Provider Prime

CLINIC GROWTH VAULT 2.0
FREE RESOURCE · 2026

SCRIPT | FRONT DESK & PATIENTS

Front Desk Insurance Capture & Eligibility Script

Most denials start at the front desk. This is the word-for-word script, the eligibility read-out and the check-in checklist that stop them there.

INSIDE

- Scheduling-call script (insurance first)
- How to read a 271 eligibility response
- COB script: "other coverage" done right
- Check-in script, new and returning patients
- Medicare, Medicare Advantage and Medicaid gotchas
- Time-of-service collection script

Front Desk Insurance Capture & Eligibility Script

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How to use this

1. Train every person who answers the phone or checks patients in. Role-play each script twice.
2. Tape the one-page desk card at each check-in station.
3. Run eligibility 72 hours before every visit (batch 270/271), then re-check day-of for anyone flagged.
4. Audit 10 registrations a week against the checklist. Feed misses back the same day — kindly.

WHO IT'S FOR
Front desk, schedulers, call center, practice managers

TIME TO PUT IN PLACE
1 hour to train; 2 weeks to habit

PAIRS WITH
Clean Claim Checklist · Patient Collections Scripts

WHAT'S INSIDE

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Educational resource. Not legal or coding advice; verify against current payer policies. Examples use invented data — no PHI. Benchmarks are commonly cited industry ranges; your payer mix and specialty will move them. Don't email PHI to anyone, including us.

SECTION 01

Why the front desk owns the denial rate

Eligibility, registration and authorization errors are consistently among the most common reasons claims deny. Every one of them is decided in the first five minutes of a patient's visit — or on the scheduling call before it.

Front desk miss	Shows up later as	Prevented by
Name/DOB/ID typed from memory	`CO-31` · rejection	Card scan + read-back (Script B)
Coverage not checked for DOS	`CO-27` `CO-26`	72-hour eligibility batch + day-of re-check
Medicare Advantage entered as Medicare	`CO-109`	"Is there a plan name on your card?" (Section 04)
Didn't ask about other coverage	`CO-22`	COB script (Section 05)
Referral / auth not checked	`CO-197` `CO-288`	Scheduling script, auth question
Copay not collected	`PR-3` → statement → bad debt	Time-of-service script (Section 06)

SECTION 02

Script A — The scheduling call

Insurance first, before you offer a time slot. It's easier to fix a coverage issue three days out than at the window.

SCHEDULING — NEW OR RETURNING PATIENT	2-3 MINUTES
YOU	"Thanks for calling `CLINIC`, this is `NAME`. Are you calling to schedule? Great — can I get the patient's full name as it appears on the insurance card, and date of birth?"
YOU	"Are you using insurance for this visit? Which plan is it — the name printed on the front of the card? *(Listen for a plan name: "Humana Gold," "Aetna Medicare," "Wellcare" = Medicare Advantage.)*"
YOU	"Can you read me the member ID exactly as it's printed, including any letters at the start? And who is the policyholder — you, or a spouse or parent?" *(If not self: get the subscriber's name and DOB.)*
YOU	"Do you have any other insurance — through work, a spouse, Medicare, or Medicaid?"
YOU	"What's the visit for? *(Check auth-required list.)* Did another doctor refer you? Some plans need a referral on file before we can see you."
YOU	"Perfect. I'll verify your coverage before your visit. If anything comes back different, we'll call you — and please bring your card and photo ID. I'm booking you for `DAY/TIME`. You'll get a text reminder; reply C to confirm."
NOTE	Can't get the insurance details? Book anyway, flag "insurance pending," and ask for a photo of the card via your secure patient portal or text-to-upload (not personal email).

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SECTION 03

Script B — Check-in

RETURNING PATIENT	60-90 SEC
YOU	"Hi `NAME`, welcome back. Can you confirm your date of birth for me?"
YOU	"May I see your insurance card and ID? I scan them each visit — plans change more often than people expect."
YOU	"Has anything changed — address, phone, employer, or any **new or other** insurance, including Medicare or Medicaid?"
YOU	"Is today's visit related to an accident or injury at work?"
YOU	"Your copay today is `$__`. Card or cash?"

NEW PATIENT	3-4 MIN
YOU	"Welcome! May I have your photo ID and insurance card? I'll scan both sides."
YOU	"I'll read back what I've entered — please stop me if anything's off: `NAME`, born `DOB`, member ID `ID`…"
YOU	"Who's the policyholder? … And their date of birth?"
YOU	"Any other coverage — a spouse's plan, Medicare, Medicaid, or a plan through school?"
YOU	"These forms cover consent, privacy notice, and financial policy. The financial policy explains copays and what happens if insurance doesn't pay — happy to answer questions."

Registration must-haves (every visit)

- [ ] Card scanned **front and back** (back has payer phone, claims address, and often the payer ID)
- [ ] Name, DOB, sex entered **exactly as on the card** — not as the patient spells it
- [ ] Member ID with prefix / suffix; group number
- [ ] Subscriber name, DOB and relationship (if not self)
- [ ] Other coverage asked — answer recorded, even if "none"
- [ ] Accident / injury question answered
- [ ] Eligibility response for today attached to the visit
- [ ] Referral / auth status checked for the visit type
- [ ] Copay / estimate collected or documented why not

SECTION 04

Reading the eligibility response (271)

A green "active" checkmark is not an eligibility check. Read these eight things on every response — the portal or clearinghouse screen shows them in some form.

