Provider Prime

CLINIC GROWTH VAULT 2.0
FREE RESOURCE · 2026

BUYER'S GUIDE | BUYING OUTSOURCING

How to Choose a Billing Partner

The buyer's guide we'd want if we were on your side of the table: the real cost of in-house billing, how vendors price, 40 questions to ask, and the red flags that should end the call.

INSIDE

- Do you need a partner? A 10-sign self-check
- Delivery models and pricing models compared
- 18 red flags
- True cost of in-house billing (worksheet)
- The 40 questions — and what good answers sound like
- Contract checklist, scoring matrix, switching plan

How to Choose a Billing Partner

Provider Prime

How to use this

1. Do the self-check and cost worksheet first. If in-house is working, keep it — this guide will tell you that too.
2. Shortlist 2–4 vendors. Send them the 40 questions in writing before any demo.
3. Score answers on the matrix in Section 08. Written answers beat sales calls.
4. Call two references per finalist using the script. Then read the contract against the checklist — before you sign, not after.

WHO IT'S FOR
Clinic owners, practice managers, physician groups, billing-company owners

TIME TO PUT IN PLACE
Read in 30 minutes; decision in 2–4 weeks

PAIRS WITH
In-House vs Outsourced Cost Model (XLSX) · Secure Remote Access Checklist

WHAT'S INSIDE

01	Do you even need a partner?	p. 3	02	The true cost of billing in-house	p. 3
03	Delivery models	p. 4	04	Pricing models	p. 5
05	The 40 questions	p. 6	06	18 red flags	p. 8
07	Contract checklist	p. 8	08	Scoring matrix	p. 9
09	Reference-call script	p. 10	10	Prepare before you talk to anyone	p. 10
11	Switching billers without losing cash	p. 11	12	Questions a good vendor will ask you	p. 12
13	One-page decision memo	p. 12			

Educational resource. Not legal or coding advice; verify against current payer policies. Examples use invented data — no PHI. Benchmarks are commonly cited industry ranges; your payer mix and specialty will move them. Don't email PHI to anyone, including us.

SECTION 01

Do you even need a partner?

Outsourcing isn't automatically better. A strong in-house biller with time, tools and backup is a great setup. The question is whether you have that — consistently, including when they're on vacation, sick, or leave.

Ten-sign self-check

✓	Sign	Why it matters
☐	Claims don't go out every business day	Charge lag delays every dollar
☐	Nobody can tell you your denial rate or days in A/R this week	You can't manage what isn't measured
☐	Clearinghouse rejections sit for more than 2 days	Timely filing clock keeps running
☐	A/R over 90 days is more than 15–20% of total	Collection odds fall below 50% after 90 days (HFMA-cited)
☐	Billing stops when one person is out	Single point of failure
☐	The owner or a provider does billing work at night	The most expensive biller in the building
☐	Denials are resubmitted, not root-caused	Same denials every month
☐	You've replaced a biller in the last 18 months	Ramp-up costs months of slower cash
☐	Patient statements go out irregularly	Patient A/R ages fastest
☐	You're adding providers or a location in the next 6 months	Volume grows faster than hiring

0–2 checked: fix the gaps in-house; the rest of this Vault will help. **3–5:** a partner (or a part-time backup) likely pays for itself — run the cost worksheet. **6+:** this isn't a billing problem. It's a capacity problem.

SECTION 02

The true cost of billing in-house

Salary is the number everyone compares. It's usually about two-thirds of the real cost.

Educational resource. Not legal or coding advice; verify against current payer policies.

Monthly cost of one full-time biller	Typical US	Yours
Salary	$3,400	
Benefits, payroll taxes, PTO coverage	$700	
Software seats, clearinghouse, eligibility tools	$350	
Real monthly cost	**$4,450+**	
Recruiting (ads, interviews, owner time) — amortized	varies	
Ramp: ~3 months to full productivity	slower cash	
Turnover: billers commonly stay 12–18 months	repeat ramp	
Manager time supervising billing (hours × your rate)	varies	

Typical figures are the planning numbers Provider Prime uses; local markets differ. The In-House vs Outsourced Cost Model (XLSX) runs this with your collections and shows the break-even.

THE HIDDEN LINE: REVENUE YOU'RE NOT COLLECTING

Cost comparisons often ignore the bigger number. If a partner moves net collection rate from 91% to 96% on $90,000/month of collectible charges, that's **$4,500 a month** — before you count any fee difference. (Illustrative.) Ask every vendor how they'd measure that improvement, starting from your baseline.

