24/7 Medical Billing Services

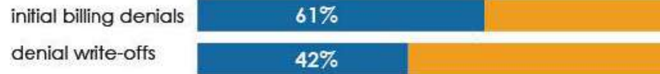
MEDICAL BILLING PROCESS TERMS EXPLAINED SIMPLY

Insurance Verification

Patient benefit eligibility is verified before an appointment is scheduled.

Patient Scheduling & Registration

Patient demographic entry is completed by collecting and verifying data and entering the information in the billing system.



Missing information on claim forms prompt 61% of initial billing denials and account for 42% of denial write-offs

Patient Co-pay collection

Co-pays are collected when the patien checks-in at the clinic.

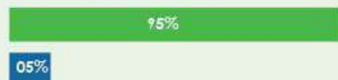
As per a survey, physicians collect just $15.77 out of every $100 owed once patient accounts are sent to collections

Documentation of Visit

Complete and accurate documentation is done to validate the care given.

Medical Coding

Documentation is sent to the coding department for assigning accurate CPT and ICD-10 codes.



Providers should keep their denial rate around 5% in order to maximise claim reimbursement revenue.

Charge Entry

Medical billing charges are entered for every code assigned in the document.

Claims Checking & Error Resolution

Entries are checked for accuracy based on the carrier requirements. Claims are thoroughly verified.

Claims Submission

Audited medical claims are submitted within deadline to the insurance company of the patient.

Payment Processing & Posting

Payment is applied into the billing software against the accurate patient account.

Insurance Follow-up

Insurance follow-ups are done for receivables to accelerate collections.

Denial Management

Trends in denials are identified and preventive measures are determined to avoid denials.

According to the MGMA, not more than 35% providers appeal denied claims

A/R Follow-up

Issues in claims are identified and resolved to get full, timely payment.

24/7 Medical Billing Services is a fully integrated RCM company that guarantees 10-20% increase in revenue generation & 50% cost reduction in your operation costs

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