PRIYANKA RAWAT

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Professional Summary

Over 2 years of experience in AR (US healthcare domain). Comprehensive understanding if industry-specific software platforms. Adept in developing working relationships with clients keeping track of claim billing, processing and denial and working with Insurance representatives tosettle cases. I am seeking to utilize my skills for professional growth and advancement.

Core Qualifications and Skills

- Well-versedoninsuranceguidelines
- Knowledge of claim–Hospital billing , physician billing, AR-followup on denial.
- Knowledge of balance adjustment and pt. billing as per Explanation of Benefits (EOB) and write off management/ appeal according to process SOP.
- Followup with Insurance representative regarding claimstatus, claim denial, paid claims and EOB and review claim status/ benefits and eligibility on web portal for national and commercial payers.
- Knowledgeablein Inpatient /Outpatient, primary/secondary, original/corrected claimbillingand processing. Electronicand paperclaimsubmission.
- Knowledgeable in the complete claims process, insurance and member verification/ eligibility(if policy is active on DOS).
- Works well as part of a teamand self-motivated.
- MS Office and denial management
- Account receivable, Claim Billing, MS Office , Denial Management, Availity, Appeals ,Citrix, Clearing house orbilling scrubber, fax, client based software, EDI, Emedix.
- I work great with a team showing dedication and commitment to any team and company oriented goals, exceeding expectations.

Experience

Associate AR (Oct 7,2020 - April 22,2022)
R1 RCM Global Pvt, Ltd. ,Gurugram, Haryana

- Worked as a Follow-up representative/hospital providers , investigates and resolves denials and contacted various insurance companies regarding patient eligibility, claim status and claim processing.
- Performed follow-up billing for Seton Family of Hospital in Austin as well as collection of payments frompatients and insurance companies.
- Obtained and review all Medical records and Itemized Bill to determine if denial are valid for medical necessity, per plan guidelines to the payer if requested through fax, certified mail or uploaded to the web portal.
- Worked on claim denial and insurance balance as per expected payment and resolve all claimdenials for commercial and national payers.
- Verified insurance eligibility for patients via insurance portals.

- Maintain timely filing submission of claims.
- Analyzed claim and hand off to the concerned dept. if any correction is required on claim.
- Reviewing insurance policies and facilitate resolution of open receivables by review of coding, product, contract, payment agreement, fee schedule and/or authorization terms.
- Diagnosis and report to management customer issues with regards to rejection trends and denials, working to improve end-to-end business processes.
- Knowledge of hospital billing , physician billing and appeal handling.
- Identify, resolve and analyze any and all outstanding issues preventing claim resolution.
- Collaborate with insurance companies to determine why claims are denied through corrected claim submissions, denial disputes and appeal submissions.
- Interact with clients for claim rejection/denial.
- Maintaining strict patient confidentiality according to HIPAA regulations.
- Maintains key performance indicators as defined by management discretion.
- Recommends accounts to be written off to appropriate categories if the provider did not meet certain payer guidelines, such as timely capture of charges.
- Meet and exceed production/ quality goals set by management

Sr. Claims Associate April 23, 2022 - Present)
CGM Aria Health Services , Noida, U.P

- Worked on Physician billing, claims processing and denial management, well versed knowledge of appeal handling.
- Worked on client based project and priority claims as per their requirement.
- Worked on claims adjustment and f/u on denied claims.
- Review denied or non paid cpt's on the claim and f/u as per the SOP, write off , appeal or claim adjustment as per the SOP instructions.
- Fax primary EOB to the insurance as per the denial and interact with insurance rep. regarding paid EOB's , request to fax or mail the bulk EOB ,further send it to the posting team for payment validation and posting.
- Worked on software – EDI, Emedix, Aprima, Availity, Console.
- Send Medical records to the ins. , proof of TFL or appeal as per the denial or in order to reprocess the claim to get further payment through the portal or specific software.
- Meet daily production target with remarkable quality.

Accomplishments

- Completed HIPPA training course
- Completed Compliance & Integrity training

Education

- Bachelor's Degree – Science
  2017
  Maharaja Agrasen College
  Vasundhara Enclave, Delhi

- Diploma in Advance Excel.

Certifications

Global Youth Employability certificate by NASSCOM Foundation

Additional Information

DOB : August 2, 1995

Sex : Female

Marital Status : Single

Nationality : Indian

Languages Known : Hindi , English