**ANa maria meza**

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Seeking a challenging position where I may utilize my customer service and technology skills to benefit my employer’s needs. With eighteen (18) years of experience in customer support, problem resolution, team development and unwavering commitment to customer satisfaction, with the ability to build productive relationships and resolve complex issues.

# Skills & Abilities

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| * Bilingual in English and Spanish * Proficient with Microsoft Office Suite * Medical Billing & Coding Procedures * Claim Cycle/Collection Strategies * Explanation of Benefits (EOB) * Proficient in ICD-9, CPT-10, HCPS & Medical Terminology * Health Insurance Portability and Accountability Act (HIPAA) Compliance * Knowledge of HMOs, Medicare and Medicaid * Authorizations, Referrals and Insurance Verification | * Call Center Operations * Excellent multi-tasker * Staff Training & Development * Detail-oriented * General Office Skills * Conflict Resolution Skills * Oral & Written Communication * Excellent Customer Service * Record Organization & Management |

# Experience

## Medical Collector II, Parkland Health & Hospital System **June 2018 – Present**

### Dallas, Texas

Responsible for all aspects of account follow up and collections, including processing appeals and collecting both inpatient and outpatient claims on behalf of the hospital. Utilize various resources to determine patient’s eligibility. Contact insurance companies to check eligibility and confirm claim status to ensure timely payment. Work with payers to determine reasons for denials. Researched and resolve daily denials that did not pass payer edits and would lead to an appeal of denied services. Resolve discrepancies and prepare adjustments or refunds as necessary. Keep current with all commercial and managed care pricing models, rules and regulations. Ensure all collection activity information is entered accurately into system; bring recurring issues to Supervisor’s attention. Print and mail Uniform Bill 04 or Health Care Financing Administration 1500s as necessary for account resolution. Knowledge of computer billing systems. Review explanation of benefits (EOBs) to ensure proper reimbursement of claims and report any problems, issues or payer trends.

## Access Service Representative II PRN, Baylor Scott & White Health **May 2018 – Present**

### Rockwall, Texas

Under indirect supervision, perform variety of patient registration, telephone and other clerical duties; determine proper financial class; maintain database integrity of systems; maintain quality and professional care of patients requiring medical attentions; educate parties regarding business practices and health plan benefits; assist patients/families in meeting their financial obligations.

Greet patients, refer them to appropriate areas of clinic/department or direct to Triage Nurse. Alert medical staff in the event of patients with emergent medical problem(s). Establish patient financial class type at point of registration; obtain necessary health plan insurance information; ensure appropriate forms are completed/initiated/routed; photocopies insurance cards and identifications, etc. Enter accurate demographic, financial class and insurance information; make revisions to systems databases immediately as errors are recognized to ensure database has updated and correct information. Answer incoming phone calls; transfer calls to appropriate areas of department/clinic/hospital. Read and/or respond to email on daily basis. Assign accommodations/bed assignments as directed for patients by supervisors.

## Member Services Department | Kaiser Permanente California **February 2006 – June 2017**

## Appeals & Grievance Case Manager **November 2012 – June 2017**

Upheld Kaiser Permanente’s Policies & Procedures, Principles of Responsibilities and applicable stated, federal and local laws. Participated in managing the organization’s Medicare and Commercial grievances and appeal process in accordance with regulations. Contacted the member or authorized representative during the research process to obtain further information regarding the member’s complaint. Maintained knowledge of regulatory and policy changes affecting Medicare and Commercial patients. Prepared appeals for external independent medical review and other state and federal governments.

Listened effectively, interviewed and investigated anxious and irate individuals. Acted as a liaison, problem-solver, critical thinker and negotiator to achieve resolution on members requests. Investigated all issues, including collection of appropriate data, preparation of documents to decision makers. Strategized with service area personnel, physicians, managers and administrators to create solutions to issues which optimized member experience with care and service. Informed member or their authorized presentative, physicians and other stakeholders of Health Plan’s determination either verbally or written.

