ANITA CRESPO

SUMMARY OF QUALIFICATIONS:

Over 40 years of experience in the healthcare industry. Demonstrated management abilities in developing highly successful operational processes in the area of Provider and Member Formal Appeals/Grievance, Denial Management, Customer Service, Government Agency Compliance and Claims Operations.

WORK EXPERIENCE

June 2004 - Present

eReceivables Inc. – Coral Springs, Florida
VP of Operations:

- Responsible for oversight and strategy of daily operations of collections and follow-up with client satisfaction focus.
- Account Management – Establish and nourish relationships with Clients while maximizing collections through the appeals and follow up process.
- Client Reporting – Providing trends and opportunities for process improvement.
- Implemented the initial Response/Action Codes Process
- Prepared and Participated in all Medicare Appeals hearings (ALJ) via teleconference.
- Extreme Knowledge of both State and Federal Appeals/Grievance Regulations.
- Monitoring performance and developing processes to increase effectiveness and recognize and celebrate achievements.
- High degree of attention to detail, with the ability to multi-task and respond to ever-changing priorities

CCS – CORAL SPRINGS, FLORIDA

- Director of Claims/Customer Service and Appeals

MAGELLAN SPECIALTY HEALTH – MIRAMAR, FLORIDA

- Director of Operations – Claims and Provider Appeals

FOUNDATION HEALTH – SUNRISE, FLORIDA

- Director of Appeals & Grievance

FAMILY HEALTH PLAN – MIAMI LAKES, FLORIDA (ACQUIRED BY PCA)

- Statewide Director of Government Relations & Appeals/Grievance

HUMANA HEALTH PLAN - SUNRISE, FL (ACQUIRED INTERNATIONAL MEDICAL CENTER 1986)

- Director of Appeals/Grievance and Customer Services 1982 - 1992

ACHIEVEMENTS AND QUALIFICATIONS

- Produce and implement policies and procedures for Medicare/Commercial Member Appeals and Grievances pursuant to State and Federal rules and regulations.
- Chairman for the Health Plan's Formal Member Grievance Committee.
- Liaison between the Plan and the Agency for Health Care Administration, Department of Insurance and Medicare, for all member complaints to the point of resolution.

- Assisted in the full NCQA Accreditation for the Members Rights and Responsibilities
- Created Denial Management Review Unit to analyze and provide feedback for process improvement.
- Determines call center operational strategies by conducting needs assessments, performance reviews, and capacity planning, identifying customer-service standards, contributing information and analysis to organizational strategic plans and reviews.
- Created statistical reports illustrating the volume of calls and time management on daily calls.
- Health Plan's Peer Review Committee Participant with Regional Medical Directors.
- Implementation of call center phone system, metrics and goals.
- Maintained an ongoing 3% abandoned call rate in the Customer Service Department servicing over 120K members.
- Leadership Qualities – Ability to identify priorities and resolve issues in the initial stages.
- Proficient in Microsoft Word, Excel, PowerPoint