

Our 12th Summit on

PREVENTING & MANAGING DENIALS

Innovative Strategies to Avoid, Reduce and Overturn Denials, Increase Reimbursement and Improve Bottom-Line Performance

July 30-31, 2007 • Hard Rock Hotel • Chicago, IL

Best practices and technological advancements for greater efficiency!

Contract underpayments and denials are costing your hospital millions of dollars per year – and there's absolutely NO reason for it!

Hear the latest, proven strategies that leading healthcare organizations are using to manage and overturn third-party denials to capture lost revenue. At this leading-edge conference, you will learn the exact tools you need to improve cash flow, enhance financial performance and gain profitability. Specifically, you will learn how to:

- **Correct** inaccurate claims and reimbursements
- **Ensure** proper physician documentation of medical necessity
- **Overcome** patient status challenges and requirements for Medicare, Medicaid and commercial payers
- **Utilize** technology to manage denials and underpayments and maximize revenue capture
- **Efficiently** identify denials of all forms, including "silent denials"
- **Integrate** financial and clinical management to identify lost revenue and eliminate undercoding
- **Properly** manage the observation vs. inpatient decision process
- **Leverage** data collection tools and reports to track and trend denials
- **Refute** the most common denials utilized by payers
- **Optimize** the role of the physician advisor to concurrently and retrospectively appeal denials
- **Identify** and **address** both clinical and technical denials
- **Maximize** proper documentation to ensure accurate medical coding and get paid for services rendered
- **Assign** appeals within your current processes to expedite claims follow-up and remediation
- **Eliminate** denials with contracted managed care payers
- **Target** problem DRGs prone to denials and eliminate them
- **Eliminate** missed charges from a pre-billing standpoint to avoid denials
- **Optimize** revenue opportunities with observation codes in the ED (A typical ED loses up to 25% of the revenue it could be collecting – you can fix this overnight!)
- **Create** accountability at all levels

Don't miss these in-depth, solution-driven case-studies from the hospital leaders who have developed innovative & effective denial management programs and have improved their processes to maximize revenue recovery, including:

- Balancing and Integrating Financial and Clinical Management
GREATER LAFAYETTE HEALTH SERVICES
- Clinical Access Management: Influencing Patient Status at the Point of Entry to Minimize Denials
PRINCE WILLIAM HOSPITAL
- Optimizing the Role of the Physician Advisor in Denial Management
BON SECOURS GOOD SAMARITAN HOSPITAL
- Best Practices for ED Denials Management: How to Maximize Revenue Capture and Minimize Denials through Accurate ED & Observation Coding & Billing
STROGER COOK COUNTY HOSPITAL
- Getting What is Due to You: A Legal Perspective on Contesting and Reducing Third-Party Denials
LAW OFFICES OF NEIL GREENE
- Best Practices for Identifying & Addressing Clinical vs. Technical Denials
SHAWNEE MISSION MEDICAL CENTER
- Utilizing Technology to Improve Patient Collections: A New, Comprehensive Approach for Collecting Money After the Insurance Payment or Denial
LEXINGTON CLINIC
- How to Develop and Implement a Team Approach to Denial Management
SHORE HEALTH SYSTEM

PANEL DISCUSSION

Prevention Pays Off: Overcoming Challenges and Obstacles to Accurate Medical Documentation
CAROLINAS HEALTHCARE SYSTEM
TAHOE FOREST HOSPITAL DISTRICT
UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO
STATEN ISLAND UNIVERSITY HOSPITAL
JAMAICA HOSPITAL SYSTEM

Don't Miss these Must-Attend, In-Depth Workshops!

Mastering the Medicare & ERISA Appeal Process:
Maximum Reimbursement through Compliance
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The Denial Diagnosis Tool Kit:
A Claim-by-Claim Action Guide to Integrating Technical, Clinical, Legal and (sometimes) Political Perspectives in Managing Denials
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Dear Colleague:

Every time an ambulance brings someone into your ED, or patients are admitted by their doctors, there's a good chance that your hospital will lose money on their care.