SECTION 03

Delivery models

Model	Good when	Watch for	Ask
In-house team	Enough volume for 2+ billers; strong manager; low turnover	Single point of failure; cost; ramp after turnover	Who covers vacations? Who audits?
US billing company	You want a local, fully managed vendor	Your account may be one of hundreds; junior staff on small clients	Who exactly works my claims?
Offshore / nearshore team	You want dedicated people at lower cost, working in your systems	Security controls; payer or state restrictions on offshore PHI access; time zones	Where is PHI accessed from? What controls?
Hybrid	Keep front desk / coding in-house; outsource follow-up, denials, posting	Hand-offs; unclear ownership	Who owns each KPI?
RCM software + your staff	You have staff; you need better tools	Tools don't work denials by themselves	What does the software do vs what do we do?

Educational resource. Not legal or coding advice; verify against current payer policies.

ON OFFSHORE TEAMS — HONESTLY

Provider Prime's team is based in Egypt, so we get asked this a lot. Offshore access to PHI is allowed under HIPAA with a BAA and proper safeguards, but **some payer contracts, Medicare Advantage plans' subcontractor rules, and certain state Medicaid programs restrict or require disclosure of offshore access.** Ask any offshore vendor (including us) how they handle that, and check your own payer contracts.

SECTION 04

Pricing models

Model	How it works	Pros	Cons / gotchas
% of collections	Fee = a percentage of money collected. Commonly quoted in mid-single to low-double digits.	Vendor only earns when you do; scales with volume	Define "collections": net insurance only? patient payments? Old A/R? Minimum monthly fees?
Per claim	Flat fee per claim submitted	Predictable per visit	Rewards volume, not collection. Who pays for rework, appeals, secondary claims?
Flat monthly	Fixed fee for defined scope	Budget certainty	Scope creep fees; incentive to do the minimum
Dedicated FTE / hourly	You pay for people's time	Control; transparent capacity	You manage productivity; results aren't guaranteed

Compare on your numbers — illustrative

Illustrative clinic: $100k/month net collections, 1,100 claims	Vendor A	Vendor B	Vendor C
Quoted model	6% of collections	$5.50 / claim	4% of net collections
Base fee	$6,000	$6,050	$4,000
Setup / onboarding	$1,500 once	$0	$0
Credentialing, per payer app	$150	included	quoted separately
Patient statements	$0.90 each	included	included
Minimum monthly fee	$2,500	none	none
Term / exit	24 months	12 months	month-to-month, 30 days

Vendors A and B are invented for illustration. Vendor C reflects Provider Prime's published terms (4% of net collections, month-to-month, 30-day notice, after a 30-day $0 pilot) — verify current terms with any vendor in writing.

SECTION 05

The 40 questions

Send these in writing. Vague answers in writing are more revealing than confident answers on a call. Each has a short note on what a good answer sounds like.

A · Fit and experience (1–6)

#	Ask	A good answer sounds like…
1	Which specialties and practice sizes do you work with most?	Specific specialties close to yours; honest about where they're less experienced.
2	Which EHR/PM systems and clearinghouses do your people work in daily?	Yours is on the list, or they explain exactly how they'd learn it.
3	Which of my payers do you work with regularly?	Names your top payers; knows their portals and quirks.
4	Do I need to change software?	No — they work inside your systems. (If yes, ask who owns the data.)
5	What does a typical client's first 90 days look like?	A dated plan: access, baseline, backlog, first report.
6	Can I start with a pilot or a limited scope?	Yes, with defined measures of success.

B · Scope and workflow (7–14)

#	Ask	A good answer sounds like…
7	Exactly which tasks are included: charge entry, coding, submission, rejections, posting, denials, appeals, A/R, patient statements, patient calls, credentialing, auths?	A written RACI: what they do, what you do, what's extra.
8	How often do claims go out?	Every business day.
9	How fast are rejections fixed?	24–48 hours, measured.
10	How fast are denials worked, and what does "worked" mean?	A number (e.g. within 2 business days) and a definition (actioned, not viewed).
11	Do you appeal? At what dollar threshold do you stop?	Yes, with a written threshold you agree on.
12	Do you work old A/R I already have, and is it priced differently?	Clear answer and clear price. Old A/R often is.
13	How do you find and fix root causes, not just individual denials?	Describes a monthly root-cause review and specific examples of upstream fixes.
14	What do you need from my staff each day / week?	A short, specific list (notes signed, documents scanned, questions answered within X).

