NATASHA HAMILTON

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PERSONAL PROFILE

Blend administrative skills with clinical training and nearly 10 years of work experience to navigate insurance claims from inception through disposition. Work closely with policyholders, claimants, and third parties to adjudicate claims in a manner that balances policyholders' rights/responsibilities with cost recovery and cost savings. Possess knowledge of medical procedures, terminology, and coding standards to research and make determinations. Areas of strength include:

- Claims Examination
- Claims Management
- Claims Investigation
- Case Management
- Data Entry
- Medical Records
- Medical Coding & Billing
- Public & Private Insurance
- Problem-Solving Skills
- Administrative Support
- Computers & Office Technology
- Medical Terminology
- Customer Service

Proficient in Microsoft Office (Word, Excel, PowerPoint), Emdeon, Script Med, Onbase, Scripting, Mainframe and claim management software

CLAIMS EXAMINATION EXPERTISE

Work with claimants, policyholders, and third parties to document, research, and fairly render decisions for workers' compensation, vehicle accident, surgical procedure, inpatient treatment, and outpatient treatment claims. Research, initiate, correct, and adjudicate claims and/or adjustments.

- Manage large caseloads of up to 50 claims concurrently; identify, organize, and prioritize individual tasks each day
- Review new cases and enter all relevant details into centralized tracking system for future action and analysis
- Interpret medical records to evaluate extent of claimants' injury and verify patient demographics
- Verify the nature and extent of injury and that injury is directly attributable to reported accident or incident
- Assess applicable coverage and claim details to make decision; notify claimants (first and third party) of decision
- Complete thorough investigations to confirm or deny liability/coverage
- Prepare and send bills to third parties as necessary to maximize cost recovery
- Refer patients to and process Medicare (Parts A & B) and Medicaid eligibility according to state/federal guidelines
- Compile and present reports according to set schedule or supervisory requests

WORK EXPERIENCE

University of Alabama at Birmingham

Patient Account Representative

2019-current

- *Account Review.*
- *Customer Service.*
- *Billing.*

● *Complete all business related requests and correspondence from patients and insurance companies.*
● *Complete all assigned projects in a timely manner.*
● *Assist client and patients in all requested tasks.*
● *Rebill claims to insurance payers*
● *Update insurance information*
● *Process and send important documents*
● *Ensure accuracy when investigating claims/accounts*
● *Implement problem-solving strategies*
● *Recognize billing trends set by payors.*
● *Calculate expected payment amounts*
● *Review medical records for submission.*

BCBS Of AL

Insurance Representative

2018-Current

● *Investigated Claims*
● *Reviewed eob's and coding on all claims*
● *Contacted billing departments for providers and facilities in regards to processing of claims* ● *Ensured claims accuracy*
● *Collected pertinent information to refile/ appeal claims to Medicare and BCBS.*
● *Updated coordination of benefit*
● *Confirmed patient liability due to copays, deductibles and/or non-covered charge*
● *Adhered to HIPPA guidelines*
● *Executed quality goals*
● *Explained members plan benefits*
● *Processed payments on unpaid premiums*
● *Worked with C-Plus , Blue Advantage, Blue RX and BCBS individual products (blue select silver, gold plans and group plans)*
● *Updated / Added provider information*
● *Research Claim information*
● *Submitted important notifications/documents via mail and fax.*

Parallon, Hoover, AL

Patient Account Representative

2017-2018

● *Followed up on unpaid claims*
● *Implemented new strategies to ensure claim resolution*
● *Gathered & documented pertinent information in regards to claim activity*

- *Adhered to payor guidelines for timely filing issues, resubmission of claims and appeals process*
- *Reviewed eobs, ubo4's, authorizations and coding of claims to determine patient /facility responsibility*
- *Updated insurance information*
- *Maintained access to payor portals*
- *Contacted patients for vital missing information*
- *Rebilled claims to primary and secondary payors*

