Insurance & Coding Certification
Qualification by Experience Documentation

NCCT
NATIONAL CENTER FOR COMPETENCY TESTING

Phone 800.875.4404
Fax 913.498.1243
www.ncctinc.com

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

Name of applicant _____

Today's Date (MM/DD/YYYY) _____ NCCT User ID # _____

The remainder of this form is to be completed by the _applicant's direct patient care supervisor_ which may include, but not limited to, a Licensed Physician or Primary Care Provider.

The person named above is applying for certification in the field of Insurance & Coding Specialist. In lieu of successful completion of an eligible Insurance & Coding program, the applicant is qualifying through work 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. In order to determine the eligibility of the applicant, we require verifiable documentation of knowledge, education, training, and proficiency in the critical skill areas as identified below. Please complete the documentation below. Only one (1) direct patient care supervisor per page. Each employer may only verify work experience performed at their own facility.

Note: This page may be photocopied if more than one employer or direct patient supervisor will be verifying cases and providing documentation.

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):*	

If this applicant was employed by your organization in a full time capacity in the last 5 years and that employment includes successful performance in the critical skills, please provide the dates of full time employment (defined by NCCT as 40 hours per week).

The applicant successfully performed the skills attested to through: ____ employment experience ____ educational training.

from _____ / _____ through _____ / _____ or ____ Present.
    month   *year*   *month*   *year*

Note: If selecting educational training and your school's program does not have an approved NCCT Program Eligibility Application, your Critical Skill Performance Competency must be earned through employment or volunteering in a clinical setting and signed by your supervisor.

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.

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 _____

Note: School may not verify skills or employment. Employment and skills are to be verified in a clinical setting by employer.