If yours is a typical hospital you will lose:

- Up to 25% of your rightful revenue from the ED
- \$3 million in contract underpayments and denials per year (based on 350 beds)
- 3-5% of net revenue system-wide

And the sad truth is that there's absolutely no reason for these losses! Why? The answer is frighteningly simple – the overwhelming majority of all denials can be prevented and almost all denials that slip through can be recovered – when you know how.

The key to improving cash flow, financial performance and profitability is to develop strategies for preventing, reducing and overturning denials and underpayments. To reach this ultimate goal and improve hospital revenue, leading edge healthcare organizations have developed denial management programs and are continually evaluating and improving their processes to maximize revenue recovery.

World Research Group's **12th Summit on Preventing and Managing Denials**, taking place on **July 30-31, 2007**, in **Chicago** will provide you with the exact tools you need to stop denials from ever appearing, recoup those that sneak through and start seeing improved results immediately.

Turn Denials into Cash!

Hear how real-world practitioners are integrating and improving communication between financial and clinical stakeholders to successfully prevent, reduce and overturn denials. Specifically, you will hear real-time, practical solutions to:

- **Ensure** proper physician documentation of medical necessity
- **Overcome** patient status challenges and requirements for Medicare, Medicaid and commercial payers
- **Utilize** technology to manage denials and underpayments and maximize revenue capture
- **Refute** the most common denials
- **Optimize** the role of the physician advisor to concurrently and retrospectively appeal denials

- **Identify** and **address** clinical vs. technical denials
- **Leverage** data collection tools and reports to track and trend denials
- **Eliminate** denials with contracted managed care payers

Our best-in-class conference faculty will share case study-driven solutions and pinpoint best practices for effectively managing denials and improving reimbursements. You will specifically hear how:

- **Carolinas Healthcare Systems** achieves physician buy-in for preauthorization compliance – an essential key to denials avoidance
- **Prince William Hospital** engages case management immediately at point of entry to get patient status accurate and target problem DRGs most prone to denials
- **Greater Lafayette Health Services** integrates financial and clinical management to identify lost revenue and missing information and eliminate costly undercoding
- **Lexington Clinic** capitalized on a new automated system for collecting money after a claim is denied, and has seen both reimbursements and collections significantly increase
- **Stroger Cook County Hospital** has markedly slashed emergency department denials through accurate ED and observation coding and billing
- **Shore Health System** has capitalized on a team-based denial management program to recoup lost revenue

World Research Group has also organized two in-depth workshops conducted by the industry's thought leaders that will drill down into the solutions you need to prevent, reduce and overturn denials. **Register for both to maximize your on-site learning experience.**

Register by June 8, 2007, to reserve your seat at the conference and take advantage of early bird discounts! Attend with your colleagues and you'll also qualify for a team discount – Register a team of 3 and the 4th person is free!

P.S. The insurance companies and other payers don't want you to know about these strategies that can prevent most denials and recover those that slip through. Attend this one-of-a kind conference to learn how to save your hospital millions. You'll be a revenue hero!

Who Should Attend

Chief Financial Officers

Chief Operating Officers

Vice Presidents

Medical Directors

Directors and Managers of:

- Patient Financial Services
- Patient Access
- Denials Management
- Revenue Cycle
- Managed Care
- Reimbursements/Underpayments
- Business Office
- Appeals
- Case Management
- Utilization Management
- Care Management
- Accounts Receivable
- Patient Accounting/Billing
- Auditing
- Contracting
- Compliance

From:

*Hospitals, Healthcare Systems,
Healthcare Facilities
and Clinics*

**Implementing effective
denial management
processes is a
team process.**

**Register a team of 3
and the 4th goes free!**

DAY ONE MONDAY, JULY 30, 2007

7:30 *Pre-Conference Workshop (See page 5 for complete details)*

9:00 *Conference Registration and Continental Breakfast*

9:30 *Chairperson's Opening Remarks*

9:45 **Balancing & Integrating Financial and Clinical Management: The Key to Denial Management Success in the Acute Care Hospital**

Remember when the Finance Department took care of the money and the Nursing Department took care of the patients and never did the two paths cross? If your organization is still functioning this way today, you have strong silos but a weak revenue cycle! Why? Because revenue is clinical – even

though the finance side may want to believe it is all about the front and back ends and nursing wants to believe that healthcare is not a business.

