Remitwright
MEDICAL BILLING

Sample report. Illustrative figures, not client data.

WEEKLY BILLING REPORT

Sample Family Practice, 3 providers

WEEK	Sample week, Monday to Friday
PREPARED BY	Your biller
REVIEWED BY	Your account lead

Charges entered	Claims submitted	Payments posted	Denials worked
400	300	$50,000	15 of 15
$70,000 in charges	290 accepted by payer	Matched to deposits	Same week

01 Collections

Payer payments	$45,000
Patient payments	$5,000
Total posted	$50,000
Bank deposits	$50,000
Difference	$0
Net collection rate, trailing	96%

02 Claims submitted

Claims submitted	300
Accepted by payer	290
Rejected	10
Corrected and resent	10
Charge lag, average	2 days
Clean claim rate	95%

03 A/R by age bucket



0-30 days	$220,000	58%
31-60 days	$85,000	22%
61-90 days	$40,000	11%
91-120 days	$20,000	5%
120+ days	$15,000	4%
Total open A/R	$380,000	100%

Days in A/R **38** (last week 40) Over 90 days **9%**

04 Denials by reason

15 received, 15 worked this week. Denial rate 5%.

CODE	REASON, IN PLAIN WORDS	CLAIMS	NEXT ACTION	OWNER
CO-16	Missing information on the claim	6	Corrected and resubmitted	Biller
CO-197	No prior authorization on file	4	Retro-auth requested, peer-to-peer if refused	Biller, with the provider's note
PR-27	Coverage had ended by the date of service	3	Eligibility rechecked, patient contacted	Front desk
CO-18	Duplicate of a claim the payer already has	2	Matched to the original, closed with a reason	Biller
	Total	15	15 worked, 0 without a next action	

05 Needs the practice's attention

- **Sign notes** — PROVIDERS
  6 visits wait on a signature before charges can go in.
- **Answer a coding query** — PROVIDER
  2 visits where the note does not support the code chosen.
- **Collect current coverage** — FRONT DESK
  3 patients whose coverage ended. Ask for current insurance.
- **Decide on 2 balances** — PRACTICE MANAGER
  $200 after a refused appeal. Write off or bill the patient?

06 Notes: what's stuck and why

- **Commercial payer A.** 6 claims pending medical records. Records sent Tuesday, follow-up booked for day 10.
- **Medicaid managed care plan.** 2 visits retro-termed. Secondary coverage found on one, patient statement on the other.
- **Commercial payer B.** 4 claims denied for authorization. Retro-auth filed, peer-to-peer requested if refused.
- **Between reports.** Payer A sent no remittances on Wednesday. A short note went to the practice with what was being done.

EACH LINE, DEFINED

How to read this report

A weekly billing report is useful when every number on it is defined, tied to your own systems, and followed by what your biller is doing about it. These are the definitions behind each line on page 1, so two people reading it get the same answer.

METRIC	HOW IT IS CALCULATED	WHAT IT TELLS YOU
Charges entered	Count and dollar value of charges entered in the week, by date of entry.	Shows whether every visit became a claim. Compared with the schedule, it exposes unbilled visits.
Claims submitted and accepted	Claims released to the clearinghouse, and the share acknowledged as accepted by the payer.	A claim that is not accepted does not exist at the payer. The gap between the two numbers is the rejection work.
Payments posted	Dollar value of payer and patient payments posted in the week, reconciled to deposits.	Cash, not promises. Tied to the bank so the number means what it says.
Denials received and worked	Denials appearing on remittances in the week, and how many were corrected, appealed or closed with a reason.	The second number should match the first. If it does not, the report says why.
A/R by bucket	Open balances grouped by age from date of service: 0-30, 31-60, 61-90, 91-120 and 120+ days.	The shape matters more than the total. Money moving right is money getting harder to collect.
Days in A/R	Total open A/R divided by average daily charges over the trailing 90 days.	How many days of billing are sitting unpaid. The trend tells you whether the cycle is speeding up or slowing down.
Clean claim rate	Claims accepted and adjudicated on first submission without rejection, pend or correctable denial, divided by claims submitted.	The clearest single measure of front-end quality: eligibility, coding, charge entry and scrubbing all show up here.
Denial rate	Claims with at least one denied line divided by claims adjudicated in the period.	Tracked by payer and reason, it tells you where the prevention work should go.
Net collection rate	Payments received divided by charges less contractual adjustments, over a trailing period long enough for claims to resolve.	What share of the money you were entitled to actually arrived. The number that write-offs and underpayments hide in.
Charge lag	Average days from date of service to charge entry, by provider.	Long lag means late claims and filing-limit risk, and it usually points at unsigned notes.
A/R over 90 days	Share of open A/R older than 90 days from date of service.	The backlog measure. If it grows while the total holds steady, old claims are being abandoned.

The metric glossary uses these definitions unless a change is agreed in writing, and the change is dated.

The monthly report

Once a month the same numbers come with the trend over the last twelve months, broken down by payer and by provider, with write-offs by reason and a written commentary on what changed and why. It ends with the prevention list: the front-end fixes raised from the month's denials and rejections, with an owner and a status.

Between reports

Some things should not wait for the next report. A payer that goes quiet, a batch that did not release, a denial reason that spikes: your biller sends a short note with what is being done.

About the figures

Every number in this report is made up to show the format. Sample Family Practice is not a real practice, and no client data was used.

Every line explained

remitwright.com/how-it-works/reporting/

Questions about a report like this: sales@remitwright.com