Educational resource. Not legal or coding advice; verify against current payer policies.

C · Performance and reporting (15–21)

#	Ask	A good answer sounds like…
15	Which KPIs do you report, how often, and can I see a sample report?	First-pass rate, denial rate & turnaround, days in A/R with buckets, net collection rate — weekly. Sample shown.
16	How do you calculate net collection rate and denial rate?	Exact formulas; adjustments excluded properly.
17	Which SLAs are in the contract, and what happens if you miss them?	Written SLAs with a remedy, not just "goals."
18	Will I have direct access to my PM data and reports at all times?	Yes — it's your system and your data.
19	How will we measure whether you improved things vs my baseline?	Baseline captured in week 1; same definitions after.
20	Who is my day-to-day contact, and how fast do they respond?	A named person; response time in hours.
21	How do you QA your own team's work?	Sampling, checklists, error tracking — with numbers.

D · Security and compliance (22–29)

#	Ask	A good answer sounds like…
22	Will you sign a BAA before any access?	Yes, always. No access before the BAA.
23	Does each person get a named login with MFA, or are accounts shared?	Named, least-privilege accounts with MFA. Never shared.
24	Is PHI ever stored on your staff's local devices?	No — work happens inside your systems or a controlled virtual desktop.
25	Where are your staff located, and will PHI be accessed from outside the US?	A direct answer, plus how they address payer/state offshore restrictions.
26	When was your last HIPAA risk analysis, and do staff get annual training?	Recent date; documented training.
27	How fast do you notify us of a security incident?	A defined window shorter than the HIPAA maximum, in the BAA.
28	How do you remove access when someone leaves?	Same day, with a confirmation to you.
29	Do you carry cyber liability and E&O insurance?	Yes, with limits stated.

E · People and continuity (30–34)

#	Ask	A good answer sounds like…
30	Who exactly will work my account, and what's their experience?	Names and roles; dedicated or pooled — stated honestly.
31	What happens when my billers are out or leave?	Documented backup coverage; SOPs specific to your account.
32	How do you train staff on my payers and specialty?	A process, not "they're experienced."
33	Are any tasks subcontracted to another company?	No, or named and under a BAA.
34	Who handles coding questions with my providers?	Certified coder access; a feedback loop to providers.

Educational resource. Not legal or coding advice; verify against current payer policies.

F · Pricing and contract (35–40)

#	Ask	A good answer sounds like…
35	Exactly what is the fee calculated on? Show me on last month's numbers.	A worked example on your data.
36	What costs extra? Setup, credentialing, statements, appeals, old A/R, reports, software?	A complete fee list, in writing.
37	What's the term, and how do I leave?	Short notice (e.g. 30 days), no penalty.
38	After termination, who works claims still in A/R, and at what fee?	A defined run-out or clean hand-back with a status file.
39	Who owns the data, notes and work files? How do I get them?	You do, always; export format and timeline stated.
40	Will you put your SLAs, KPIs and security commitments into the contract?	Yes.

SECTION 06

18 red flags

One red flag isn't always fatal. Three should end the conversation.

- ☐ **Guaranteed results** ("we'll increase revenue 30%") before seeing your data
- ☐ **Asks for PHI before a BAA** — or by email
- ☐ **Shared logins** or "just give us your password"
- ☐ **Can't name who'll work your account**
- ☐ **No sample report**, or KPIs without formulas
- ☐ **Long lock-in** (24–36 months) with termination fees
- ☐ **Fee on gross charges** instead of collections
- ☐ **Fee on money they didn't touch** (patient payments at the desk, old A/R you collected)
- ☐ **Requires you to switch PM/EHR** to their system and keeps the data
- ☐ **Vague on location** of staff or subcontractors
- ☐ **No run-out terms** — what happens to A/R when you leave is "to be discussed"
- ☐ **"We appeal everything"** with no root-cause process
- ☐ **Upcoding talk**: "we'll code higher to boost revenue"
- ☐ **Can't explain denial rate vs adjustments**
- ☐ **No references** in your specialty or size
- ☐ **Pressure to sign this week** for a discount
- ☐ **Fake-sounding testimonials** with no names or verifiable details
- ☐ **Won't put SLAs in the contract**

SECTION 07

Contract checklist

- ☐ **Scope / RACI** attached as an exhibit — every task, who does it
- ☐ **Fee definition** with a worked example; complete list of extra fees
- ☐ **Term and termination**: notice period, no penalty for convenience termination

Educational resource. Not legal or coding advice; verify against current payer policies.