At Greater Lafayette Health Services in Lafayette, IN the mantra has become: "Our Business is Patient Care" because you cannot have one without the other. Improving cash flow makes finance happy; having the "latest and greatest" equipment and programs for their patients makes clinical happy and the key to making them both happy is denial management success.

This session will examine and identify key players, processes and profit opportunities, including:

- Deal or No Deal: Clinical and finance must deal with each other for your organization's success—getting started

TO REGISTER, PLEASE CALL 800-647

- Weakest Link: No department wants to be the “weakest link” of the revenue chain with the most denials
- Stop the Bleeding: Categorize denials, who’s responsible, measure, track and manage denials and appeals; create a dashboard that is meaningful to both finance and clinical
- The Shining Star: Develop the organization’s “shining star”: Case Management Department – the liaison between clinical and finance, the one that centers the five “P’s” and understands clinical denial/appeal process
- Survivor: Don’t get voted off the healthcare island; revive and thrive as a team that knows what it takes: communication, collaboration, coordination, commitment, compliance, cost-containment and cash capture



Margie Roberts, RN, BSN, MBA

*Division Director
Case Management, Social Work,
Denial Management, Observation Unit*
GREATER LAFAYETTE HEALTH SERVICES



10:30 *Networking Break and Refreshments*

10:45 Clinical Access Management: Influencing Patient Status at Point of Entry to Minimize Denials

This presentation will focus on how essential it is to get patient status correct from point of entry, and how eliminating the need for excessive rework after admission results in fewer denials. It will examine processes that can be designed to put case management at point of entry with minimal deployment of resources. The presentation will include an examination of problem DRGs that present status challenges while attempting to balance Medicare, Medicaid as well as managed care requirements. The value and use of data from denial reports as well as Medicare PEPPER report will be presented.

By attending this session, you will learn how to:

- Understand financial and clinical impact of getting patient status correct at point of entry
- Determine how to target select DRGs prone to denials for focused reviews
- Make a business case for a process designed to screen encounters upon entry



Kathy Tyrrell, RN, BSN, CPUM, CPHQ
Director of Case Management
PRINCE WILLIAM HOSPITAL



11:30 Best Practices for Managing Emergency Department Denials: How to Maximize Revenue Capture and Minimize Denials through Accurate ED & Observation Coding & Billing

The typical emergency department is losing 10-25% of the revenue that it could be collecting! In a time when payers are penny pinching more and more, hospitals must be able to squeeze the most out of every service in an appropriate fashion. The most efficient and cost-effective organizations need to understand proper coding usage in order to avoid the headaches that accompany denials from different third-party payers.

This presentation will provide you with the solution-driven approach Stroger Cook County Hospital in Chicago, IL has taken to maximize revenue and reduce denials through accurate ED and observation coding and billing, including how to:

- Optimize revenue opportunities with observation codes in the ED
- Implement best practices for proper coding and billing for the appropriate procedures

- Identify the documentation requirements for the common ED E/M and observation codes
- Improve compliance with ED and observation regulations and ensure reimbursement

Trevor Lewis, MD

Director, Emergency Medicine Observation Unit
STROGER COOK COUNTY HOSPITAL



12:15 *Luncheon for Delegates and Speakers*

1:30 Optimizing the Role of the Physician Advisor in Denial Management

The role of the Physician Advisor may be one of the most under-utilized and misunderstood positions in your organization. The Physician Advisor can concurrently and retrospectively appeal denials, evaluate the efficiency of medical services rendered with respect to the revenue cycle continuum and systematically reduce length of stay by overcoming discharge barriers. This session will examine how Bon Secours Good Samaritan Hospital in Suffern, NY is capitalizing on the role of the Physician Advisor in denial management to improve both medical management and bottom-line performance, including:

