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Healthcare Terminology Crossword

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| **Across****3.** A facility other than a hospital, medical or dental office, whose main function is performing surgical procedures on an outpatient basis.**4.** An amount the insured person must pay before insurance payments for covered services begin.**8.** An immediate family member of a subscriber by marriage, birth or legal acquisition and who is legally dependent upon the subscriber to the Intern Revenue Service. **10.** Dollar amount over the negotiated rate to be written off by a participating provider for services to a participating provider member. This dollar amount if the difference between the total charge and the allowed amount. **11.** The period of time which must elapse before benefits are payable under an insurance contract.**15.** Medical services rendered to a member that are covered in the plan, i.e. office visits and in return paid by health insurance**16.** An individual or institution that render medical care.**17.** Equipment and supplies such as wheelchairs, hospital beds, crutches, nebulizers, etc., and must be prescribed due to a medical condition of injury. **18.** Itemized bill for services rendered to a member**22.** The person with whom an insurance contracts to provide health benefits for that person and enrolled dependents.**23.** A subscriber or covered dependent who occupies a hospital bed while receiving hospital care, including room, board and general nursing care. **24.** Termination of membership for a subscriber’s contract.**25.** Benefits, as stated in the policy, for which an insured is eligible.**26.** Coding system used to identify services rendered.  | **Down****1.** Medical expenses not covered under a benefit agreement that an insured is required to pay.**2.** Services received for a sudden, serious, or unexpected illness, injury or condition, emergency other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such conditions.**5.** A form sent to the subscriber after a claim for payment has been processed by the insurance company explaining the action taken on that claim. **6.** Medical services that have been authorized and approved as medically necessary by the primary care giver.**7.** The date that the member’ policy/coverage is no longer active (in effect).**9.** Maximum dollar amount that an insurance company will reimburse a provider for a given service.**12.** The amount a physician or other provider of care actually bills for a particular medical service or procedure. The actual charge may differ from the customary and/or reasonable charges under insurance programs. **13.** Any person covered under an insurance policy.**14.** Satisfaction of requirements for membership as stated in the policy; the state of being qualified or eligible to receive coverage.**19.** Three-digit codes used in the billing of hospital claims. **20.** An insurance policy purchased by an organization or association as a benefit to its employees or members.**21.** Aims to protect privacy of all the members. |