical information required on every claim form.
Downcoding	When an insurer changes a billed procedure code to a lower-paying code, usually because they believe the original code was too high.
DRG (Diagnosis-Related Group)	A system hospitals use to categorize inpatient stays for billing. Each DRG has a fixed payment rate from Medicare.

E

EDI (Electronic Data Interchange)	The electronic transfer of claim data between providers and insurance companies. Faster and more accurate than paper claims.
EOB (Explanation of Benefits)	A statement from the insurance company showing what was billed, what they paid, what was adjusted, and what the patient owes.
ERA (Electronic Remittance Advice)	The electronic version of an EOB. Shows how claims were paid or denied, sent directly to your billing system.
Excluded Service	A service that is not covered by an insurance plan at all. Billing for excluded services results in automatic denial.

F

Fee Schedule	A complete list of maximum prices an insurance plan will pay for each service or procedure.
Fraud	Intentionally billing for services not provided, or misrepresenting information to receive payment. A serious federal crime with severe penalties.

G

Global Period	The number of days after a surgery during which all related follow-up care is included in the original surgery fee — no separate billing allowed.
Group NPI	A National Provider Identifier number assigned to a group practice or clinic (as opposed to an individual provider's NPI).

H

HCPCS Code	Healthcare Common Procedure Coding System. Includes CPT codes (Level I) and alphanumeric codes for supplies, equipment, and non-physician services (Level II).
HIPAA	Health Insurance Portability and Accountability Act. Federal law protecting patient health information privacy and setting standards for electronic billing.
HMO (Health Maintenance Organization)	A type of insurance plan requiring patients to use a specific network of providers and get referrals to see specialists.

I

ICD-10	International Classification of Diseases, 10th Edition. The code system used to describe a patient's diagnosis or the reason for their visit.
In-Network	A provider with a contract with a specific insurance plan. In-network services cost patients significantly less out-of-pocket.

J

J-Code	HCPCS Level II codes used to bill for injectable drugs administered in a clinical setting, such as chemotherapy agents.
---------------	---

L

LCD (Local Coverage Determination)	A Medicare policy defining when a specific service is considered medically necessary in a specific region of the country.
---	---

M

Medicaid	A joint federal and state program providing health insurance to low-income individuals and families. Coverage and eligibility vary by state.
Medicare	Federal health insurance primarily for people age 65 and older, and some younger people with disabilities. Has Parts A, B, C, and D.

Modifier	A two-character code added after a CPT code to provide additional information — such as that a procedure was bilateral, or performed by two providers.
-----------------	--

N

NPI (National Provider Identifier)	A unique 10-digit number assigned to every healthcare provider. Required on all claims submitted to insurance.
Network	The group of providers and facilities that have a contract with a specific insurance plan.

O

Out-of-Network	A provider who does NOT have a contract with the patient's insurance plan. Services typically cost the patient more.
Out-of-Pocket Maximum	The most a patient will ever pay in a single plan year. Once reached, insurance covers 100% of all covered services.

P

Patient Responsibility	The portion of the bill the patient is expected to pay after insurance processes the claim (copay + coinsurance + deductible).
Payer	An entity — like an insurance company — that pays healthcare claims. Also called a carrier or payor.
Place of Service (POS) Code	A two-digit code indicating where the service was performed. Example: 11 = Office, 21 = Hospital Inpatient, 23 = Emergency Room.
PPO (Preferred Provider Organization)	An insurance plan with a network of preferred providers. Patients can see out-of-network providers but pay higher costs.
Premium	The monthly amount paid to keep a health insurance policy active, separate from any cost-sharing when care is received.
Prior Authorization (PA)	Approval required from the insurer before certain services, medications, or referrals will be covered by the plan.

R

Remittance Advice (RA)	A document from the insurer explaining how a claim was processed — what was paid, denied, or adjusted.
RVU (Relative Value Unit)	A unit used to calculate Medicare payment for a service, based on provider work, overhead costs, and malpractice insurance.

S

Secondary Insurance	The second insurance plan that pays after the primary plan has already processed the claim.
Self-Pay	When a patient has no insurance and pays the entire bill themselves.
Superbill	A detailed itemized receipt listing diagnoses, procedures, and fees. The main document used to submit insurance claims.
Subrogation	When an insurer recovers money it paid from a responsible third party — common after auto accidents.

T

TIN (Tax Identification Number)	The federal tax ID number of a provider or practice. Required on all insurance claims.
Timely Filing Limit	The deadline for submitting a claim after the date of service. Missing this window means automatic, non-appealable denial.

U

UB-04	The standard claim form used by hospitals and inpatient facilities to bill insurance companies.
Upcoding	Deliberately using a higher-level code than what was actually performed in order to receive more payment. This is fraud.
Utilization Review	The process of checking whether services are medically necessary before, during, or after care is provided.

V

Verification of Benefits (VOB)	Checking with an insurance company to confirm a patient's coverage, deductibles, copays, and authorization requirements before services are provided.
---------------------------------------	---

W

Write-Off	An amount the provider agrees to remove from the bill — typically the difference between the billed charge and the payer's allowed amount.
Workers' Compensation	Insurance covering medical costs for employees injured on the job. Billed separately from regular health insurance.

X / Z

X12 837	The standard electronic format used to submit healthcare claims. 837P is for professional (CMS-1500) claims; 837I is for institutional (UB-04) claims.
----------------	--

Zero Pay EOB

An Explanation of Benefits showing no payment — usually because the patient owes the full amount due to an unmet deductible.