- [ ] **Run-out / transition**: who works open claims after termination, fee, and duration; status file at exit
- [ ] **Data ownership and return**: format, timeline, deletion certification
- [ ] **SLAs and KPIs** with definitions and reporting cadence; remedy for misses
- [ ] **BAA** signed, with breach-notification window and subcontractor flow-down
- [ ] **Security exhibit**: named accounts, MFA, least privilege, no local PHI, offboarding
- [ ] **Offshore disclosure** where applicable; compliance with payer/state restrictions
- [ ] **Insurance**: E&O and cyber, with limits; indemnification both ways
- [ ] **Compliance**: coding accuracy responsibility; no incentive tied to code levels; audit cooperation
- [ ] **Audit rights**: you can review their work and access logs

SECTION 08

Scoring matrix

Criterion	Weight	Vendor 1 (1-5)	Vendor 2 (1-5)	Vendor 3 (1-5)
Fit: specialty, payers, systems	15%			
Scope clarity (RACI)	10%			
Speed SLAs (claims, rejections, denials)	15%			
Reporting & KPI definitions	15%			
Security & compliance	15%			
People & continuity	10%			
Total cost on your numbers	10%			
Contract terms (exit, data, run-out)	10%			
Weighted score = Σ(weight × score)	**100%**			

Educational resource. Not legal or coding advice; verify against current payer policies.

SECTION 09

Reference-call script

REFERENCE CALL	10 MINUTES
YOU	"Thanks for taking the call. How long have you worked with them, and what do they handle for you?"
YOU	"What changed in your numbers after the first 90 days — denial rate, days in A/R, collections? How do you know?"
YOU	"When something went wrong, what happened and how fast did they fix it?"
YOU	"Who do you actually talk to week to week? Has that person changed?"
YOU	"Anything you wish you'd put in the contract?"
YOU	"If you were choosing again, would you pick them? What would make you leave?"

What the first 90 days should look like

When	Expect
Week 0	BAA signed; named accounts with MFA created by your admin; scope and KPIs agreed in writing
Week 1	Live: claims going out daily; baseline KPIs captured; first report by Day 7
Weeks 2–4	Rejection queue at zero; denial backlog triaged by deadline and dollars; weekly report every Friday
Month 2	Top denial root causes identified with fixes proposed to your team
Month 3	Trend vs baseline on all four core KPIs; decision point

SECTION 10

Prepare before you talk to anyone

Vendors quote better — and you compare better — when everyone works from the same facts. Put together a one-page data pack. No PHI: totals and percentages only.

Educational resource. Not legal or coding advice; verify against current payer policies.

Data point	Where to get it	Your number
Providers (by type) and locations	You know this	
Visits / claims per month (last 3 months)	PM claim report	
Gross charges and payments per month	PM financial summary	
Payer mix (% Medicare, MA, Medicaid, commercial, self-pay)	PM payer report	
A/R total and by bucket (0–30 … 120+)	PM aging report	
Denial rate and top 5 denial reasons	PM denial report / ERAs	
EHR / PM / clearinghouse names	You know this	
What you want handed off (and what stays)	Your decision	
Current cost of billing (staff, software, fees)	Payroll + invoices	

Send this pack to every shortlisted vendor with the 40 questions. Ask each one to price your actual numbers, not a sample clinic.

SECTION 11

Switching billers without losing cash

The riskiest 60 days in any billing change are the transition. Most lost revenue comes from claims nobody owned during the hand-off. Plan it like a project.

When	Do	Owner
Before notice	Read your current contract: notice period, run-out terms, data return. Pull a full A/R aging and denial list as a baseline. Confirm you (not the vendor) own the clearinghouse, payer-portal and EFT/ERA enrollments.	Owner / PM
Day 0	Written notice. Agree a cut-over date and who works which claims: e.g. old vendor finishes claims with DOS before cut-over for 60–90 days; new partner takes everything after.	Owner
Days 1–14	New partner gets BAA, named accounts, MFA. Payer portal sub-users created under your admin. ERA/EFT routing checked so payments don't go to the old vendor's account.	PM + new partner
Days 15–30	Overlap: both teams see the same aging. Weekly reconciliation of what each has worked. Status file of every open claim from the outgoing vendor.	Both vendors
Days 31–90	Old vendor's run-out ends. Remaining old A/R moves to new partner with notes. Old vendor's access removed; PHI return/destruction certified.	PM

THREE THINGS THAT GO WRONG MOST

- **ERAs and EFTs still routed to the old vendor's clearinghouse** — payments arrive, nobody posts them.
- **Payer portal accounts owned by the old vendor** — you lose access to claim status overnight.
- **Claims in "pending" with no owner** — they age past timely filing during the overlap.

