National Center for Competency Testing

7007 College Blvd., Ste. 385, Overland Park, KS 66211
Phone 800.875.4404; Fax 913.498.1243
Office Hours: M-F 7:30am - 7:00pm CST
Saturday 9:00am - 3:00pm CST

Insurance & Coding Certification Qualification by Experience

(Official Documentation of Route 2)

Rev: September 2016

To be completed by the applicant: (Please return this form to NCCT with your application.)

Name of applicant _____

Today's Date (MM/DD/YYYY) _____

To be completed by the applicant's supervisor: (Licensed Physician or Primary Care Provider).

The person named above is applying for certification in the field of Insurance & Coding. In lieu of successful completion of an eligible Insurance & Coding program, the applicant is qualifying through work experience (NCCT Route 2 - Qualification by Experience). As such, the applicant must have documentation reflecting a minimum of one (1) year full-time work experience, within the past five (5) years, including performance in each of the critical skills for Insurance & Coding Specialists. Each employer may only verify work experience performed at their own facility.

Verification Statement: Minimum Critical Skill Competency Requirements

By signing this form, I am verifying the applicant named above is competent (dependable, consistent, and successful) in performing each of the critical skill areas as identified below. Please verify competency by providing your initials next to each skill that you are attesting to, within the Insurance & Coding scope of practice/employment, according to individual state laws. Your signature and legible information are required for valid completion of this form.

Critical Skill Performance Competency	***Initials***
Medical Insurance	
Medical Billing (EMR/EHR)	
Collections	
Claims Processing	
Coding (CPT, ICD-10, HCPCS)	
Law and Ethics	
Additional comments *(optional):*	

The applicant's employment dates from _____ / _____ through _____ / _____ .
month *year* *month* *year*

Today's Date: MM/DD/YYYY _____

Supervisor/Verifier Contact Information:

Supervisor/Verifier Signature _____

Supervisor/Verifier Printed Name _____

Company Name _____

Supervisor's Title _____

Address _____ City, State, Zip _____

Phone _____ Email _____