- How to leverage Physician Advisors to reduce clinical denials and effectively increase reimbursement by improving coding compliance and documentation
- Qualities of an effective physician advisor
- Length of stay reduction techniques to eliminate unpaid days

Marc Chasin, MD, FAAFP, CHCQM, FAHQ

Physician Advisor
Medical Director, Utilization Management
BON SECOURS GOOD SAMARITAN HOSPITAL

2:15 Get What is Due to You! A Legal Perspective on Contesting and Reducing Third-Party Denials

A provider’s failure to identify and contest the wrongful denial of claims will result in revenue shortfalls, an alienated base of patients who have been sent to collection and an emboldened group of payers who are positively reinforced for their harmful actions. Analyzing and responding to denial issues from a logical legal perspective will generate greater reimbursement and reduce recurring denials. This session will provide you with practical information, including how to:

- Work with the patient and their employer to access all practical and legal avenues to obtain payment
- Refute the most common denials utilized by payers, including pre-existing illness, medical necessity and usual and customary reductions
- Eliminate denials with contracted managed care payers through solid, fair and enforceable contract terms

Neil Greene, JD

President
LAW OFFICES OF NEIL GREENE



3:00 *Networking Break and Refreshments*

PANEL DISCUSSION

3:30 Prevention Pays Off: Overcoming Challenges and Obstacles to Accurate Medical Documentation

Medical necessity is one of the top reasons for payment denials for services rendered in the hospital setting.

Since all revenue stems from the proper coding of medical documentation, the accuracy of physician documentation and the efficiency of the medical coding process are critical to your bottom line. Unless facilities take a fresh approach to addressing the inherent causes that contribute to these

denials, this problem will not go away. This panel discussion will provide you with real-world solutions and proven strategies to proactively prevent and reduce denials due to lack of medical necessity, preauthorization or proper medical documentation, including how to:

- Ensure physician documentation of medical necessity
- Manage the observation vs. inpatient decision process
- Track and identify trends in lost revenue
- Eliminate missed charges from a pre-billing standpoint
- Optimize your organizational processes to improve medical reimbursement
- Promote unique physician advisor-case management collaboration to prevent denials and create a win-win situation
- Implement systems that help with the pre-certification process
- Maximize proper documentation to ensure accurate medical coding and get paid for services rendered
- Achieve physician buy-in for preauthorization compliance
- Determine if this is an internal process or physician responsibility

Panelists:

Raul Coronado, MD
Chief Medical Officer
JAMAICA HOSPITAL SYSTEM

Alexander Yu
Chief Financial Officer
TAHOE FOREST HOSPITAL DISTRICT



Aaron Gottesman, MD, FACP
Director of Hospitalist Services and Associate Program
Director, Internal Medicine Residency
STATEN ISLAND UNIVERSITY HOSPITAL



Pamela Coleman, BSN, RN, ACM
Director, UM/DC Planning
UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO

Sunny Sain, RHIA
Charge Master Manager
CAROLINAS HEALTHCARE SYSTEMS

5:00 Day One Concludes

DAY TWO TUESDAY, JULY 31, 2007

7:30 Workshop (See page 5 for complete details)

9:30 Chairman's Recap of Day One

9:45 Utilizing Technology to Improve Patient Collections: A New, Comprehensive Approach for Collecting Money After the Insurance Payment or Denial

Money due from the patient is an ever increasing part of most healthcare organizations' accounts receivable. When a claim is denied, it often becomes receivables that can be collected from the patient. This session will focus on the system utilized by Lexington Clinic, a 190 provider multi-specialty physician group practice, in Lexington, KY, for combating the ever increasing self-pay receivables. These tools are currently utilized by multiple hospitals and physician groups to focus resources on the self-pay accounts that are most likely to be collectible. By attending this session, you will learn how to:

- Better collect personal pay balances resulting from denials, co-pays, co-insurance, deductibles, and uninsured accounts

- Reduce demographic errors and reduce bad debt write-offs
- Analyze and identify the accounts that will provide the greatest opportunity for successful collections
- Prioritize internal resources for the greatest return on investment
- Reduce your cost to collect while decreasing your personal pay accounts receivable



