The Brownsville Multi-Service Family Health Center is an NCQA recognized Patient Centered Medical Home (PCMH) Level 3. We offer the best possible care for everyone in the communities we serve. BMS adopts an “integrated primary care community based health” service model reflecting our commitment to treating the “whole person” and our mission driven goal to enable every individual and family in the communities we serve to achieve total health.

If you are looking for a place to work where you can provide the care that will change the lives of the people in the community, BMS is the one for you.

**We are currently hiring a Patient Account Associate**

The Patient Account Associate functions and responsibilities consist of billing and collecting patient service rendered. Assist in monitoring write-offs, posting of all payments to patient accounts, creating and maintaining reports (i.e. Denial Reports, Discrepancy Reports, Insurance aging, collections Reports, etc.). Patient Account Associate is under the supervision of the Patient Accounts Manager.

***RESPONSIBILITIES AND DUTIES:***

* Insure receipt and billing of all billable office visits.
* Evaluate and interpret office visit diagnoses and procedures into ICD10, CPT4, HCPCs, Modifiers, and CDT codes.
* Review and evaluate EHR office visit charges.
* Transport and /or enter charges in the Electronic Practice Management System (EPM) for billing
* Review patient accounts and provide necessary adjustments (i.e. Sliding fee schedule, Medicare Sliding fee, Grant Adjustments) and apply cashier receipt to patient accounts.
* Adjust information of claims for accuracy and compliance within payer insurance policy.
* Identify and Bill claims to insurances.
* Document in Patient Check In/Check Out missing and/or inaccurate office information.
* Transmit and process all billable claims.
* Review, Appeal and attach all necessary documentation on claims to ensure appropriate reimbursements (i.e. referrals, authorizations, etc.).
* Review patient statements for accuracy, completeness and obtain any missing information.
* Handle confidential patient information with professional discreet.
* Export/process claims thru clearinghouse.
* Review Athena and claims rejections.
* Review, modify, document denial reason code, correct and regenerate denied claims.
* Utilize assigned reports to process denials within 45 day time frame
* Utilize reports to monitor and collect outstanding revenues over 45 days of date of service.
* Maintain communication with assigned Insurance Provider Representatives on any claim issues that may arise (i.e. inappropriate payments, rate changes, non-payment issues, etc.).
* Answer all patients or insurance telephone inquiries pertaining to assigned accounts
* Create, monitor and maintain assigned departmental reports as directed.
* Generate insurance and billing reports as directed.
* Provide assistance resolving denial conflicts.
* Balances all remittance file with payments received.

***QUALIFICATIONS/REQUIREMENTS:***

* High School Graduate or G.E.D. required.
* Computer literate with strong Excel and Microsoft Word skills.
* At least 4 years of medical billing and reimbursement experience.
* Certified in ICD10& CPT4 Coding with knowledge of medical terminology, HCPCS, Modifiers and CDT.
* Experienced in resolving denial conflicts.
* Strong skills in: Interpersonal, analytical, communication and writing.

Please contact Roberta Pompeu, BMS HR Recruiter, at [rpompeu@bmsfhc.org](mailto:rpompeu@bmsfhc.org) for additional information or to submit your resume

**We offer competitive salary and full benefit package**