

HEALTHCARE/ MEDICAL INDUSTRY – SKILLS AND YEARS OF EXPERIENCE

MEDICAL ADMINISTRATION	Yrs. Exp.	<input type="checkbox"/> POS / HMO Referrals	_____	<input type="checkbox"/> Doctor's Office	_____
<input type="checkbox"/> Appointment Scheduling	_____	<input type="checkbox"/> Practice Manager	_____	<input type="checkbox"/> Emergency	_____
<input type="checkbox"/> Billing	_____	<input type="checkbox"/> Pre- certification	_____	<input type="checkbox"/> Family Practice	_____
<input type="checkbox"/> Charge Entry	_____		Yrs.	<input type="checkbox"/> Geriatrics	_____
<input type="checkbox"/> Chart Analysis	_____	Exp.			Yrs. Exp.
<input type="checkbox"/> Chart Assembly	_____	<input type="checkbox"/> Quality Assurance	_____	<input type="checkbox"/> Hospital Administration	_____
<input type="checkbox"/> Collect Co- pays	_____	<input type="checkbox"/> Reception	_____	<input type="checkbox"/> Hospital financial	_____
<input type="checkbox"/> Credentialing	_____	<input type="checkbox"/> Registration	_____	<input type="checkbox"/> Hospital Health Information	_____
<input type="checkbox"/> Denial of Benefits	_____	<input type="checkbox"/> RN/ Case Manager	_____	<input type="checkbox"/> Internal Medicine	_____
<input type="checkbox"/> Explanation of Benefits	_____	<input type="checkbox"/> Secretary/ Administration	_____	<input type="checkbox"/> OB / GYN	_____
<input type="checkbox"/> HCFA 1500	_____	<input type="checkbox"/> Surgical Scheduling	_____	<input type="checkbox"/> Oncology	_____
<input type="checkbox"/> ICD-9 / CPT Coding	_____	<input type="checkbox"/> Terminal Digit Filing	_____	<input type="checkbox"/> Ophthalmology	_____
<input type="checkbox"/> Insurance Claim Processing	_____	<input type="checkbox"/> Transcription	_____		
	Yrs. Exp.	<input type="checkbox"/> Tumor Registry	_____		Yrs. Exp.
<input type="checkbox"/> Insurance Follow- up	_____	<input type="checkbox"/> UB92	_____	<input type="checkbox"/> Outpatient Center	_____
<input type="checkbox"/> Loose Filing	_____	<input type="checkbox"/> Utilization Review	_____	<input type="checkbox"/> Pediatrics	_____
<input type="checkbox"/> Medical Coding	_____	<input type="checkbox"/> Other _____	_____	<input type="checkbox"/> Psychiatry	_____
<input type="checkbox"/> Medical Collections	_____			<input type="checkbox"/> Radiology	_____
<input type="checkbox"/> Medical Data Entry	_____	MEDICAL SPECIALTY	Yrs.	<input type="checkbox"/> Research	_____
<input type="checkbox"/> Medical Insurance Verification	_____	Exp.		<input type="checkbox"/> Surgery	_____
<input type="checkbox"/> Medical Records	_____	<input type="checkbox"/> Assisted living	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Patient Collections	_____	<input type="checkbox"/> Cardiology	_____		
<input type="checkbox"/> Payment Posting	_____	<input type="checkbox"/> Dental	_____		

MEDICAL SOFTWARE	Yrs. Exp.	<input type="checkbox"/> Medisoft	_____	<input type="checkbox"/> Other _____	Yrs. Exp.
<input type="checkbox"/> EPIC	_____	<input type="checkbox"/> Med Manager	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> IDX	_____	<input type="checkbox"/> Meditec	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Medical MasterMind	_____				

I authorize ExecuTeam to check all references and verify accuracy of my application. Falsification of application will result in termination of further employment consideration. Furthermore, I understand that I will **not** be charged a fee for employment at any time by ExecuTeam Staffing.

Applicant's Signature **X** _____ Date _____