BENEFITS VERIFICATION

APPLICATION SERVER

US WORK HOURS



Front office staff schedules appointments in the practice management system. Insurance coverage data is collected, verified, and entered into the system

Patient calls in to schedule an appointment



PATIENT

Patient is called and notified of benefit status or inconsistent information





FRONT OFFICE

9am – 5pm

Benefits information is accessed by the front office staff and the following action is taken:

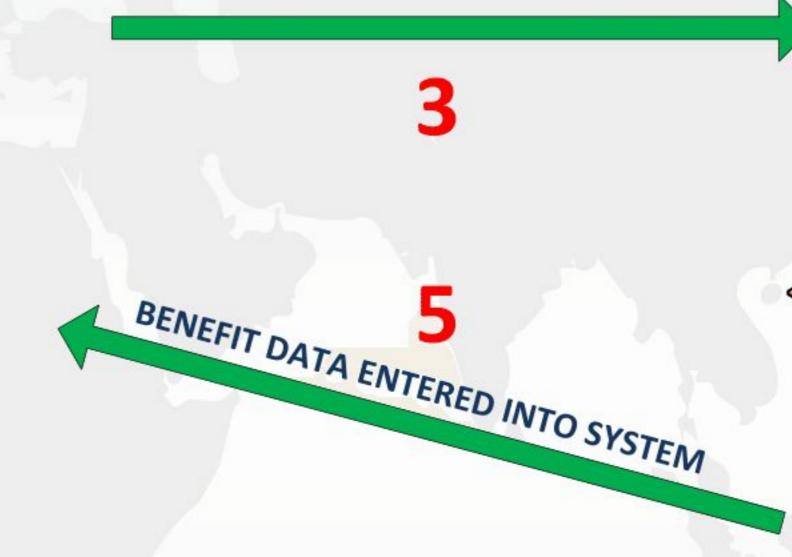
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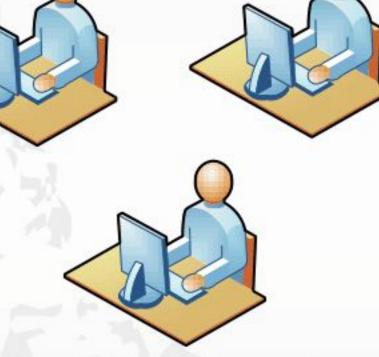
- 1. If the patient is ineligible, the patient is called and notified of their status.
- 2. If there is inconsistent demographic data found for the patient, the patient is called and the information is validated

Appointment schedule is downloaded:

- 1. New Patients 2 weeks in advance
- 2. Existing Patients 1 to 3 days before
- 3. Daily Benefits are checked a few hours in advance for all patients coming in that day new or existing. This is done so the data is current

US NIGHT HOURS





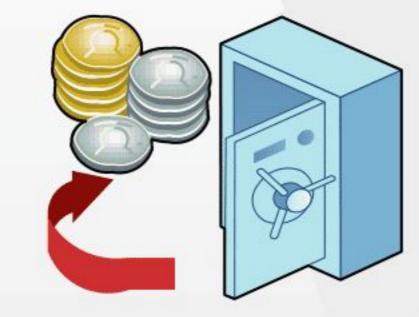


BOOMERANG TEAM

Benefits are verified first, via web, and if not available, by phone.

The following information is collected:

- 1. Verify if patient's insurance is current
- 2. Verify patient demographic information and update if necessary
- 3. If AHCCCS or HMO, determine if practice is PCP for patient
- 4. [New Patients] Determine Co-pay, Max allowable, what is covered and what is not, \$ amount of visit limitations, limit on # of tasks per year etc.
- 5. Deductible amount over a certain threshold (determined by the practice) If patient is not eligible, raise an alert for that patient in the system



PAYER



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