Randy LeMay
Chief Financial Officer

Kim Newland
Director of Patient Financial Services
LEXINGTON CLINIC

10:30 Networking Break and Refreshments

11:00 Best Practices for Identifying & Addressing Clinical vs. Technical Denials

This session will focus on the strategies utilized at Shawnee Mission Medical Center in Overland Park, KS to effectively resolve clinical and technical claim denial issues. By attending this session, you will learn best practices for:

- Distinguishing between clinical and technical denials
- Targeting key performance indicators
- Minimizing the impact of denials on the revenue cycle

William L. Cashner, CHFP
Revenue Cycle Officer
SHAWNEE MISSION MEDICAL CENTER

11:45 How to Develop and Implement a Team Approach to Denial Management

In order to efficiently coordinate utilization review and maximize revenue and reimbursement, hospitals need to overcome two critical obstacles – disjointed communication and fractured relations between different departments. To breach this communication barrier and recoup lost revenue, several departments need to work seamlessly together.

This session will examine the evolution of Shore Health System's Denial Management Program (Easton, MD) into one that is truly a team effort. By attending this session you will learn how they are:

- Defining and addressing denials of all forms, including "silent denials"
- Benefiting from data collection tools and reports that track and trend denials
- Creating and defining the team
- Recognizing the impact of hard and soft denials
- Creating accountability at all levels
- Importance of training and communication



Karen Moore
Manager, Patient Accounts
SHORE HEALTH SYSTEM



12:30 Conclusion of Conference

"Attending this conference was very beneficial. Learning one technique that can help recover thousands of dollars makes attending worthwhile."

– Charleeda Redman, Manager, Case Management
UNIVERSITY OF PITTSBURGH MEDICAL CENTER

"Great opportunity to see how facilities in different states are dealing with similar problems. Great networking opportunity!"

– Neelam Nagle, Reimbursement Manager, Revenue Cycle
BLANCHARD VALLEY HEALTH ASSOCIATION

Registration • 7:00 a.m.

Workshop A • 7:30 a.m. – 9:30 a.m.

The Denial Diagnosis Tool Kit: A Claim-by-Claim Action Guide to Integrating Technical, Clinical, Legal and (sometimes) Political Perspectives in Managing Denials

For hospitals trying to manage denials, one of the most effective strategies is to integrate the technical, clinical, legal and sometimes political aspects of working a claim. By going back to a claim-by-claim analysis, hospitals can dissect each claim, aggregate information and prevent future denials.

This interactive and case study-driven workshop will provide you with real-life scenarios in which a denied or short-paid claim is dissected and analyzed.

By utilizing real-life examples, you will develop a multi-faceted approach to working denials that, when aggregated, can be used to prevent denials as well.

Specifically you will learn:

- How to work through diagnosing the issue to determine if a technical fix is possible
- If and when you may need clinical input to eradicate the problem
- How to determine if legal intervention is needed
- When there may be political factors that need to be considered

ABOUT YOUR WORKSHOP LEADERS:

Connie Perez, RN, MBA, a former client while a Vice President at Phoenix Children's Hospital, joined **ADVANCED REIMBURSEMENT MANAGEMENT** as the *Chief Operating Officer* in May of 2004 and became the *Chief Executive Officer* in July of 2005. Managing all company operations, she has helped to develop a business plan and revitalize the infrastructure. She has also

worked to establish a new corporate identity and build awareness of Advanced Reimbursement Management in the hospital community.

Linda Krater, Chief Clinical Officer, joined the ARM team in April of 2000 after serving 13 years helping to build Arizona's AHCCCS program. Her experience from 1993 to 2000 as the Administrator for the AHCCCS Fee for Service and Utilization Management programs has been invaluable to ARM. During her tenure there, Linda literally helped "write the book" that serves as today's guide to program administration. Linda also worked to create the structured edit tables utilized to manage quality at AHCCCS.

