

Alleviate Administrative Burdens With the Power of End-to-End Revenue Cycle Management

Revenue Cycle Management Solutions

Speed up revenue. Gain valuable confidence.

Simplify and automate claims processing, reduce the risk of claims denials, and ensure end-to-end visibility with innovative solutions.

Identify correct coverage the first time



Increase data accuracy

Minimize the risk of claims denials due to missing information by improving accuracy through automation in eligibility processes.



Improve satisfaction

Streamline verification processes and increase satisfaction by allowing patients and residents to receive timely information regarding their coverage status.



Reduce costs

Drive cost efficiencies and strengthen payer relationships with cleaner transactions.



Speed access to care

Further the care journey experience with smoother eligibility verification processes to speed up patient and resident access to care.

Speed up verification to protect revenue



Prevent denials early

Stop revenue loss before it starts. Quickly confirm coverage, reduce resubmissions and get paid faster all from one place with zero guesswork.



Verify patient details

Improve accuracy and reduce rework by validating demographic data across trusted sources. Prevent delays, detect issues early and keep records clean across systems.



Find missing coverage

Reveal overlooked insurance and capture lost revenue with fast automated checks across payers. Surface active coverage even when networks are hard to reach.



Find MBIs fast

Quickly locate Medicare Beneficiary Identifiers (MBIs) and streamline eligibility checks to ensure accurate billing, reduce delays, and keep patient records up to date.

Accelerate revenue with one system to manage claims for all payers



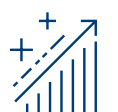
Maximize staff efficiencies

Boost productivity with instant, clear claims information displayed on intuitively designed dashboards. Customize staff workflow assignments based on the type of claim and action needed.



Correct errors before claims go out the door

Utilize an advanced rules engine that immediately scrubs claims against the most up-to-date CMS and commercial payer rules.



Enhance audits and appeals

Increase claims revenue with automated workflows for faster, more successful audits and appeals.



Prevent write-offs

Leverage automated secondary claims submissions to prevent timely filing write-offs.

Gain end-to-end visibility into the health of your revenue cycle



Access real-time insights

Make better informed decisions with actionable dashboards that deliver quick, comprehensive views of your data.



Automate repetitive tasks

Increase visibility to repetitive tasks that can be automated to save staff time and boost productivity.



Strengthen denial prevention

Predict and prevent denials with insights into primary denial-causing categories. Identify opportunities to improve eligibility, coding, and custom edit workflows.



Improve payer relations

Facilitate better payer negotiations with data on payer-specific denials, reimbursements, and turnaround times.

Advantages for your organization

1

Trusted: Over 20 years of industry partnerships

2

Chosen: Inovalon applications used by 50,000 active, licensed customers¹

3

Experienced: Over 1.6 billion claims and remits processed annually²

4

Established: Largest and longest-standing NSV, with connections to Medicare, Medicaid, and 2,300 commercial payers³

5

Proven: 98% or better first-pass payer acceptance⁴

Discover your pathway to improved financial performance TODAY!

Schedule Demo

1. Internal reporting, Inovalon, July 2025

2. Internal reporting, Inovalon, January 2026

3. Internal reporting, Inovalon, August 2025

4. Internal reporting, Inovalon, Claims Management Pro, January 2026