**CURRICULUM VITAE**

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| **Tony**  Email: [tony.357069@2freemail.com](mailto:tony.357069@2freemail.com) |  |

**Career Objective**

Seeking challenging career in Health Care Sector to get a position of responsibility, using my skills and efficiency to communicate my ideas and views and commit myself for achieving organizational objectives with the team effort and my positive attitude and performance.

**Personal Details**

Name : Tony

Sex : Male

Date of Birth : 22 JUL 1984

Nationality : Indian

Religion : Christian

Marital Status : Married

Language Known : English, Tamil, Hindi, Kannada and Malayalam

Visa Status : Long Term Tourist Visa

**Educational Qualification**

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| **COURSES** | **INSTITUTION** | **UNIVERSITY / BOARD** | **YEAR OF PASSING** |
| S.S.L.C | St. George High School, Kottickal | Govt of Kerala | March 2001 |
| Higher Secondary | J.J Murphy HSS Yendayar | Govt of Kerala | March 2003 |

**Professional Qualification**

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| **COURSES** | **INSTITUTION** | **UNIVERSITY / BOARD** | | **YEAR OF PASSING** |
| Diploma in Nursing | Global college of Nursing Bangalore | Karnataka Nursing  council | | FEB 2007 |
| Bsc Nursing (PB ) | Goldfinch College of Nursing Bangalore | | RGUHS Bangalore | AUG 2012 |

**Technical course Completed**

* **CPC 3** months training Course ( AAPC Member id 01399765) completed in

**Apex Medicom training Institute Bangalore.**

**Employment History**

* **The Calcutta medical Research Institute ( CMRI ) , Kolkata**

From 04AUG 2007 to 20 NOV 2009 (2.3 Years)

Designation: Staff Nurse

* **Lotus Lab Pvt. Ltd , Bangalore**

From - 01 MAR 2010 to 30 APR 2013 (3.2 years)

Designation: Nurse cum Phlebotomist

* **Hinduja Global Solutions (HGS), Bangalore**

From 06 May 2013 to 18 SEP 2015 (2.4 Years)

Designation: Claim Processing Executive

* **Remedinet Technologies Pvt. Ltd , Bangalore**

From 09 MAR 2016 to 10 MAR 2017 ( 1 year )

Designation : Executive -Validation & Coding **(** MAR 2016 to SEP 2016 **)**

**:**Domain Specialist Health Insurance (SEP 2016 to MAR 2017 )

**Job Responsibility in HGS**

* Verifying and reviewing all the claims ( Hospitals inpatient , outpatient. And specialist claims).
* Responsible for assisting insurance providers for the purpose of verifying eligibility of insurance claims and processing claims.
* Responsible for answering questions on processing insurance claims, insurance coverage.
* After proper investigation processing the claims
* Understanding the medical history of the member / provider claims
* Reviewing the total premiums paid by the customer.
* Resolved problems resulting from claim settlement.
* Delivered timely service to the members, providers, billing departments on the subject of claims.
* Reduces claim frequency.
* Improves productivity and morale.
* Improve the claim-reporting consistency.
* Increases preferred provider network penetration.
* Instant information leading to early intervention and prevention.
* Independent claims medical reviews.
* Supervisors collaborate in decision and stay involved.
* To ensure quality claims processing.
* To ensure proper payment of claims.
* Audit the claims with proper investigation.
* Provided training to new employees.
* Immediate communication of the MST and IHAT team response.
* Payment Validation , contract analysis
* Processing claims within TAT and delivering with high accuracy, etc.

**Job Responsibility in Remedinet**

* Evaluates claims referred for medical management and makes recommendations for follow-up, further investigation or documentation as necessary.
* Checking all available documents mainly are-cover letter, pre-auth form, approval letter, Photo id, discharge summary, Final bill, co-pay receipts, invoice/stickers, investigation reports and Supporting Investigation report for diseases.
* All demographic details should be crosschecked comparing documents and in our system.
* Diagnosis & Line of treatment should be checked as per the standard policy exclusions.
* Non-medical expenses and Co-pay, Discount amount are checked as per the standard policy terms and condition.
* Co-pay, Discount amount is checked, calculated, remaining amount becomes claim amount for Insurer.
* 24 hours hospitalization mandatory in medical management, day care procedure with ailments need to be checked.
* In maternity claim, 9 months waiting period, number of children covered in policy need to be checked, if applicable.
* Claim should be processed within the policy coverage terms.
* There should be no discrepancy in throughout the claim documents.
* Responds to all query’s, or telephone calls regarding the company's cost containment program, utilization review decisions, and reductions.
* Assists and advises claims examiners concerning the monitoring of claimants' medical treatments.
* Reviews all medical/surgical billings for reasonable and necessary charges.
* To protect against fraudulent claims and billing activity.
* The claims should be processed as per approval letter from TPA/Insurer.

I hereby declare that the particular furnished above are true and correct to the best of my knowledge and belief.

Date:

**Tony**

Place: Abu Dhabi

PradeP