Special, In-Depth Workshop • Tuesday, July 31, 2007

Workshop B • 7:30 a.m. – 9:30 a.m.

Mastering the Medicare & ERISA Appeal Process: Maximum Reimbursement through Compliance

Both ERISA and Medicare claim regulations regulate and govern more than 90% of hospital reimbursement in USA.

With an unprecedented crisis in claim denials and delays, hospitals have been practicing "squeaky wheel appeals" with minimum success, without any ERISA knowledge or training for executives and senior management, and without any trained claim specialists in ERISA claim regulation and new Medicare appeal regulations in reimbursement operation.

This workshop will provide you with the specific tools you need to optimize maximal legally entitled reimbursement through compliance. You will learn best practices for appealing any delayed or denied claims strictly in accordance with ERISA or

Medicare claim regulation.

By attending this workshop you learn how to master Medicare and ERISA 2007 appeal processes and maximize reimbursements, including:

- The law protecting patients against managed care problems for claims with employer-sponsored health plans
- Demystifying the new Medicare appeal regulation for senior executives and management to optimize your bottom-line performance
- How to best use federal ERISA and state laws in utilization review (UR/medical necessity review) and external reviews to get your claim paid in a timely manner and reasonably

• ERISA claims compliance and anti-fraud and abuse prevention

• Train and utilize ERISA and Medicare claim specialists within in your organization

ABOUT YOUR WORKSHOP LEADER:

Dr. Jin Zhou is a national speaker, consultant, author and publisher of healthcare ERISA claim denials and appeals, regulation education and compliance. He pioneered, authored and published the nation's first *ERISA Healthcare Claim Appeal System* in a CD book, and the nation's first website (www.ERISAclaim.com) in ERISA healthcare claim denials, appeals, claim regulation education and compliance.

OFFICIAL PUBLICATIONS

Briefings on **APCS**

CMS' rules create significant challenges when coding and billing for appropriate OPPS reimbursement. It's tough to meet all of the OPPS demands without the proper tools to do the job. HCPro's monthly newsletter *Briefings on APCs* is the tool HIM professionals need to keep up with regulatory changes and understand what those changes mean to their facility. For more information go to www.hcmarketplace.com or call the Customer Service Department at 800-650-6787 and ask for a complimentary sample issue.

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HCPro is pleased to introduce PARC—the Patient Access Resource Center—an online resource loaded with tested strategies, expert advice, and downloadable tools and techniques all designed to help you strengthen your organization's financial integrity. In addition to the online Web site, your membership includes a monthly newsletter, weekly email updates, quarterly benchmarking reports, and a 20% discount on related products from HCPro's Healthcare Marketplace. For more information, visit www.accessresourcecenter.com or call the Customer Service Department at 800/650-6787.

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The National Association of Healthcare Access Management is the only national professional organization dedicated to promoting excellence in patient access services in all areas of the healthcare delivery system including admissions, registration, scheduling, patient finance, guest relations and other related services. NAHAM is a leader in defining and promoting best practices in healthcare access through education and advocacy initiatives. Our Certified Healthcare Access Manager (CHAM), and Certified Healthcare Access Associate (CHAA) examinations mark the professional excellence of those working in patient access. <http://www.naham.org>

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results immediately!

Registration Information:

	Healthcare Facilities		Standard Rate	
	Early Bird Rate Before June 8, 2007	Regular Rate After June 8, 2007	Early Bird Rate Before June 8, 2007	Regular Rate After June 8, 2007
Conference ONLY	\$1295	\$1595	\$1595	\$1895
Conference and 1 Workshop	\$1595	\$1895	\$1895	\$2195
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Fee includes continental breakfast, lunch, refreshments, and conference documentation CD-ROM. Please make checks payable to WRG Research, Inc.

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Registration Card

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Yes! Please register me for the 12TH SUMMIT ON PREVENTING & MANAGING DENIALS.

Also register me for: Workshop A Workshop B

I would like to take advantage of the early-bird discount by registering before June 8, 2007.

I cannot attend. Please send me a Conference Documentation CD-ROM. Please send me future information via e-mail

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