1. Evaluated accuracy and quality of data entered into agency management system.
2. Maintained knowledge of benefits claim processing, claims principles, medical terminology and procedures and HIPAA regulations.
3. Reviewed provider coding information to report services and verify correctness.
4. Followed up on potentially fraudulent claims initiated by claims representatives.
5. Managed large volume of medical claims on daily basis.
6. Tracked all pending authorizations to resolve discrepancies and avoid revenue loss.
7. Used administrative guidelines as resource or to answer questions when processing medical claims.
8. Reported policy changes and company conditions affecting customer satisfaction.
9. Paid or denied medical claims based upon established claims processing criteria.
10. Collaborated with claims department and industry anti-fraud organizations to resolve claims.
11. Communicated verification and authorization status updates with [Type] department to facilitate decision-making for patient admissions and insurance coverage.
12. Communicated effectively with staff, including members of operations, finance and clinical departments.
13. Maintained confidentiality of patient finances, records and health statuses.
14. Acted as [Type] subject matter expert, answering internal and external questions and inquiries.
15. Processed [Number] invoices each [Timeframe] and mailed documentation to clients.
16. Demonstrated respect, friendliness and willingness to help wherever needed.
17. Coordinated with contracting department to resolve payer issues.
18. Presented insurance options to customers in order to close sales on new policies.
19. Drove operational improvements which resulted in savings and improved profit margins.
20. Reviewed outstanding requests and redirected workloads to complete projects on time.