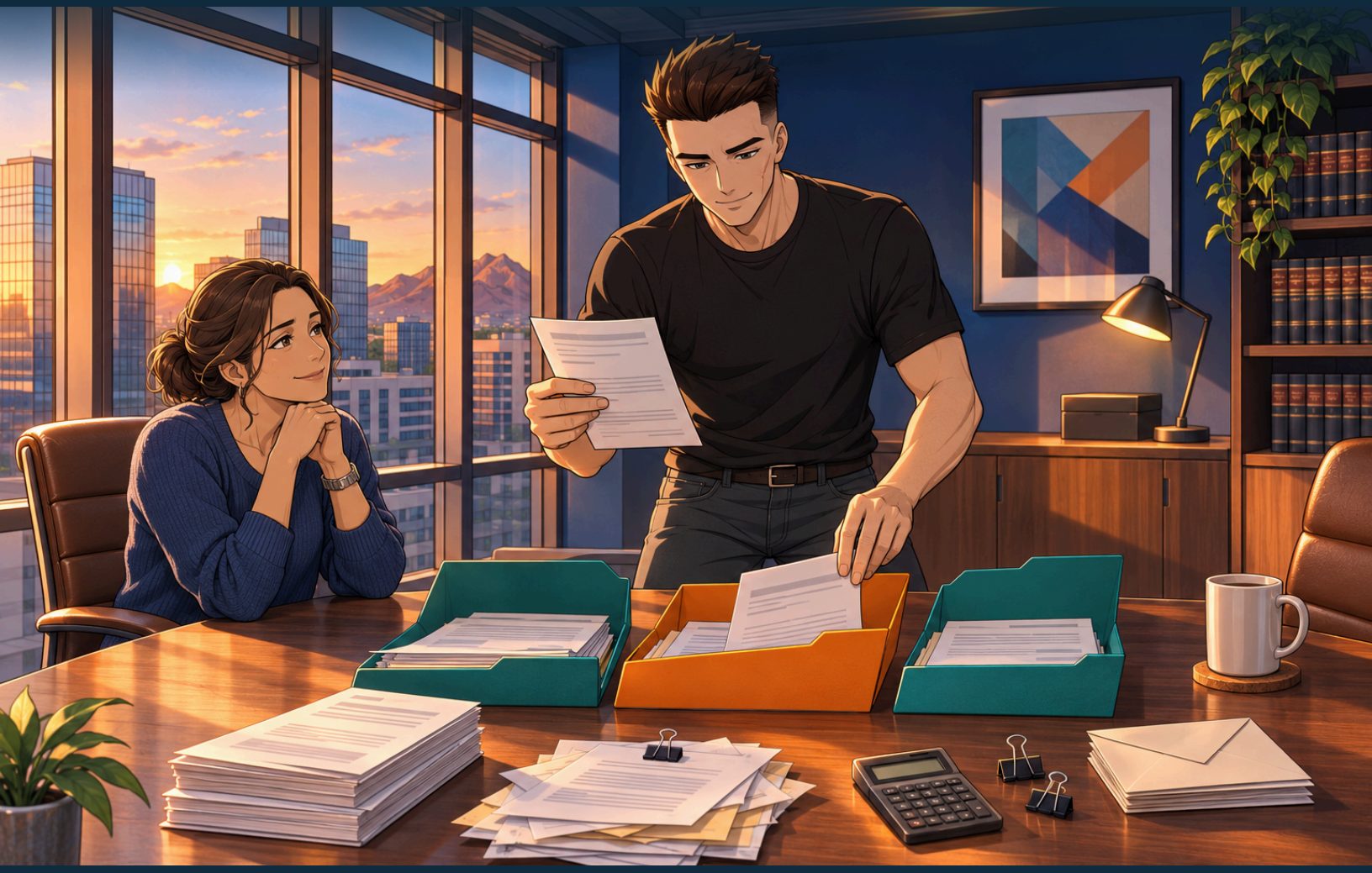
IMPACT LEGAL
Car Accident Attorneys

T-SHIRT LAWYER

05 ARIZONA FIELD GUIDES

THE BILLS. THE PAPER TRAIL.

What was billed. What was paid.
What still needs an answer.