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Field	What to look for	If it's off
Coverage status for DOS	Active on the *date of service*, not today	Inactive → call patient before the visit; self-pay or new coverage
Plan / product name	HMO / PPO / EPO / MA / Medicaid managed care	HMO/EPO → network & referral rules apply
Name / DOB match	Exactly what the payer has	Update registration to match the payer
Copay / coinsurance	For *this* service type (office, specialist, urgent care)	Use the specific service-type benefit, not the generic one
Deductible remaining	Individual and family; in-network	Large remaining deductible → estimate & collect (Section 06)
PCP on file	HMO / Medicaid: is it your provider?	Not yours → referral or PCP change before visit
Other payer info	"Other insurance" or Medicare primary indicators	Run the COB script
Carve-outs	Behavioral health, lab, PT, imaging managed by another company	Bill and auth through the carve-out vendor

Medicare, Medicare Advantage & Medicaid gotchas

- **Red-white-blue Medicare card ≠ how they're covered.** Many patients carry their original Medicare card but are enrolled in a Medicare Advantage plan. Ask: "Do you have a separate card from a plan like Humana, UnitedHealthcare, Aetna, or Wellcare?" Bill the MA plan, not Medicare.
- **Use the MBI** (Medicare Beneficiary Identifier, `11` characters). The old SSN-based HICN no longer works on claims.
- **Medicare Secondary Payer.** If a Medicare patient (or spouse) is still working with employer coverage, that plan may be primary. Ask the MSP questions at intake and update them regularly.
- **Medicaid eligibility can change month to month.** Check every visit. Medicaid managed care plans have their own IDs and PCP rules.
- **Dual eligibles** (Medicare + Medicaid): Medicare (or the MA plan) is primary; Medicaid is payer of last resort. Don't collect Medicare cost-sharing from Qualified Medicare Beneficiaries (QMBs).

SECTION 05

Script C — Other coverage (COB)

When the eligibility response shows other coverage, or a claim comes back `CO-22`, the patient usually needs to call their plan. Only they can update it.

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COB — AT THE DESK OR BY PHONE	2 MINUTES
YOU	"Your plan is showing that you might have another insurance policy on file — sometimes it's an old plan from a previous job, or a spouse's plan. Do you have any other coverage right now?"
PATIENT	"No, just this one."
YOU	"Thanks. The plan won't pay until it confirms that. It's a quick call on your side: please call the member services number on the back of your card and say, **'I'd like to update my coordination of benefits — I have no other insurance.'** They'll update it right away, usually in under five minutes."
YOU	"Once that's done, we'll resubmit and you won't get a bill for this. Could you call them today or tomorrow? I'll check back on `DATE`."
NOTE	If they DO have other coverage: scan that card too, determine primary (birthday rule for dependent children; employee plan before spouse's plan; Medicare rules for 20+ employee employers), and re-verify both.

SECTION 06

Script D — Collecting at the time of service

Collecting before the visit is kinder than a surprise statement in six weeks. Say the number, then stop talking.

COPAY AND ESTIMATE	60 SECONDS
YOU	"Your copay for today's visit is `$__`. Would you like to use a card, or cash?" *(Not "Would you like to pay today?")*
YOU	Deductible: "Your plan shows `$__` left on your deductible. Based on today's visit, the estimate is `$__`. We collect `$__` today, and you'll get a statement for any difference after insurance processes it."
PATIENT	"Can't you just bill me?"
YOU	"I understand. Our policy is to collect the copay at the visit — it's set by your plan. If today is hard, I can take part of it now and set a date for the rest. What works for you?"
NOTE	Uninsured / self-pay patients scheduling at least 3 business days ahead are entitled to a Good Faith Estimate under the No Surprises Act. Have a template ready.

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Front desk card

EVERY PATIENT · EVERY VISIT

ASK EVERY VISIT

- "Can you confirm your date of birth?"
- "May I scan your insurance card and ID?"
- "Any **new or other** insurance — including Medicare or Medicaid?"
- "Is this visit related to an accident or work injury?"
- "Your copay today is $__. Card or cash?"

SCHEDULING CALL

- Name + DOB as on card
- Plan name on front of card (MA?)
- Member ID incl. prefix; policyholder
- Other coverage?
- Visit reason → auth / referral?

READ THE 271

- Active on **DOS**
- Plan type (HMO/PPO/MA/Medicaid)
- Name/DOB exact match
- Copay for **this** service type
- Deductible remaining
- PCP on file
- Other payer indicators
- Carve-outs

COB LINE

"Please call the number on the back of your card and say: 'I'd like to update my coordination of benefits.'"

TIMING

Eligibility batch 72 hours before · re-check day-of if flagged · card scanned every visit · read-back every new patient.

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DONE READING? TWO OPTIONS.

Run it yourself. Or we run it for you.

Everything in this guide works without us. If your team doesn't have the hours, Provider Prime's billing team does this work every day — inside your EHR, PM and clearinghouse. You change nothing.

01 · SNAPSHOT

Free revenue snapshot: denial patterns, A/R by bucket, and the three fixes worth doing first.

02 · PILOT

30-day risk-free pilot. $0. Claims out every business day, denials reworked within 2 business days.

03 · DECIDE

Keep going at 4% of net collections, month-to-month, 30-day notice. Or keep the plan and walk.

Free revenue snapshot → providerprime.com/get-started

hello@providerprime.com · WhatsApp +20 100 539 8585

- We make money when you collect money.
- BAA before access
- Live in one week

You didn't go to med school to babysit a clearinghouse.

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Please don't send PHI by email or web form — we'll set up secure access after a BAA is signed.
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