Optum, Hoover, AL

Patient Assistance Coordinator
2014-2017

- *Created, organized and maintained patient assistance determination database*
- *Managed a caseload of 30-50 applications per month*
- *Screened patients for foundation assistance*
- *Built and maintained relationships with physicians , patients , pharmaceutical representatives*
- *Billed foundations after primary insurance payment*
- *Demonstrated exceptional customer service skills in the performance of work assignments and duties.*
- *Researched Patient Assistance Programs for both insured and uninsured patients*
- *Created and viewed test claims to ensure coverage for specialty drug medications*
- *Ensured that claims are processing correctly.*
- *Processed applications for in house financial assistance programs.*
- *Assisted patients with completing financial assistance applications with various charity organizations*
- *Gathered, documented and mailed pertinent information in regards to approval information for financial assistance.*

York Risk Services Group, Homewood, AL

Workers Compensation Claims Associate

2014-2014

- *• Assumed responsibility for effectively and efficiently supporting the Claims department.*
- *• Identified, organized, and prioritized daily work assignments.. Maintained and runs daily diary. Checks daily diary no less frequently than four times per day to identify new, incoming work assignments.*
- *• Checked in-basket each morning to organize and prioritize daily work assignments.*
- *• Completed all assigned work in a timely and accurate manner. This may include, but is not limited to: preparing new losses; issuing compensation or mileage payments; issuing state forms; generating form letters; preparing records requests; indexing for claims search; copy work and other miscellaneous requests designated by claims examiner.*
- *• Provided quality customer service to clients, vendors and internal claims staff.*
- *• Communicated to management any workflow problems, issues or backlog*

  immediately • Completed special projects and assignments as directed.

- *• Prepared memos, letters, and documents as needed.*

DST Health Solutions, Meadowbrook, AL

Medical Claims Examiner

2013-2014

• Reviewed and sets up new and reassigned medical claims and reserves in tracking system • Assessed coverage applicable to loss description and notifies first and third party claimants of outcome

• Conducted investigation of claims to confirm or deny coverage and liability, compensability and damages, prepares and bills third parties to ensure payment of claims are recovered

• Interpreted medical records to properly evaluate the extent of the claimants injury. • Determined any pre-existing injury; or if injury is directly related to the reported accident or incident. • Researched, initiated, corrected and adjudicated claims and adjustments

• Processed Medicare Part A & B, Medicaid in accordance to Centers for Medicare and Medicaid Services guidelines.

• Processed claims such as: Workers Compensation, Coordination of Benefits, Motor Vehicle Accidents, Multiple Surgical Procedures and Co-Surgeons, Inpatient and Outpatient Claims

Optimum Outcomes

Patient Advocate

2011-2013

• Researched all account information on paid or partially paid claims and analyzed the status of the payment related to the expected payment calculation and itemization provided by the remittance advice

• Determined if payment is appropriate according to contract specifications

• Analyzed any denied, disallowed or non-covered claims and determines if non-payment is based on medical or technical reasons

• Resolved any technical issues when warranted with health plans via phone or website • Prepared requests for account balance adjustments in accordance with client specific procedures

• Prepared claims for clinical audit processing in the case of authorization, coding, level of care and/or length of stay denials

• Processed overpayment transactions in accordance with client specific procedures • Followed guidelines for prioritization, timely filing deadlines, hospital and database documentation • Respond to physicians, patients and an insurance carrier inquires.

• Answered 60-80 calls per day.

• Monitored call time and inbound call queue.

• Executed all revenue and quality performance goals set by company.

• Answered billing questions

• Verified insurance coverage

• Submitted explanation of benefits

Children's Hospital of Alabama, Birmingham, AL
Clinical Assistant
2010-2011

- *Verified patient information by interviewing patient; reviewing and/or recording medical history; taking vital signs; confirming purpose of visit or treatment.*
- *Welcomed patients by greeting them, in person or on the telephone; answering or referring inquiries.*
- *Maintained patient confidence and protects operations by keeping patient care information confidential*
- *Kept supplies ready by inventorying stock; placing orders; verifying receipt.*
- *Completed records by recording patient examination, treatment, and test results.*
- *Generated revenues by recording billing information of services rendered; completed insurance forms; responded to insurance and other third-party inquiries*

EDUCATION & TRAINING

Medical Billing & Coding Program (In Progress), Jefferson State Community College
Bachelor Degree Coursework in Health Information Management, Alabama State University
Medical Assistant Certification, Tri-State Institute