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**Suresh**

**E-mail**: suresh.333293@2freemail.com

**UAE Experience in Medical Insurance: Coding & Claim Submission**

**Career Objectives**

To be part of high technology revolution and to obtain a good position in dynamic and challenging market where my abilities knowledge and enthusiasm can be shared and utilized for corporate and personal growth.

**Education**

* **Certified Professional Coder with ICD-9 & ICD-10 Proficiency** from American Academy of Professional Coders, Abu Dhabi, UAE
* **Master of Business Administration** from University of Madras, India,

2005-2007 with 65%

* **Bachelor of Business Administration** from University of Madras, India, 2002-2005 with 52.60%
* **Diploma in Post Graduate in Diploma Computer Application** from Institute of SISI of Tamil Nadu, India, 2008 with A+ grade

**Professional experience**

Total 9.6 Years experience in Medical Claims processing and Medical Coder.

**Experience in UAE**

**March 2015 to Present**

**Medical Insurance Coordinator**

**Revenuce Cycle Management, VPS Healthcare Group, Abu Dhabi, U.A.E**

* Medeor Hospital 24x7 Abu Dhabi – SAP Software & Clinicsoft
* Burjeel Hospital Abu Dhabi – SAP Software & Clinicsoft
* Life care Hospital Mussafah – SAP Software & Clinicsoft
* LLH Hospital Abu Dhabi – ACCPAC Software & Clinicsoft
* Pattaya Medical Center Mussafah (Out Source) – Shade Software
* Medeor Medical Center Yas Mall – SAP Software & Clinicsoft
* Medeor Medical Center Al zeina – SAP Software & Clinicsoft

**Roles & Responsibilities**

* Handling submission team and assign task and targets to employees.
* Auditing Medical claims & sending to Insurance companies.
* Assign Evaluation and Management (E/M) codes for outpatient
* Coding outpatient claims using ICD 9CM and CPT codes.
* Experience in using E-claims and electronic health record
* Resubmission knowledge of Outpatient denial management.
* Comprehensive knowledge of Resubmission of rejected claims.
* Extensive knowledge of electronic billing systems.
* Generating XML files through E-claim on SAP systems IP & OP.
* Generating XML files through E-claim on Clinicsoft systems for Dental claims.
* Generating XML files through E-claim on SAP systems for NonPbm Pharmacy.
* Generating XML files through E-claim on Shade systems.
* Generating XML files and Error check in Green Rain for Accpac systems.
* Entering e-claims of IP, OP, Dental and Pharmacy (more than 23 insurance companies).
* Checking ICD-9 & ICD-10, CPT and HCPCS Codes in claim forms and entering in E-claim software (E-Claim Express, Green Rain) according to the HAAD rules and regulations.
* Preparing, sending and updating status of pending approvals for out-patient, Dental and Pharmacy procedures.
* Check claim forms for all requirements needed before submitting to insurance companies. (E.g.stamp and sign of doctor, signature of patient, lab and radiology reports.)
* Entering the discount profile for each insurance companies of each patient in the system.
* Preparing Submission files (more than 23 insurance companies) correcting whole errors with Insurance & HAAD Guidelines.
* Handling unit pending and queries and grievances regarding their insurance policies and other complaints.
* Consults the relevant department for missing /supporting documents.
* Making KPI report and observe about early or delay claim submission.

**Experiences in INDIA**

**Team Leader, Medical Billing: July 2011 – March 2015**

**Cognizant Technology Solutions India Pvt Ltd**

**Chennai, India.**

**Roles & Responsibilities**

* Verify eligibility for insurance, entering patient demographics into System.
* Outstanding in acting as a liaison between medical facilities and insurance carriers (HMOs, PPOs, Medical, Medicare).
* Familiar with ICD codes and CPT Codes.
* Processing electronic claims and paper claims, posting co - pays and insurance payments.
* Ability to read and interpret EOBs, and face sheets from medical facilities.
* Handle claims with different Insurances.
* Knowledge with insurance authorizations and denials.
* Correct denial claims with correct information and resubmit claims.
* Follow up on unpaid claims as well as old claims.
* Providing both external and internal audit reports with monthly analysis.
* Maintain patient records and answer customer billing enquiries.
* Knowledgeable in medical terminology and hospital, clinic, or laboratory procedures

**Senior Medical Claims Adjudicator: Feb 2010 - July 2011**

**Technosoft Solutions India Pvt Ltd**

**Chennai, India.**

**Roles & Responsibilities**

* Denial Analysis and Resubmit to Insurance Company.
* Underpayment: follow-up for underpayment issue and write off for small balance.
* Overpayment: checking the Insurance overpayment and refund the overpayment to insurance.
* Correspondence: Taking action for correspondence received.
* Medicare supplemental unit: Working for the sec denial and patient liability after Medicare processed.

**Medical & Health Insurance Claims Adjudicator: March 2006 – Feb 2010**

**Ajuba Solutions India Pvt Ltd**

**Chennai, India.**

**Roles & Responsibilities**

* Adjudicate claims for a variety of plans
* Reviews claim information in both electronic and paper media, to determine the nature of the members injury or illness
* Determines and understands the coverage provided under a member’s plan
* Posting the policy holders information and charges
* Investigate the claims thoroughly before releasing the claim
* Review the processed claims
* To achieve set quality and production targets with in the Turnaround Time
* Contribute to improve team production and quality as an associates
* Training given to associates based on new form types

**Personal Details**

* Date of Birth : 17 Dec 1983
* Gender : Male
* Nationality : Indian
* Languages Known : English & Tamil
* Marital status : Married
* Visa status : Employment
* Driving License : UAE & India