

Instructions Page for Verifiers

Thank you for assisting this applicant in completing the form required prior to approval for the NCICS certification exam. This form provides essential verification of crucial skill competency in the Insurance & Coding Specialist field, and verification of employment dates through the Experience Pathway.

Instructions for Completing This Form:

1. Documentation Requirements

- Complete all fields clearly and legibly
- Facility-specific verification only (no cross-facility attestations)
- One (1) verifier per form
- Simulated training demonstrations do not qualify for competency verification.
- Forms that appear altered or falsified will not be accepted and may result in denial of eligibility.

2. Who Should Complete Which Parts

- **Applicant:** Section A (Applicant Information)
- **Verifier:** Sections C-E
 - Must provide a work email address (facility domain) and a direct business phone number.
**Personal email accounts or personal phone numbers will not be accepted*
 - The verifier must be currently employed at the facility where the applicant's employment took place and must have had direct supervisory responsibility for the applicant's billing and coding performance.

3. Experience Pathway Guidance

- **Experience requirement:** One (1) year (2,080 hours) of full-time work in medical billing and coding within the past five (5) years, with demonstrated competency in all required billing, coding, and insurance skills.
**Experience must be obtained within the United States or its territories*
- **Full-time definition:** 40 hours/week (as defined by NCCT)
- **Who verifies:** Direct supervisor in a billing/coding/insurance capacity (e.g., Billing Supervisor, Coding Supervisor, Revenue Cycle Manager, HIM Supervisor, or Medical Office Manager). *Human Resources staff may verify employment dates only but are not permitted to verify competency in critical skills*
- **What is verified:**
 1. Critical skill competency (reflecting consistent, safe performance)
 2. Dates of employment (Start Date/Through or "Present")
 3. Applicant's job title

4. Additional Notes

- Each Employer may only verify work performed at their own facility.
- Illegible/incomplete forms may delay processing.
- NCCT staff may contact the verifier directly to confirm employment or training verification.
- Approval to test is subject to employment verification



Insurance and Coding Certification Qualification by Experience Documentation 2025 - TE-0210CSQE

Section A: To Be Completed by the Applicant

Please enter your full legal name as it appears on a government-issued ID (e.g., driver's license, passport).

Legal Name of Applicant _____ NCCT User ID # _____

Section B: To Be Completed by Verifier

Important: Before completing this section, **please read the Instruction Page (Page 1)**. Verifier must be the applicant's direct supervisor in a billing, coding, insurance, or revenue cycle capacity. *Each employer may only verify work performed at their facility.*

Section C: Critical Skill Performance Competency

Verifier must only initial skills they have directly supervised and confirmed as being performed accurately, consistently, and in compliance with professional billing and coding standards.

Critical Skill Performance Competency	Initials
Medical Insurance	
Medical Billing (EMR/EHR)	
Collections	
Claims Processing	
Coding (CPT, ICD-10, HCPCS)	
Law & Ethics	

Additional comments (optional): _____

Section D: Verification of Employment and Skills

I am verifying Critical Skills Experience *Experience must be obtained within the United States or its territories.

- Employment: Full-time Part-time
- Applicant's job title: _____
- Applicant's dates of employment at my facility
Start Date: ___/___/___ End Date: ___/___/___ Present

Section E: Verification Statement

By signing this form, I attest that the applicant named above has consistently and accurately demonstrated the required critical billing and coding skills, including insurance, claims, collections, and compliance with law and ethics, under my direct supervision. I further attest that the information provided is complete, true, and correct to the best of my knowledge.

I acknowledge that falsifying, omitting, or misrepresenting information on this form may result in denial of the applicant's eligibility, cancellation of examination results, or revocation of certification. I understand that my role as verifier requires that I am currently employed at the facility listed below and had direct supervisory responsibility over the applicant during the period verified. I also understand and agree that NCCT staff may contact me directly to verify the accuracy of this attestation.

Today's Date: MM/DD/YYYY _____

Supervisor/Verifier Signature _____

Supervisor/Verifier Printed Name _____

Supervisor/Verifier Job Title _____

Institution/Company Name _____

Institution/Company Address _____ City, State _____ Zip _____

Business Phone _____ Business Email _____

**Personal email accounts or personal phone numbers will not be accepted*