Make the paperwork earn its keep

A bill organizer and a closer look at repayment claims.

Start with the paper trail

Same visit. Different numbers.

A bill, an insurance explanation and a repayment demand aren't three bills to add together.



Give each document a job

A provider's bill requests payment. An explanation of benefits (EOB) explains the health plan's processing; it isn't a bill, and it may not reflect money you've already paid. A reimbursement demand says someone claims a right to recover earlier payments. Keep these categories separate.

Match the patient, provider, service dates and account or claim number. A hospital visit can produce separate facility, physician, imaging and ambulance records. Similar dates alone don't establish a duplicate.

Start a folder for each provider

Save the itemized charges, EOBs, receipts, payment history and latest statement together. Write the statement date beside each balance. When a corrected statement arrives, keep the old one and mark which version replaced it.

Use the provider ledger to compare the records. Leave a question mark where information is missing. A guessed number looks surprisingly official once it lands in a spreadsheet.

YOUR FIRST USEFUL REQUEST

Ask the billing office for an itemized bill and complete account ledger showing charges, payments, adjustments and the current balance. Ask the health plan for the matching EOB and any denial explanation.

THE MAIL PILE ISN'T AN ACCOUNTING SYSTEM.

While the injury claim is open

Find the payment route now.

A possible settlement later doesn't tell the billing office what to do today.

Ask about both parts of the process

Paying the provider
Submission, eligibility and remaining benefits.

Possible repayment
Who may claim reimbursement, and on what basis?

Ask both payers for instructions

Give the provider accurate health-plan and applicable auto-coverage information. Ask where the claim was sent, when it was submitted and whether anything is missing. If each payer says the other goes first, request the provision each relies on in writing.

MedPay can cover eligible crash-related medical expenses up to its limit. Check who is insured, covered services, submission deadlines and amounts already paid. DIFI explains the coverage. Don't assume a fixed health-insurance-versus-MedPay order fits every policy.

If a bill is unaffordable

Ask about financial assistance, payment plans and the review of billing errors. The CFPB's medical-bill guide explains these starting points. Get any arrangement in writing, including whether collections will pause while the issue is reviewed. A pause isn't automatic.

If a provider offers to wait for settlement, read the payment agreement before signing. Ask what happens if the claim fails or the recovery is smaller than the bill. Don't delay urgent care while sorting out payment paperwork.

Disclaimer

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KEEP TWO QUESTIONS SEPARATE

How can this visit be paid now? Could a payer later claim reimbursement from a recovery? Record both answers. Paying a bill through insurance doesn't necessarily end every repayment issue.

'WE'LL DEAL WITH IT LATER' NEEDS A NAME, A DATE AND A PLAN.

When someone asks for money back

Find out which rule applies.

The word 'lien' doesn't make every demand the same, or every amount correct.

One worksheet for each asserted claim

Who is asking?
Provider, insurer, plan or public program.

What supports it?
Law, contract and related payments.

What is resolved?
Written terms, credits and release needs.

Provider and MedPay claims

A provider lien has statutory limits and exceptions; a signed payment contract raises separate questions. Request the recorded lien, itemized charges, insurance credits and agreement. Recording a lien doesn't settle whether the full demand is enforceable.

Under A.R.S. § 20-259.01(J), a qualifying MedPay lien concerns benefits paid above $5,000, in the excess amount. Perfection requirements and fair compromise apply. This is a benefits-paid threshold, not a settlement threshold.

Health plans and public programs

For health-plan reimbursement, request the governing plan documents, the reimbursement provision and an itemized list of crash-related payments. Ask whether the plan is insured or self-funded. The name on the insurance card doesn't answer every legal question.

For Original Medicare, a conditional-payment amount can change; check related charges and the formal recovery process. CMS explains the steps. AHCCCS has separate recovery authority. Identify the actual program or plan handling the claim; don't apply one program's rules to another.

BEFORE CALLING AN AMOUNT FINAL

Confirm the legal basis, related payments, credits, written payoff terms and any required release. Put unresolved demands in the repayment worksheet; don't silently turn them into approved settlement deductions.

A VERY CONFIDENT LETTER IS STILL A LETTER.

