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WebsiteImperial Management Administrators Services**Imperial Management Administrators Services**

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People are the most important asset of Imperial, for this reason the difference and plurality of people, equality of opportunities, non-discrimination and inclusion in the workplace are priority and strategic factors in the Organization. Imperial maintains a strong will to promote Diversity, Equity, and Inclusion, through inclusive leadership as a lever change and business sustainability.

Imperial Health Plan of California, Inc. is approved by California Department of Managed Health Care to offer full-service Medicare Advantage coverage, including a Medicare Advantage Prescription Drug plan, and a Chronic Condition Special needs plan over numerous counties in California. Through its affiliate, Imperial Insurance Companies, Imperial also offers Medicare Advantage plans in Texas, New Mexico, Utah, and Arizona.

Our mission: To deliver valuable care so that members are healthy in body, mind, and spirit to achieve their inherent potential.

Our vision: To deliver value based care that is clinically effective, sustainable, and achieves exceptional outcome.

THIS IS IN-OFFICE – NO REMOTE IS AVAILABLE

JOB SUMMARY: This position is responsible for analyzing and validating claim data elements and claims processing. The incumbent is responsible for adhering to the regulator and internal processing guidelines in conjunction with the company’s policies and procedures related to claims adjudication. Highly knowledge understanding of EZ-CAP relative to claims payments. Your efforts will support the accurate & timely payment of claims.

ESSENTIAL JOB FUNCTIONS:

1. Process non-institutional claim types.

2. Process basic claims to an adjudicated status.

3. Analyze, process, research, adjust and adjudicate simple claims timely and accurately with the use of accurate procedure/revenue and ICD-10 codes, under the correct provider and member benefits, i.e., co-payment, deductible, etc.

4. Analyze and process claims from providers based on provider contractual agreement, health plan division of financial responsibility, claim processing guidelines, and company policies and procedures.

5. Perform thorough review of pended claims for billing errors and/or questionable billing practices that might include duplicate billing and unbundling of services.

6. Process claims based on contractual agreements, health plan division of financial responsibility, applicable regulatory legislature, claims processing guidelines and client groups and company policies and procedures.

EDUCATION/EXPERIENCE:

· High school graduate or equivalent.

SKILLS/KNOWLEDGE/ABILITY:

· EZ-CAP knowledge; or equivalent combination of education and experience.

· Willingness and ability to read, write, speak, understand English and have the communications skills necessary to provide accurate information to residents and staff.

· Willingness and ability to follow written and verbal direction in English.

· Willingness and ability to maintain appropriate level of confidentiality and privacy.

· Willingness and ability to interact professionally with all customers, members, and co-workers, individually and as part of a team.

· Willingness and ability to effectively handle multiple items/tasks as required and adapt favorably to changing priorities.