MERCURY

Mastering Insurance Verification & Claims Management for Healthcare Professionals Training

15 – 19 November 2027
Dar es Salaam (Tanzania)



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Ref: 16017_1067939 **Date:** 15 – 19 November 2027 **Location:** Dar es Salaam (Tanzania) **Fees:** 5300 Euro

Introduction:

Efficient healthcare insurance verification services and claims management processes are vital to maintaining revenue integrity and operational efficiency within healthcare institutions. The Insurance Verification and Claims Management for Healthcare Professionals training course equips healthcare professionals with the tools to navigate complex insurance frameworks and streamline administrative workflows.

Participants will learn about insurance eligibility verification, including real-time patient coverage confirmation and pre-authorization requirements. The Insurance Verification and Claims Management for Healthcare Professionals program explores in-depth strategies to improve the claims management process in healthcare, focusing on accuracy, compliance, and communication.

This Insurance Verification and Claims Management for Healthcare Professionals training bridges the communication gap between providers and payers, enhancing understanding of payer guidelines and reducing the frequency of denied or delayed claims. Attendees will learn how to optimize healthcare claims management systems and automation tools for increased operational effectiveness.

Moreover, the Insurance Verification and Claims Management for Healthcare Professionals course addresses common challenges in healthcare insurance verification and offers structured solutions to manage them efficiently. Upon completion, participants will support organizational goals, maximize reimbursement, and reduce financial risk across the healthcare revenue cycle.

Targeted Groups:

This Mastering Insurance Verification and Claims Management for Healthcare Professionals training targets professionals seeking specialized knowledge and skills:

- Healthcare billing professional
- Medical office administrators.
- Revenue cycle management staff.
- Insurance verification specialists.
- Claims management officers.
- Healthcare finance team members.
- Medical coders and billers.
- Healthcare operations supervisors.
- Patient financial service representatives.
- Front desk and registration staff.
- Healthcare insurance verification consultants.
- Professionals working in claims management systems in healthcare.

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• Administrative staff are involved in the claims management process in healthcare.

Course Objectives:

Participants will achieve the following objectives by mastering the Insurance Verification and Claims Management for Healthcare Professionals course:

• Understand the end-to-end process of healthcare insurance verification.
• Identify critical documents needed for accurate patient eligibility confirmation.
• Classify various health insurance plans and analyze policy structures.
• Determine patient eligibility based on payer policies and coverage data.
• Implement effective pre-authorization and referral procedures.
• Accurately prepare and submit healthcare claims using clean claim principles.
• Detect and prevent common billing and coding errors.
• Integrate digital tools and healthcare claims management systems to enhance workflow.
• Assess and resolve claim discrepancies using structured approaches.
• Adapt to insurance coverage expirations and mitigate related financial risks.
• Apply reimbursement guidelines from public and private payers.
• Improve payer-provider communication for smoother claim processing.
• Evaluate claims data using reports to identify areas of improvement.
• Streamline verification processes to reduce delays and denials.
• Design internal procedures that support optimal claims approval rates.
• Develop a performance-based action plan to elevate claims processing efficiency.

Targeted Competencies:

Participants will gain the following competencies during the Insurance Verification and Claims Management for Healthcare Professionals program:

• Proficiency in patient insurance eligibility verification and documentation.
• Understand healthcare coverage limits and exclusions.
• Learn about the ability to manage policy coordination and benefit structures.
• Explore skills to process accurate and timely healthcare claims.
• Explain competence in identifying and resolving claim denials.
• Understand compliance with regulatory guidelines.
• Explore proficiency in using claims management healthcare solutions and software tools.
• Understand strengthened communication with patients and insurers on financial responsibilities.
• Learn about enhanced decision-making in claims resolution and appeals.
• Explore adaptability to evolving trends in healthcare insurance verification.

