JOB DESCRIPTION FORM

Job Title: **Customer Service Supervisor/ Examiner 1**	**Location:** Philippines
Reports to: Sr. Customer Service Supervisor	

Job Summary:

Reports directly to the Sr. Customer Service Supervisor and responsible for receiving, documenting, researching and responding to member inquiries, complaints, appeals and/or grievances. Gathers and presents all relevant data of case for medical review and makes recommendation for resolution and/or determination of next step. Also responsible for coordinating problem resolution for members, providers, and employer groups amongst various internal departments and external resources/contacts. Examiner and will analyze and process medical and dental claims. This position is responsible for following regulatory and internal guidelines in conjunction with TakeCare policies and procedures as they apply to claims adjudication.

Duties and Responsibilities:

1. Customer Service Responsibilities

    1. Acts in a leading capacity for the entire PI Customer Service Team, Particularly when the CS Sr. Supervisor is absent.
    2. Receives, documents, researches and responds to member inquiries, complaints, appeals and/or grievances.
    3. Prepares and/or initiates a variety of correspondences/documents in response to inquiries, complaints, appeals, and/or grievances.
    4. Gathers and presents all relevant data of case for medical review and makes recommendations for resolution and/or determination of next step.
    5. Coordinates problem resolution for members, providers, and employer groups amongst various internal department and external resources/contacts.
    6. Authorizes payment of claims within pre-establish limits or guidelines.
    6. Educates federal members on benefits, use of plan, premiums and status of claims or appeals/grievances.
    7. May contact providers to notify them of overturned appeals and changes of financial responsibility.

8. Conducts “Federal/Commercial Open Season” presentation to members.
9. Handles primary duties of the receptionist (i.e. collection of recovery claims, member payments).
10. Acts as designated department resource with extensive knowledge of precuts and provides guidance to other staff members.
11. Helps with the preparation of the monthly statistic reports for Dashboard (presented during Executive and Shareholders Meeting).
12. Accumulates and collects updated member demographics.
13. Generates membership cards.
14. Acts as operator as well as messaging entity.
15. Assigned Appeals Coordinator. Handles all organizational appeals including coordination of the Appeals Committees Level 1 and Level 2.
16. Performs other duties that may be assigned from time to time

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2. Medical and Dental Claims Processing

2.1 Process claims based on compliance regulation and timeframes.

2.2 Process both professional (CMS-1500); dental (ADA) and facility (UB-04) claim types. In addition to member claims as assigned.

2.3 Claims processing based upon contractual and/or TakeCare agreements, involving the use of established payment methodologies, applicable regulatory legislation, claims processing guidelines and company policies and procedures.

2.4 Prepare written requests to providers; follow up and handle completion of claim for returned correspondence.

2.5 Review services for appropriateness of charges and apply authorization guidelines during claims processing.

3. Claim Quality Responsibilities

3.1 Analyze, process, research, adjust and adjudicate claims with the use of accurate procedure/revenue and ICD-9 codes, under the correct provider and member benefits, i.e. co-payments, deductibles, etc.

3.2 Responsible for an accuracy rate of 95% during first 90 days. Expectation to reach 98% accuracy after completion of 180 days probationary/temporary period.

3.3 Alerts Manager or Supervisor of issues that impact production and quality, i.e. incorrect database configurations, non-compliant claims, etc.

4. Performance and Goal Expectations

4.1 Expected to meet performance goals and objectives as defined by TakeCare Management policies.

4.2 Routinely updates milestones within the performance goal system; Success Factors

Job Specifications:

1. Graduate of Bachelor's Degree in Nursing; RN License is required.

1. Minimum of 2 years experience in supervising the day-to-day functions of receiving, documenting, researching and responding to member inquiries, complaints, appeals and/or grievances. Gathers and presents all relevant data of case for medical review and makes recommendation for resolution and/or determination of next step. Also responsible for coordinating problem resolution for members, providers, and employer groups amongst various internal departments and external resources/contacts. Call Center experiences a plus.

2. Able to work any shifts including graveyard.

3. Effective team player. With very good interpersonal relationship skills and can work and relate well with co-employees, patients and customers.

4. Must have the behavioral sensitivity, maturity, diplomacy and tact in addressing complex situations and handling irate customers.

5. Outstanding oral and written communication skills.

6. Strong ethics and a high level of personal and professional integrity.

7. Must have basic familiarity on federal and state laws and requirements relating to healthcare management and claims administration.

8. Computer literate and very highly proficient in using MS office programs.