Educational resource. Not legal or coding advice; verify against current payer policies.

SECTION 12

Questions a good vendor will ask you

How a vendor discovers your practice says a lot about how they'll run it. If a vendor quotes a price without asking most of these, they're pricing a generic clinic — not yours.

- [ ] What are your top denial reasons, and which payers drive them?
- [ ] How old is your A/R, and how much is past 90 days?
- [ ] Who enters charges and codes today? Are notes signed same-day?
- [ ] Which payers need prior auth for what you do most?
- [ ] Are all providers fully credentialed with every payer you see?
- [ ] Who owns your clearinghouse and portal accounts?
- [ ] What does your front desk collect at the visit today?
- [ ] What reports do you look at now, and what do you wish you had?
- [ ] What would make this partnership a failure in your eyes?
- [ ] Who on your team will be our day-to-day contact?

SECTION 13

One-page decision memo

Write this before you sign. It forces the decision into numbers and gives you a baseline to judge the partner against in 90 days.

Decision	Engage `VENDOR` for `SCOPE` starting `DATE`.
Why now	The 2–3 signs from the self-check that apply to us.
Baseline (today)	First-pass `__%` · Denial rate `__%` · Days in A/R `__` · A/R >90 `__%` · NCR `__%`
Targets at 90 days	The same five numbers, with the vendor's committed targets.
Cost today vs proposed	In-house real cost `$__`/mo vs vendor all-in `$__`/mo on our numbers.
Alternatives considered	Vendors scored (weighted score) and why this one won.
Risks & mitigations	Transition, security, offshore rules, staff impact — and what we're doing about each.
Exit plan	Notice period, run-out terms, data return, who owns accounts.
Review date	`DATE` (day 90) — decide continue / adjust / exit.

Educational resource. Not legal or coding advice; verify against current payer policies.

Buyer's card

THE 10 QUESTIONS TO ASK FIRST

1	Do I need to change software? (#4)
2	Exactly which tasks are included — and what's extra? (#7, #36)
3	How fast are claims sent, rejections fixed, denials worked? (#8–10)
4	Show me a sample weekly report with KPI formulas. (#15–16)
5	BAA before access? Named logins with MFA? No local PHI? (#22–24)
6	Where is PHI accessed from? (#25)
7	Who exactly works my account? (#30)
8	What is the fee calculated on — show me on my numbers. (#35)
9	How do I leave, and what happens to open A/R? (#37–38)
10	Will you put SLAs and security in the contract? (#40)

WALK AWAY IF…

- They guarantee results before seeing your data
- They want PHI or passwords before a BAA
- They won't say who works your account or where
- They lock you in for 2+ years with exit fees
- They talk about coding higher to boost revenue

ASK US THE SAME 40

Send the 40 questions to hello@providerprime.com. We'll answer in writing — including the ones about being offshore.

Educational resource. Not legal or coding advice; verify against current payer policies.

DONE READING? TWO OPTIONS.

Run it yourself. Or we run it for you.

Everything in this guide works without us. If your team doesn't have the hours, Provider Prime's billing team does this work every day — inside your EHR, PM and clearinghouse. You change nothing.

01 · SNAPSHOT

Free revenue snapshot: denial patterns, A/R by bucket, and the three fixes worth doing first.

02 · PILOT

30-day risk-free pilot. $0. Claims out every business day, denials reworked within 2 business days.

03 · DECIDE

Keep going at 4% of net collections, month-to-month, 30-day notice. Or keep the plan and walk.

Free revenue snapshot → providerprime.com/get-started

hello@providerprime.com · WhatsApp +20 100 539 8585

- We make money when you collect money.
- BAA before access
- Live in one week

You didn't go to med school to babysit a clearinghouse.

Educational resource. Not legal or coding advice; verify against current payer policies.
Please don't send PHI by email or web form — we'll set up secure access after a BAA is signed.
© 2026 Provider Prime · How to Choose a Billing Partner

Provider Prime