When the numbers don't match

Ask a question they can answer.

Point to the service, date and amount. Then ask for the specific correction or explanation.

Turn a mismatch into a trackable task

Identify	Submit	Follow up
Service, date and disputed entry.	Requested correction and supporting copy.	Confirmation, result and formal deadlines.

Make the issue easy to find

Try: 'Your statement shows $420 due for the visit on this date. My receipt shows a $100 payment. Where does that payment appear on the account?' Attach a copy and keep the original. If something was billed twice, identify both entries.

Log who you spoke with, what they agreed to do and when you'll follow up. Save confirmation numbers and proof of submission. Ask for a corrected statement when the adjustment posts; a telephone promise isn't an updated ledger.

Use the right review process

A denied benefit may need a formal appeal, even if someone is also checking a bill. Read the denial and track its deadline. The U.S. Department of Labor's health-benefit guide covers many employment-based plans; the correct route depends on your plan.

Arizona DIFI's complaint guidance explains its jurisdiction and health-appeal route. It doesn't handle every plan. Ask for help identifying the correct process; don't assume a general complaint preserves an appeal deadline.

CARRY THE VERIFIED NUMBERS FORWARD

Once a payoff is resolved, keep its terms and proof of payment. Match those amounts to the closing statement. Our settlement-statement explainer shows how deductions and held funds affect the distribution.

Sources and next steps

Keep the paperwork working for you.

Use the worksheets as private organizers. They don't decide what you owe.

Bills and benefit decisions

CMS: reading an EOB explains why it differs from a provider bill. CFPB: medical-bill help covers error checks and payment-assistance questions.

U.S. DOL: health-benefit claims covers claims and appeals for many employment-based plans. Arizona DIFI: complaints and appeals helps identify its role and limits.

Continue with Impact Legal

MedPay and health insurance · Medical liens and reimbursement · Read your insurance policy.

For questions about an Arizona injury claim, contact Impact Legal or call 602-345-1818. Share medical and account records through a trusted private channel.

Coverage and asserted repayment

Arizona DIFI: auto insurance; A.R.S. § 20-259.01(J): MedPay liens; § 33-931: provider liens; § 36-2915: AHCCCS recovery.

CMS: Medicare recovery. These programs and legal claims have different rules. A source link is a starting point for checking your facts, policy and documents.

ABOUT THIS COMPANION

General Arizona information, November 2026. It doesn't determine coverage, establish a debt or replace advice about your situation. Keep original documents and track the deadlines in each notice.

WORKSHEET 01 / KEEP WITH YOUR RECORDS

One provider. One clear ledger.

Copy this page for each provider or account. Use source documents; mark unresolved amounts as questions.

01 Reference details

Provider / billing contact

Account reference (last four digits only)

Service dates / records covered

Latest statement date

02 My record

Date / document	Charge	Payment / payer	Adjustment	Stated balance

03 Mismatch / records requested / next action and follow-up

The stated balance is the provider's current figure, not a legal determination. An EOB's patient-responsibility amount may not reflect payments already made. Keep repayment demands on the separate worksheet.

WORKSHEET 02 / KEEP WITH YOUR RECORDS

Check the repayment request.

Use one page per organization asserting a lien or reimbursement right.

01 Reference details

Organization / verified contact / reference

Type: provider | MedPay | health plan | Medicare | AHCCCS | other

Amount claimed / as-of date

02 Basis claimed / supporting documents

03 Related payments / disputed entries

04 Credits or earlier payments to confirm

05 Payoff terms / release needed

06 Current status / next action / person and date

Record the demand as asserted until it has been checked. This worksheet neither admits an obligation nor promises a reduction. Avoid full policy, member or Social Security numbers.

WORKSHEET 03 / KEEP WITH YOUR RECORDS

Make the next call count.

Keep a dated record of the problem, the requested fix and what happened next.

01 Reference details

Provider or payer / account reference

Question or disputed entry / document date

02 My record

Date / person / reference	Answer or promised action	Who / due date / result

03 Formal appeal or other deadline / where it came from / submission proof

04 Written confirmation or corrected statement still needed

A call or general complaint may not satisfy a formal appeal requirement. Follow the applicable notice and procedure. Keep this organizer private.