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Course Content:

Unit 1: Insurance Eligibility Verification Process in Healthcare:

- Define the role and significance of insurance verification.
- Identify the data points needed to confirm eligibility.
- Differentiate between primary and secondary coverage.
- Explain the coordination of benefits in multi-plan coverage scenarios.
- Examine the difference between in-network and out-of-network benefits.
- Use healthcare portals to conduct real-time insurance verification.
- Apply digital verification tools in day-to-day operations.
- Manage re-verification for patients with recurring visits.
- Create accurate verification logs for internal audit readiness.
- Handle verification during emergency admissions.
- Understand privacy standards when handling patient insurance data.
- Link verification outcomes with claims processing accuracy.

Unit 2: Understanding Coverage Limits and Policy Provisions:

- Read and interpret policy documents to determine financial responsibilities.
- Differentiate between co-payment, deductible, coinsurance, and out-of-pocket maximums.
- Identify service exclusions and their billing consequences.
- Understand the process and timing for pre-authorizations.
- Distinguish lifetime maximums versus annual coverage caps.
- Manage scenarios involving secondary insurance payers.
- Calculate patient liabilities after insurance payment.
- Communicate patient payment expectations upfront.
- Use coverage limit data to forecast reimbursement amounts.
- Record financial counseling discussions with patients.
- Educate patients on their insurance plans' limitations.
- Understand state-level variances in policy structures.

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Unit 3: Healthcare Claims Submission Procedures:

- Describe the full claims submission lifecycle.
- Enter accurate demographic and policyholder data into claim forms.
- Apply correct codes using ICD-10, CPT, and HCPCS standards.
- Leverage clearinghouses and EDI for claims transmission.
- Ensure submissions meet payer timelines and documentation criteria.
- Avoid duplicate submissions and understand rejection protocols.
- Identify payer-specific guidelines affecting claim formatting.
- Utilize software for claim validation before submission.
- Implement methods for tracking claim status in real time.
- Address rejected claims and understand the correction process.
- Organize billing audits to reduce recurring claim errors.
- Understand the connection between claim accuracy and healthcare insurance verification services.

Unit 4: Managing Denials, Appeals, and Reimbursement Optimization:

- Recognize the most common denial codes and their root causes.
- Categorize denial types: technical, administrative, and clinical.
- Develop procedures for denial tracking and reporting.
- Construct effective appeal letters with supporting documentation.
- Collaborate with providers to ensure documentation of medical necessity.
- Monitor claim follow-up timelines to meet payer deadlines.
- Utilize healthcare claims management systems for denial analysis.
- Analyze denied claim trends to revise internal procedures.
- Apply payer guidelines for correcting and resubmitting claims.
- Train staff on real-time response to denial notifications.
- Link reimbursement delays with gaps in verification processes.
- Increase approval rates using automated claims management healthcare solutions.

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Unit 5: Compliance, Best Practices, and Future Trends in Claims Management:

- Maintain compliance with HIPAA, CMS, and ACA regulations.
- Integrate payer-specific compliance rules into daily operations.
- Explore the impact of AI and RPA on claims management.
- Use digital dashboards to track KPIs and reimbursement trends.
- Conduct regular internal audits for documentation and coding accuracy.
- Foster a culture of continuous learning in claims and verification processes.
- Collaborate across departments for seamless claims flow.
- Align claims management strategies with organizational financial goals.
- Monitor legislative updates affecting healthcare claims management.
- Adapt to trends in patient-centered billing and transparency.
- Implement new healthcare claims management and system upgrades.
- Plan for future innovations in digital insurance verification training.

Final Insights & Key Takeaways:

Mastering healthcare insurance verification and claims management is essential for optimizing financial performance in medical institutions. This Insurance Verification and Claims Management for Healthcare Professionals course provides in-depth training on handling complex policies, verification procedures, and streamlined claims workflows. By applying practical tools and strategies, participants will reduce claim errors, enhance reimbursements, and ensure compliance. Well-executed claims management improves operational efficiency and patient satisfaction in modern healthcare settings.