RAJAT PANDEY

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ABOUT ME

Healthcare insurance specialist with excellent planning and problem-solving abilities. Offering months of experience and willingness to take on any challenge. Organized, driven and adaptable professional with successful history managing high caseloads in fast-paced environments.

EXPERIENCE

Optum Global Solutions

Gurgaon. // Appeals Coordinator // 02/2019

- Assist member or provider, or provider on behalf of the member, in filing a formal appeal and grievance
- Complete projects and other research tasks as assigned by area management
- Coordinates and handles all member and provider appeals and grievances, including the member grievances, appeals, requests and disputes
- Generates all reports related to the appeals process
- Identifies deficiencies and develop corrective action plan to ensure compliance is met
- Maintain knowledge of all system, contractual, compliance standard changes and policy updates, and attend additional training sessions as necessary
- Provide input to management regarding current inventory issues for inquiry analysis
- Provides superior customer service to clients, members, providers, facilities etc.
- Review and apply new and updated procedures and guidelines. Identify quality-related problems and recommend process improvements

IBM Daksh

Noida // Customer Care // 01/2018 – 01/2019

- Act as an escalation point for your team on unresolved customer issues and flag business and potentially contentious issues to senior management
- Communicate any escalated customer concerns to the Account Management team and work together to mitigate any customer attrition
- Conduct and document effective monthly and annual performance reviews with your team
- Independent work ethic and commitment to providing exceptional customer service will ensure you success in this exciting role.

(Currently working in R1RCM as an AR Follow up rep)

EDUCATION

Chhatrapati Shahu Ji Maharaj University (CSJMU), formerly Kanpur University.
Bachelor In Science// 2015 – 2018

SKILLS

Claim adjudication, Investigated and compared insurance policies Analyzed insurance organizational structures, business and intermediaries; studied basic documents, including common clauses, policies and insurance contracts. Created master spreadsheet to record procedures, denials and approvals. Recognized by management for providing exceptional customer service. Proven experience providing customer support in busy call center environments. An unwavering commitment to customer service, with the ability to build productive relationship, resolve complex issue and win client loyalty

KEY RESPONSIBILITY AREA

- Determines covered medical insurance losses by studying provisions of policy or certificate.
- Establishes proof of loss by studying medical documentation; assembling additional information as required from outside sources, including claimant, physician, employer, hospital, and other insurance companies; initiating or conducting investigation of questionable claims.
- Documents medical claims actions by completing forms, reports, logs, and records.
- Resolves medical claims by approving or denying documentation; calculating benefit due; initiating payment or composing denial letter.
- Ensures legal compliance by following company policies, procedures, guidelines, as well as state and federal insurance regulations.
- Maintains quality customer services by following customer service practices; responding to customer inquiries.
- Provides legal support by assembling documentation for settlement action.
- Protects operations by keeping claims information confidential.
- Prepares reports by collecting, analyzing, and summarizing information.
- Updates job knowledge by participating in educational opportunities; reading professional publications; maintaining personal networks; participating in professional organizations.
- Accomplishes organization goals by accepting ownership for accomplishing new and different requests; exploring opportunities to add value to job accomplishments.