Guided members/patients through difficult process by kindly talking them through the steps and answering their questions and concerns. Educated the member on how to utilize the services available within Kaiser Permanente by checking eligibility and benefit verification for treatments, hospitalizations and procedures. Explained in detail Explanation of Benefits (EOB), reviewed claims for accurate processing and assisted with resubmission. Updated member demographics in the data system. Assisted with copying medical records to fax or send via electronically to outside providers. Provided the member or prospect members with different plans available within the organization. Consulted with member or authorized representative to assess needs to coordinate services. Provided information, support, clarification and explanations to member regarding contracts, benefits and services available within the organization. Defused anger when necessary with members, when dealing with issues that significantly impact their health on a face to face basis or on the telephone with a high level of member satisfaction.

Prioritized workload and inbox with minimal supervision to independently carry out the duties of the position. Ability to multi task and manage time to perform well on long term projects while being flexible enough to assimilate short term projects on an ongoing basis. Ensured integrity of departmental database by thoroughly, timely and accurate entry. Met timeframes for performance while balancing the need to produce high quality work related to complex and sensitive member issues.

Identified trends and made recommendations for process/system improvements. Established work schedules and assignments for staff, according to workload, space and equipment availability. Mentored new employees in preparation for position of increased responsibility. Side by side auditing and provided feedback to staff and management regarding progress of accuracy and comprehension. Provided supplemental training when gaps were identified during monthly audits or coaching sessions. Developed and implemented training programs to assist new staff. Created presentations using MicroSoft Power Point.

**Senior Health Plan Representative** April 2010 – November 2012

Overseen daily activities to insure department standards were met, provided daily feedback in regards to patient registration process, staffing issues, audited data entry and grievance cases entered into the system for processing, mentored and trained to ensure consistency in performance and followed established policies and procedures, handled escalated issues forwarded by staff, conducted weekly team meetings to discuss weekly and monthly goals, productivity updates, changes in process.

Identified, investigated and analyzed members’ concerns, then provided information and resolution to the member or their authorized representative. Responded to members’ questions via, telephone or written correspondence regarding their concerns and complaints. Prioritized workload in the inbox to meet and exceed department standards. Followed instruction, process and procedures when dealing with unfamiliar or unusual members’ concern. Responsible for case coding, documentation integrity and compose letters.

**Health Plan Representative** February 2006 – April 2010

Greeted members, assisted with entering grievances into the system, updated demographics, verified eligibility, provided benefit counseling services to members and non-members, educated the member in obtaining authorization for specialized services, assisted with scheduling appointments, answered incoming phone calls, communicated with patients regarding appointments and instructions for procedures and tests, provided co-payment and deductible information.

## Member Services Representative, Health Net, Inc. **March 2004 – February 2006**

### Woodland Hills, California

Inbound call center handled 60-100 calls daily. Effectively communicated with members to resolve issues and answer questions according to department protocols and requirements. Received incoming calls involving routine inquiries involving Medicaid, Medi-Cal Access Program (MCAP), Healthy Families and Healthy Kids from members, providers and employer groups relating to eligibility, benefit coverage, pharmacy, claims and provider services.

Utilized multiple database programs for accessing member information and used judgment for obtaining only the relevant information. Updated members’ addresses and phone numbers in the data system. Ordered member identification cards, as needed. Determined appropriate resolution, listened effectively to members and provided or solicited appropriate help. Facilitated with filing of grievances through accurate and timely collection of information.

Reviewed claims for accuracy by comparing claim processing with contracts, assisted with having claims resubmitted for reprocessing of any errors found. Gave providers benefit information according to the members’ coverage, explained how to obtain authorization and provided where to submit claims for processing.

Mentored new employees in preparation for position process and procedures according to department guidelines. Side by side auditing and provided feedback to staff and management regarding progress of accuracy and comprehension.

# **Education**

## Southeastern University – Florida – Bachelor Business Administration, in progress

**Related Coursework**

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| * Introduction to Business * Business Computations * Business Communications * Business Law I & II * Principles of Marketing * Principles of Selling * Small Group Communication * Organizational & Management Theory * Introduction to Computers and Their Use * Foundations in Finance | * Principles of Economics * Introductory Accounting I & II * Business Management * Office Administration * Instructional Technology * Computer Applications * Medical Terminology * Medical Claims Process * Medical Billing Process * Medical Coding Process |