Claims processing job description:

There is a full time medical claims processor position available in Roseland, NJ. Hours are Monday through Friday, 8:00 – 4:30. Job responsibilities include telephone customer service in addition to processing medical claims. Candidates must be detail oriented and able to multitask. Our company administers claims for several different plans. Candidates should be able to learn and administer multiple plans. Familiarity with medical coding and/or medical billing along with knowledge of medical terminology is preferred, but not required. Training is provided.

Telephone customer service includes:

Confirming eligibility and plan benefits for members and dependents. Processors will have access to resources that enable them to refer callers to other companies, who manage prescription or mental health and substance abuse benefits for members.

This office also does claim status for members and non-participating providers. We will request stop payments and reissue payments on lost checks. Prescription overrides are also handled through this department. Appeals are handled by a separate department, but the claims department relays info regarding appeals. The claims department also both initiates and responds to Horizon BCBS and other plan benefit managers regarding any problems or issues that come up.

All member services are done through this office regarding medical claims. Every effort is made to satisfy the members of the groups we handle.

Claims processing includes:

Review and release of electronic claims. Diagnosis needs to be reviewed to see if further information is needed regarding injury or if claim should be denied due to plan rules. If further information is requested, claims will be reviewed again upon receipt of that information and will either be paid, denied or passed to a different department or supervisor if additional work is needed on the claim. The processor also needs to verify that authorizations were received, if required. Each plan has different rules regarding authorizations.

Most electronic non-participating claims are automatically sent to an outside review company who reviews the claims for correct medical billing and coding. Claims are returned electronically from this company and payment is released according to their recommendations.

Entry, review and release of manual claims. Each group has different rules regarding manual claims. Some groups have no out of network benefits, so there will be no manual claims. Other groups have out of network benefits so there will be payments made to the member for covered services which member has already paid for. Some groups have vision benefits which are reimbursable to the member, so all those claims are manually processed.

This job requires attention to detail and an ability to multitask.