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