Provider-Based Clinics
Frequently Asked Questions

Nebraska Medicine clinics generally operate as hospital outpatient departments or provider-based clinics. Provider-based clinics are often referred to as hospital-based clinics. Federal health care guidelines differentiate clinics that a hospital owns and employs the staff involved in patient care. These provider-based clinics are held to high standards of care and are required to meet federal accreditation standards for hospitals, which are greater than those of physician-based clinics.

Visits to a provider-based clinic result in two charges to the patient. One charge for hospital services and one charge for physician services. Depending on your insurance benefits, this model may result in higher out-of-pocket expenses.

Below are answers to frequently asked questions related to provider-based clinics. If you have additional questions or require additional assistance, please contact Nebraska Medicine Customer Services at 402.559.3140 or 888.662.8662.

Q: What does “provider-based clinic” mean?
A: This term is used to describe clinics that are actually part of a hospital. Clinics located miles away from the main hospital campus may be considered part of the hospital. When you see a physician or receive services in a provider-based clinic, you are being treated within the hospital rather than a traditional physician’s office. Provider-based clinics are held to higher quality standards. This is a common model of practice for health systems locally and around the nation.

Q: What is different about patient billing in a provider-based clinic?
A: According to health care billing rules, when you see a physician in a provider-based clinic, physician and hospital charges are billed separately. When you see a physician in a private office setting, all services and expenses are bundled into a single charge. Services provided in provider-based clinics cost more (for nursing, utilities and facilities) which may result in greater out-of-pocket expenses to you. For patients with insurance, physician services are processed under physician benefits, which are generally subject to patient copayments, while hospital services are processed under hospital benefits and subject to deductibles and coinsurance amounts.

Q: How will I know if a clinic is a provider-based clinic?
A: Signs are posted in each clinic that is considered a provider-based clinic. Nearly all Nebraska Medicine clinics operate as provider-based clinics.

Q: What should I ask my insurance carrier?
A: Many insurance plans cover facility charges in provider-based clinics. To understand your out-of-pocket costs, ask how much of the charge will be covered and what will be applied to your deductible or subject to coinsurance.

continued >
Q: Does this affect co-pays or deductibles?
A: This will depend upon each patient’s specific insurance benefits. Additional out-of-pocket expenses may be incurred in a provider-based clinic. Medicare patients will incur a coinsurance cost to the hospital that you would not incur if the facility was not a provider-based clinic.

Q: What if I have Medicare with secondary insurance coverage?
A: Coinsurance and deductibles are generally covered by secondary insurance. Check your benefits or contact your insurance company for details.

Q: What can I do if I am having difficulty paying for health care services?
A: Nebraska Medicine offers a variety of options to assist you if you need help in paying for health care services. You may visit a financial counselor in person at several locations or talk with them over the phone at 402.559.5346. Walk-in locations are available at:

Patient Access Services – Financial Counseling
• Nebraska Medical Center
  « Clarkson Tower
  « Durham Outpatient Center
  « Lauritzen Outpatient Center
• Nebraska Medicine – Bellevue, 2500 Bellevue Medical Center Drive

Patient Financial Services
• Mutual of Omaha Building – 3333 Farnam St., 3rd floor