Frequently Asked Questions: Providers

Q: My patient is a Lancaster County resident, but I practice in a different county. Can I still enroll in your program?
A: YES! The provider does not need to be in Lancaster County, only the patient.

Q: How can my patient be sure they will be financially eligible?
A: Total household income cannot exceed 250% of the Federal Poverty Guidelines. The patient can usually get this number from the "Total Income" line of last year's tax return and compare that to the 2023 Federal Poverty Guidelines (Don't forget to multiply by 2.5). Here is an example:

Number in Household	Federal Poverty Guideline	250% of Poverty Guideline
1	$14,580	$36,450
2	$19,720	$49,300
3	$24,860	$62,150
4	$30,000	$75,000

Q: My patient has co-insurance, not copays; will you reimburse for co-insurance?
A: We will cover co-insurance payments up to $40. The patient is responsible for paying you for any remaining co-insurance over $50 (their $10 + our $40).

Q: My patient has not reached their deductible- are you able to assist them with the cost of their visit?
A: As the provider, you must bill the insurance company so the patient will eventually reach their deductible. In the meantime, we can cover up to $40 per visit. The patient is responsible for paying you for the remainder of the bill. We encourage patients with high-deductible plans to contact the PA Health Access Network (PHAN) at https://pahealthaccess.org/gethelp/ to get help with choosing a plan that might better meet their needs.

Q: My patient needs a specific type of therapy that is not covered by their insurance- can you help?
A: Occasionally, we can support a patient with therapy not covered by their insurance. We would need the provider to contact us directly to discuss the details.

Q: Do you need ICD/CPT codes on the invoice?
A: NO! Our HIPPA disclosure agreement with the patient is only for their name, DOB, the providers name, date, time, and location of treatment, and billing information. We DO NOT want any additional information which would be protected under HIPPA.

Q: What should and shouldn't be included on the invoice to Touchstone Foundation?
A: -Patient name (or another pre-arranged identifier)
-Date of service

-Total cost of service (as reimbursed by the patient's insurance),
-A line showing the patient's $10 contribution
-A line showing the amount due by Touchstone, which should specify:
    amount of copay OR
    calculated amount of co-insurance OR
    a statement that patient has not met the annual deductible, and a line billing $40
-Do NOT include HIPPA information, such as CPT or ICD codes, patient DOB, patient contact info, etc.
-Terms are 30 days from the date the invoice is emailed or postmarked, however we typically mail the check within one week of receipt.

Q: How often should I send you an invoice?
A: We recommend no more than weekly and no less than monthly. We will not reimburse for visits more than 90 days past, unless by prior agreement. Under no circumstances can we reimburse for visits from the previous year after March 30th of the following year.

Q: A patient was enrolled, but their card is expired- what should we do?
A: Touchstone sends reminders to patients that they need to update their enrollment annually, but sometimes these reminders are lost or forgotten. If a patient's enrollment has expired, please do not bill Touchstone for services. The patient should be billed in accordance with your office's regular procedures. The patient should be reminded to re-enroll as soon as possible.
If they are still eligible and their re-enrollment is approved, we will issue them a new card. Once they are approved, you may send us the invoice for any visits during the gap and we will pay retroactively up to 90 days prior to the date they re-enrolled. You must reimburse the patient for funds paid by Touchstone.