Steps to follow with the AVR (Automated Voice Response) System :

Call the appropriate phone number for the insurance company.

- If the number is unreachable, make a note of it.
- If it reaches an AVR, listen the entire options listed by the AVR carefully.
- Select the most appropriate option to check eligibility, claims or other info, as required.

For all Medicare carriers, claim status should be checked only through the AVR.

- Most AVR systems will first ask for the Tax ID# or provider#, enter the required.
- If the provider# has alphabetical characters, enter the option to get the help from the AVR on how to enter alpha characters and enter accordingly.
- The patient's ID# might also have alpha characters, in this case follow the AVR instructions and enter the ID# carefully.

Numbers should be entered very carefully, missing or entering a wrong number will give an incorrect result.

- In the same manner, for claim status verification, enter the DOS when prompted.
- The date format should be taken into consideration here. Some AVR systems still follow the 'mmddyyyy' format. In such cases, the DOS should be entered as required.
- For example : if the DOS in our system is '010103', the date in 'mmddyyyy' format is '01012003'.

Usage of * and # signs has significance with AVR calls. These signs should not be ignored when prompted for.

- Some AVR systems will list the number of claims for a specific DOS, on file. In such cases, the status of all the available claims for that DOS should be listened first and then, notes for the most relevant claim should be entered.

In general, AVR of different carriers differ in their own steps. Therefore, listening the AVR instructions carefully is vital and would definitely yield good results, if followed as instructed.

Steps to follow while on conversation with Insurance Representatives :

Call the appropriate phone number for the insurance company.

- If the number is unreachable, make a note of it.
- If it reaches an AVR, listen the entire options listed by the AVR carefully.
- Select the most appropriate option to reach a representative for verifying eligibility, claims or other info, as required.

For all Medicare carriers, claim status should be checked only through the AVR. Only denials and other issues should be verified with the rep.

Self-Introduction :

- When an insurance rep comes on the line, greet him/her accordingly and introduce yourself as a representative of the provider's billing office, giving your Pseudo name.
- Tell her the reason for your call.
- For example : "Good Morning Ma'm/Sir, my name is Kevin, I'm calling from Dr XYZ's billing office. I'd like to check claim status/eligibility for a patient".

As a common procedure for provider verification, the insurance carrier rep will first request for the Tax ID# or the prov#, in order to reveal any information. The requested info should be given to prove that the call is an authenticated one.

Verifying eligibility :

- If you are verifying eligibility, the rep will ask for the patient's ID#, name and DOB (Date Of Birth). Sometimes, the rep might even ask for the group# or plan#. This info should be provided to help the rep locate the patient's file.
- Once the insurance rep locates the patient's file, get the patient's coverage effective date and verify the patient's current eligibility.
- If the patient's coverage is terminated, get the termination date.
- Verify if the insurance carrier acts as primary or secondary for the coverage period.
- Ask if they have any other insurance coverage info for the patient.
- Get the correct claims mailing address, filing limit and processing time for the claims, the direct phone# to contact the corresponding customer service center to check claims and other related info.

Verifying claim status :

- If you are verifying claims status, the rep will ask for the patient' s ID# and name.

- Once, the insurance rep locates the patient' s file, he/she will ask for the DOS (Date Of Service) and the total billed amount. Even the Dr' s name on the claim may be required for this purpose.

For paid claims :

- If the rep says that the claim is paid, get the paid amount, check#, check date, the bulk amount of the check and the mailing address of the check. Ask if the check was cashed and if so, get the cashed date.

- If the check was issued to an incorrect address, inquire why the check was sent to that address and ask the rep to verify the address, they have for the provider. Then, ask the rep to make a stop payment on the check and reissue a new one to the correct address.

- If the check was issued to the correct address, but if we have not received any EOB (Explanation Of Benefits), ask the rep to send us a copy of the check and duplicate EOB. Try to get it faxed or mailed to us at the earliest.

For unpaid claims :

- If the rep says that the claim is denied, get the exact denial reason. If the claim can be adjusted and sent for a reprocess, over the phone, get it done. Get the claim control# for our reference, which would help in future follow-ups.

- If the rep says that the claim is pending or suspended for more info, get the actual info they need to get the claim processed.

- If the claim needs to be corrected and refiled with any additional info, get all the details of the info they need, to get the claim reprocessed for payment. Verify if they have a different review or appeal address to submit the refiled claim.

For claims not on file :

- If the rep says that the claim is not on file, verify if their claims mailing address matches with the one in our records. If it differs, note down the correct mailing address and get the filing limit and processing time for the claims. Ask if the claim can be faxed and if so, get the fax# and name or dept, to whom the claim should be faxed.