SUJISHA ANOOP

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SUMMARY

- Masters in nursing professional with Over 10 years' experience in insurance coordination, administrative roles and customer service within the healthcare industry.
- Completed Medical coding and billing; completed CPMA training course from AAPC.
- Gained experience from International Insurance Broker (Marsh) in Dubai in handling more than 80 Key accounts as Client facing Medical Claims Administrator.
- Direct handling of corporate clients, conducting meetings and training sessions.
- Proven expertise in streamlining communication between insurance entities, managing routine office administrative tasks, and processing insurance claims accurately and efficiently, exceptional claim settlement on Ex-gratia basis.
- Adept at managing office operations, providing exceptional customer support, and ensuring efficient workflow
- Versatile in leading cross-functional teams, implementing effective administration strategies, and cultivating a positive office environment
- Proficient in relevant tools such as Microsoft Office, G Suite, zoom; Pursuing Insurance Administration **(LOMA)**
- Good communication skills (bilingual), adaptability, critical thinking, problem-solving and collaboration abilities

CORE COMPETENCIES

Insurance Coordination, Customer Service, Administrative Management, Claims Processing, Communication and Liaison, Confidentiality and Record Keeping, Financial Management, Relationship Building, Organizational Skills, Training and Development, Project Coordination, Stakeholder Coordination, Operational Efficiency, Strategic Planning

PROFESSIONALEXPERIENCE

Sr. Insurance coordinator
Dental Healthcare group, Dubai-(Aug 2020-Present)

- Successfully reviewed and processed insurance and disability claims, ensuring adherence to billing requirements and achieving a consistent 98% accuracy rate, resulting in expedited claims processing
- Efficiently managed the reconciliation of orders, identified discrepancies between bills, compensation, and customer accounts, leading to a 15% reduction in billing errors and improved financial accuracy
- Streamlined communication processes by receiving and forwarding messages to various branch staff and departments, enhancing interdepartmental collaboration and reducing response times by 20%
- Demonstrated strong organizational skills by coordinating meetings and schedules for clinic staff and doctors, contributing to a 30% improvement in overall schedule efficiency
- Conducted comprehensive training sessions for front desk staff and coordinators, focusing on customer service, billing guidelines, and office protocols, resulting in a 25% increase in team efficiency and a smoother workflow.

In -charge of the Insurance Dept., 09/2018 - 08/2020
Dental Club Clinic; Dubai.
(Submission; Resubmission; Pre-authorization; Reconciliation; Collection; Network Empanelment)

- Coordinating, liaising and networking between insurance companies regarding eligibility, payments, approvals, reconciliation and other requirements.
- Greet patients, visitors on the telephone: answering or referring inquiries…
- Manage the routine Office Administrative duties.
- Perform other duties as instructed by the Administration Manager which contribute to the effective office management of the company.
- Updating patient records and documenting recent treatments and procedures.
- Responsible for coordinating and supporting initiatives relative to the evaluation, processing, and handling of claims for an organization.
- Acts as a liaison between the organization, its insurance provider and agents, claimants, and policy holders regarding the status and eligibility for coverage for all relevant claims.
- Responsible for filing and tracking insurance.
- Reviews claims to make sure that billing requirements are met, updates accounts as necessary, answers inquiries, and makes recommendations for resolution.
- Process insurance and disability claims in a timely manner.
- Prepares insurance forms and associated correspondences.
- Maintains strict confidentiality related to medical records and other data
- Establishing and maintaining relationships with patients, physicians, medical staff, insurance companies, and other medical providers
- Preparing itemized bills for services rendered, using software such as EXCEL or ACCESS
- Coordinating with insurance companies to obtain approval for hospital services
- Maintaining accounting records by updating financial records and generating reports for management review
- Managing accounts receivable collections by contacting patients who have not paid their bills or collecting from patients who have insurance but are not submitting claims to their carriers.

Claims Supervisor 09/2017-07/2018
GMC healthcare LLC (Dutco Grp)

(Submission; Resubmission; Pre-authorization; Reconciliation; Collection; Network Empanelment)

- Provide daily support to claim staff on claim managing and filing activities.
- Suggest and implement new strategies to ensure that targets are met for department Turnaround time, Quality and Productivity.
- Make suggestions with regard to the staffing requirements of the Medical Department. Responsible for developing a strong high performing team, overseeing and providing ongoing coaching, mentoring, and skill development opportunities for each member of the team.
- Reviews adjudicated claims. Actively leads efforts to reduce rework, including resubmissions, adjustments, appeals & claim disputes and encounter reversals through root cause analysis.
- Clarified the queries received from the Insurance carriers with regard to adjudicated claims.
- Oversees department workflow procedures and participates in cross-functional meetings, participating in office efforts and planning to implement changes, review system set up, and exceed overall efficiency and service objectives.
- Exhibits excellent knowledge of all particular coverage and benefits, and claims adjudication process related details.
- Coordinates with the Networking Department for appropriate claim submission and payment resolution issues. Works closely with other departments to assure a smooth coordination of efforts and resources.

- Identifies problem accounts with payers; investigates and correct errors, follow-up on missing account information, and resolves past-due accounts.
- Ensure that claim team follows state regulations and standard operating procedures..

Medical Claims Administrator (client facing admin)
Marsh Emirates Insurance Brokerage LLC, Dubai –(March 2016– August 2017)

- 70% of time during the week will be dedicated to answering phone calls from claimants and providing correct and concise guidance;
- Recognize and report discrepancies to Supervisors and Management.
- Perform analytical review of documentation received.
- Data entry in company database.
- Review and verify data entered in system.
- Following detailed written instructions to make independent decisions on next steps.
- Monitor claim status and generate reports through database.
- Verify and update information needed on claims.
- Assist in customer claim submissions to ensure completeness and accuracy.
- Conduct weekly calls with customers to update and/or answer any questions they may have.
- Communicate with customers via phone and email to help gather missing details and support documentation.
- Onsite visit to conduct meeting and training to corporate clients

Claims Examiner-Medical Benefits Emirates
Airline-(March2015–March2016)

- Manages routine daily claims administration work.
- Coordinates work flow & meet deadlines.
- Evaluates claims with regards to eligibility.
- Takes decisions on high cost and complicated cases based on standard operating procedures.
- Handles International Preauthorization cases as required.
- Attends calls and e-mails from insurance companies, clients, and providers.
- Coordinates with international providers for direct billing.
- Makes suggestions to improve service.
- Increases efficiency, minimizes errors and administration time.

Medical Claims Officer (Reimbursement -In charge)
Dubai Insurance Company-(2014-2015)

- Monitor daily target of the reimbursement team and maintain TAT for Reimbursement claims processing.
- Send electronic bordereau of the E- claims to the payers in order to inform them of approved claims and settlement amounts
- Prepare weekly and monthly processing reports for internal and external usage of information
- Answer provider/ insured member's / PICs queries relating to claims processing, coverage limit inquires as and when required
- Train newly hired processors / PICs/Brokers/Insured Groups in reimbursement claims processing
- Reviewandauditthereimbursementclaimsprocessedinlinewithauditingguidelines and introduce innovative ways to minimize errors and enhance quality standards
- Analyze medical trends/utilization rates and detect any fraud and abuse cases
- Entering claims data into system
- Resolve problems resulting from claim settlement
- Followadjudicationpoliciesandprocedurestomakesureproperpaymentofclaims