Frequently Asked Questions

Good Samaritan Direct Health is available to answer your questions over the phone or online. In order to assist you with your healthcare benefits 24 hours a day, Client Services' most frequently asked questions are available at your fingertips. For other questions contact Good Samaritan Direct Health Client Services by:

Phone:
Toll Free: (888) 690-3044
Local: (812) 245-5303

Mail:
Good Samaritan Direct Health
P.O. Box 2109
Columbus, IN 47202-2109

Email:
Member.Services@gshvindirect.org

Claims

How do I file a claim?

Check your Summary Plan Document for specific information for your Health Plan. Your Good Samaritan Direct Health contracted provider should file your claim directly to Good Samaritan Direct Health or the elected Rental Network. However, if it becomes necessary for you to file the claim yourself, send to Good Samaritan Direct Health --- P.O. Box 2109 --- Columbus, IN 47202-2109

How long do I have to file a claim?

Typically submission of claims to the Claims Administrator (Good Samaritan Direct Health) should be filed within ninety (90) days after the services are rendered. Please check your Summary Plan Document for specific claims filing limits.

A provider has billed me, how do I know how much of the bill to pay?

Refer to your Good Samaritan Direct Health Explanation of Benefits. The Explanation of Benefits will indicate your responsibility for the bill. For more information, check your Summary Plan Document.

What is a deductible?

Deductible means the specific dollar amount of covered charges that must be incurred during a Calendar Year before any covered charges can be considered for payment by the Health Plan. Check your Schedule of Medical Benefits in your Summary Plan Document for specific plan amounts and more details regarding the definition.

What is a copayment or coinsurance?

A specific dollar or percentage of covered charges indicated in the Schedule of Benefits for which a covered person is responsible.

How does my out-of-pocket maximum work?

The out-of-pocket maximum is the dollar amount of a deductible and/or coinsurance expense paid by a covered person and/or family for covered services in a benefit period. After you reach your out-of-pocket limit, your plan covers 100% of the eligible charges for the remainder of the benefit period unless specified by your Health Plan. Check your Summary Plan Document for details.

What is Coordination of Benefits?

Your Summary Plan Document lists the definition in detail. Coordination of Benefits, or COB, applies when you are covered by multiple health benefit plans at the same time. Under one plan you will be designated as a primary member and benefits will be applied first. The second plan will coordinate with the first for any other possible payment.

Do I need to complete and return a Coordination of Benefits questionnaire?

You received this Coordination of Benefits questionnaire because we have missing or outdated information, this indicates you may be eligible for more than one insurance coverage. Please fill out the questionnaire and return to: Good Samaritan Direct Health COB, P.O. Box 2109 --- Columbus, IN 47202-2109

Appeals

Do I have the right to appeal a claim denial or claims payment?

Check your Summary Plan Document for specific information regarding your Appeal Rights and Procedures. Any appeals should be directed in writing to Good Samaritan Direct Health, Appeals, P.O. Box 2109 --- Columbus, IN 47202-2109

Physicians and Other Providers

How do I find a Good Samaritan Direct Health Network Provider?

These providers may be found in the Good Samaritan Direct Health Provider Directory.

What is the advantage of using Good Samaritan Direct Health Network Provider?

If you use Good Samaritan Direct Health network provider, your provider will be responsible for filing the claim on your behalf and will directly receive payment from us for covered services. In most cases, you will only be responsible for deductibles, coinsurance or copayments. If you utilize a non-network provider, you may be subject to balance billing for any outstanding amount. Check your Summary Plan Document for more information and the Good Samaritan Direct Health Provider Directory for network providers.

How is my claim processed if I do not use a Good Samaritan Direct Health Network Provider?

If your Health Plan design requires you to utilize a Good Samaritan Direct Health Network Provider, your charges could be denied or require an increased amount of responsibility for your portion of the payment. Refer to your Summary Plan Document for more information.

What is a Primary Care Physician (PCP)?

Your PCP acts as your regular physician and can help coordinate other care you may need, such as a specialist office visit or hospital inpatient or outpatient services. Check the Good Samaritan Direct Health Provider Directory for a list of these PCP's.

Can I utilize a non-network provider?

You can do so, but your claims could be denied or processed with out-of-network benefits, causing you to incur more out-of-pocket expenses. See your Summary Plan Document for details.

Miscellaneous

What do I do in case of an emergency?

Call 911 or seek medical help immediately to receive care. However, you should contact Good Samaritan Direct Health within 48 hours of going to the hospital to ensure the highest level of benefits are paid for covered services.

How do I order additional ID Cards?

Call Good Samaritan Direct Health Member Services to request an ID card, (812) 245-5303 locally or Toll Free at (888) 690-3044.

Should I carry my ID card at all times?

Yes, you will be asked to present this card each time you visit a physician's office, pharmacy or hospital to verify eligibility for health benefits.

What does HIPAA actually do for me as a Good Samaritan Direct Health Member?

The HIPAA Privacy Rule has, for the first time, created national standards to protect individuals' medical records and other personal health information. It sets boundaries on the use and release of health records and establishes appropriate safeguards for healthcare providers and others must achieve to protect the privacy of health information. The legislation sets limits on releasing health information to a minimum or reasonably needed purpose of disclosure. Also, HIPAA rules empower individuals to control certain uses and disclosures of their health information. HIPAA generally provides patients the right to examine, obtain and review a copy of their own health records and allows individuals to request corrections.