MERCURY

Medical Insurance Claims and Pre-Approval for Providers

23 – 27 November 2026
Rome (Italy)

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Medical Insurance Claims and Pre-Approval for Providers

Ref: 15269_1075327 **Date:** 23 – 27 November 2026 **Location:** Rome (Italy) **Fees:** 6200 Euro

Medical Insurance Claims and Pre-Approval for Providers is a 1-week course for hospital, clinic and pharmacy staff who check patient coverage, request treatment approvals and submit claims to insurers. You practice eligibility checks, pre-authorization requests, coding and documentation, claim submission, rejection handling and appeals, and you leave with a Claims and Pre-Approval Desk Guide for your facility. Mercury Training Center delivers this medical insurance claims course.

About This Course

Providers lose revenue and patient goodwill when approvals stall, claims bounce for missing details or rejections are never appealed. This course shows you how to get each request right the first time and recover what is refused. You should already work at a patient access, approvals or billing desk. You practice on policy schedules, request forms and rejection notices.

Who It Is For

- Staff who verify patient insurance coverage at registration and admission.
- Staff who prepare and follow up pre-approval requests with insurers.
- Staff who code, compile and submit claims for inpatient and outpatient care.
- Staff who handle rejected claims, appeals and insurer correspondence.
- Supervisors accountable for approval turnaround, rejection rates and cash collection.

This course is not for insurer staff who design products, price premiums or manage reinsurance, who are better served by a longer course on medical insurance management, nor for clinicians seeking detailed coding certification, who need a dedicated medical coding course.

Competencies You Will Build

- Coverage Verification: you confirm eligibility, benefit limits, deductibles and co-payments before treatment.
- Pre-Approval Requests: you submit complete requests with the clinical justification insurers expect.
- Claim Preparation: you compile claims with correct codes, documents and amounts.
- Rejection Analysis: you sort rejections by cause and fix the process that produced them.
- Appeals Writing: you draft clear appeals backed by policy terms and medical records.
- Payer Relationship Handling: you keep correspondence and network agreements with insurers in order.

What You Will Be Able to Do

By the end of the course you will be able to:

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- Given a member card and policy schedule, determine coverage, exclusions and the patient's share for a planned procedure.
- Using a physician's notes, complete a pre-approval request that states diagnosis, procedure and medical necessity.
- From an episode of care, assemble a claim with ICD diagnosis codes, itemized charges and supporting documents.
- Given a month of rejection notices, classify causes and set corrective actions for the front desk and billing team.
- Using a rejected high-value claim, write an appeal that cites the relevant contract terms.
- From claims data, calculate approval turnaround, first-pass acceptance and rejection rates.

Course Content

Day 1: Medical Insurance Basics for Providers

- Insurance Principles, Risk Pooling And The Roles Of Insurer, Insured And Provider
- Individual And Group Policies And Common Coverage Types
- Benefit Schedules, Exclusions, Deductibles And Co-Payments
- Provider Network Agreements And Tariff Schedules
- Underwriter, Claims Adjuster And Provider Relations Roles

Day 2: Eligibility and Pre-Approval

- Eligibility Verification At Registration And Admission
- Pre-Authorization Triggers For Inpatient, Day Case And High-Cost Items
- Medical Necessity Statements And Supporting Clinical Notes
- Approval Turnaround Tracking And Escalation Paths
- Patient Communication On Partial Approvals And Self-Pay Amounts

Day 3: Claims Preparation and Submission

- ICD Diagnosis Coding And Procedure Code Accuracy Checks
- Itemized Billing, Claim Calculation And Document Packs
- Electronic Claim Submission And Batch Reconciliation
- Personal Accident Cover And Its Link To Medical Claims
- Insurer Correspondence Templates And Record Keeping

Day 4: Rejections, Appeals and Fraud Controls

- Rejection Codes And Root Cause Categories
- Appeal Letters Built On Contract Terms And Medical Records
- Medical Insurance Fraud And Abuse Warning Signs
- Internal Audit Checks Before Claims Leave The Facility
- Contract Renewal Discussions Using Claims And Rejection Data

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Day 5: Claims Desk Practice

- Exercise: Coverage Check And Pre-Approval For A Planned Surgery
- Exercise: Claim Assembly For An Emergency Admission
- Exercise: Appeal Of A Rejected Diagnostic Imaging Claim
- Claims KPIs, Aging Reports And Monthly Review Routine
- Claims and Pre-Approval Desk Guide Completion And Peer Review

Case Studies and Exercises

The following are suggested activities used during the course:

- Case study: a private hospital sees approvals for day-case surgery delayed for days; you decide what is missing from the requests and redesign the form.
- Case study: an outpatient clinic group receives repeated rejections for unbundled charges; you trace the coding cause and set checks.
- Exercise: for a community pharmacy, you check coverage and co-payment rules for chronic medication claims.
- Exercise: for a dental center, you draft an appeal for a procedure refused as cosmetic.

What You Take Back

You return with a Claims and Pre-Approval Desk Guide written for your facility. In your first month back, use it to brief registration and billing staff, apply the request and claim checklists on every case and start tracking rejection causes weekly.

- An eligibility and coverage checklist.
- A pre-approval request template with clinical justification prompts.
- A claim submission and document checklist.
- An appeal letter template and rejection tracking sheet.

Quick Answers FAQ

What should I know before a medical insurance claims course?

You should already work in patient access, approvals, billing or a related desk at a healthcare provider. Basic familiarity with medical terms helps. No prior coding qualification is needed; coding checks are taught at the level billing staff use.

How does a medical insurance claims course for providers differ from a medical insurance management course?

A management course looks at insurance from the insurer's side: products, premiums, actuarial study and reinsurance. This one-week course stays on the provider's side: checking coverage, getting approvals, submitting claims and recovering rejected amounts.

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Why are medical insurance claims rejected most often?

Most rejections come from preventable causes: expired or wrong eligibility, missing pre-approval, coding that does not match the diagnosis, incomplete documents or services outside the policy. A front-end checklist removes many of them before submission.

What do I take back from claims and pre-approval training?

You take back a Claims and Pre-Approval Desk Guide: an eligibility checklist, a pre-approval template, a claim document checklist, an appeal template and a sheet for tracking rejection causes.

For Your Manager

After this course, the team member will be able to verify coverage, submit complete pre-approval requests and claims, analyze rejections and write appeals backed by contract terms. They return with a Claims and Pre-Approval Desk Guide for the facility, first used to brief front-desk and billing staff and to cut avoidable rejections.

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