

# Twelve payer portals. Zero logins.

How Valley Diabetes & Obesity automated its most fragile daily workflow — and stopped discovering coverage problems weeks later, on the Explanation of Benefits.

PRACTICE	LOCATION	TYPE	SIZE	AGENT LIVE	MODEL
Valley Diabetes & Obesity	Modesto, CA	Independent specialty	1-5 physicians	October 2025	Human-in-the-loop

## THE CHALLENGE

Two to three days before a patient arrives, someone on the front desk runs the ritual: open a portal, enter credentials, wait for the two-factor code, click through three screens, copy the result into the chart, close the tab — then repeat across **twelve portals** spanning Medicare, Medicaid, commercial plans, and IPA networks.

The EHR's built-in check doesn't close the gap. Staff aren't confirming "active or inactive." They're pulling the current copay, deductible status, and out-of-pocket maximum, confirming in- or out-of-network status for that exact plan, and verifying the patient is actually assigned to the practice's PCP — because if they're not, the claim won't pay no matter what coverage says.

### WHAT A REAL VERIFICATION REQUIRES — EVERY PATIENT, EVERY VISIT

Copay

Deductible met

Out-of-pocket max

In / out-of-network

PCP assignment

Medicare Part C switches

All of it depends on one person knowing which portal needs which workaround. When they call in sick — or give two weeks' notice — that institutional knowledge walks out the door, and Thursday's schedule starts failing before anyone knows why.

*Miss a single switch from Original Medicare to a Part C Advantage plan, and you bill the wrong payer entirely. You find out weeks later — as a denial.*

## WHAT THE AGENT DOES



### Runs ahead of the schedule

Checks every patient on the upcoming schedule automatically, 2-3 days out, across every payer type — no logins, no two-factor codes.



### Confirms what gets you paid

Verifies in / out-of-network status and PCP assignment, and surfaces Medicare Advantage switches before they become denials.



### Pulls the financial detail

Extracts real-time copay, deductible status, and out-of-pocket maximum so the front desk can set expectations before the visit.



### Flags only the exceptions

Coverage gaps, plan changes, and COB issues arrive pre-flagged. The agent handles the volume; your team handles the judgment calls.

THE RESULTS — 12 WEEKS IN PRODUCTION

ANNUAL FINANCIAL IMPACT Projected, per physician / yr

# \$107K–\$129K

Driven by denial prevention, fewer write-offs, recaptured staff capacity, and higher appointment throughput — from a live independent practice, not a pilot.

<h2>95%</h2> <p>automation rate on eligibility checks</p>	<h2>65%</h2> <p>fewer eligibility-related denials</p>	<h2>~10 hrs</h2> <p>recovered per staff member, weekly</p>
---	---	--

<p>BEFORE</p> <h1>12</h1> <p>portal logins / session</p>	<p>→</p>	<p>AFTER</p> <h1>0</h1> <p>logins — checks pre-run</p>	<p>Verification quality went <b>up</b>, not down — checks now run at every touchpoint automatically.</p> <p>Industry cost of a check, manual vs. electronic: <b>\$6.78</b> – <b>\$0.34</b> (2025 CAQH Index).</p>
--	----------	--	---

“*We used to start every morning logging into twelve different payer portals across Medicare, Medicaid, Commercial and IPA. Now the agent has already run the checks before we arrive. We’re catching issues before the patient walks in instead of finding out on the EOB.*”

**VP of Practice Operations**  
Valley Diabetes & Obesity · Modesto, CA

**Why it matters beyond one practice.** The U.S. spends roughly **\$43 billion a year** on eligibility, most of it still manual — and most small practices are still logging into portals one at a time, because the solutions were built for health systems, not for them. That is the gap an eligibility agent closes.

**See what an eligibility agent does for your front desk.**

One agent. One workflow. No IT department, no big-bang rollout.

[Talk to our team →](#)

[agentman.ai](#)