ClaimTek Systems

Below is a list of EOBs proving payments by insurance for the Patient Assessment Service Surveys (P.A.S.)

Anthem

700 BROADWAY
DENVER, CO 80273-0002

000829030200

EXPLANATION OF BENEFITS

002269

ISSUE DATE	PAGE C002532
April 27, 2009	00002 OF 00004

[redacted]

Sequence Number: [redacted]
Provider ID:
NETWORK PROVIDER: Y
FOUNDATION PHYSICIAN: N

NOTE PLEASE: PAYMENT FOR Code 96102 (CES-DM) EXCEEDS THE AMOUNT PAID FOR THE ACTUAL DOCTOR VISIT ITSELF.

Patient N[redacted] ID[redacted]
Claim ID:[redacted] Claim Received Date:[redacted] PARTICIPATING PROVIDER

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
04/16/09	99214	001	231.00	47.37	183.63/02		20.00/01	27.37
04/16/09	96102	001	123.00	52.69	70.31/02			52.69
	TOTAL THIS CLAIM		354.00	100.06	253.94	0.00	20.00	80.06

FOR INFORMATION CALL: 888-817-3717

[redacted]

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
03/23/09	99204	001	358.00	82.25	275.75/02		25.00/01	57.25
	TOTAL THIS CLAIM		358.00	82.25	275.75	0.00	25.00	57.25

FOR INFORMATION CALL: 877-833-5742

[redacted]

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
04/13/09	99214	001	231.00	47.37	183.63/02		25.00/01	22.37
	TOTAL THIS CLAIM		231.00	47.37	183.63	0.00	25.00	22.37

FOR INFORMATION CALL: 877-833-5742

[redacted] P.O. BOX 14079
[redacted]NGTON, KY 40512-4079

EXPLANATION OF BENEFITS

Please Retain for Future Reference

[redacted] *R MD / PIN:* [redacted]
Check No: [redacted]

[redacted]

Date Printed:	07/02/2009
Tax Identification Number:	[redacted]
Check Number:	
Check Amount:	$254.10

Notes:
Update your address, telephone number, email address and/or NPI information by visiting www.aetna.com/provweb/ or www.aetnadental.com and select Update Personal Information.

Patient Name: [redacted]
Claim I[redacted] ID [redacted]
Membe[redacted]
Group [redacted]
Product: Open Choice
Group Number[redacted]
Network[redacted]

Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
06/09/09	11	99204	1.0	358.00	135.96	10.00					10.00	125.96
06/09/09	11	93000	1.0	64.00	27.00							27.00
TOTALS				**422.00**	**162.96**	**10.00**					**10.00**	**152.96**

ISSUED AMT: **$152.96**

For Questions Regarding This Claim P.O. BOX 14079 LEXINGTON, KY 40512-4079
CALL (888) 632-3862 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $10.00
Claim Payment: $152.96

Patient Name: [redacted]
Claim ID[redacted]
Member[redacted]
Group N[redacted]
Product[redacted]
Group Nur[redacted]
Network ID[redacted]
Aetna Li[redacted]

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
06/04/09	11	99214	1.0	231.00	82.01	25.00	NOTE PLEASE, 96102 CODING EXCEEDS AMT PAID FOR OFFICE VISIT ITSELF				25.00	57.01
06/04/09	11	96102	1.0	123.00	44.13							44.13
TOTALS				**354.00**	**126.14**	**25.00**					**25.00**	**101.14**

ISSUED AMT: **$101.14**

For Questions Regarding This Claim P.O. BOX 14079 LEXINGTON, KY 40512-4079
CALL (888) 632-3862 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $25.00
Claim Payment: $101.14

[redacted] ***Total Payment to*** [redacted] ***MD*** ***$254.10***

PVBB9028002

2009032545O3

Anthem
PO Box 795180
San Antonio, TX 78279

Anthem.

[redacted]

Return Service Requested

MIXED AADC 890

3972 2.2232 MB 0.619

[redacted]

207

ENV 3972

Payment Date: 03/19/09

Reference ID: [redacted]

For Customer Service Call
1-866-364-2374
TTY for the hearing impaired
1-800-425-5705

PAYMENT SUMMARY

Group Name: [redacted]

Paid To:

Tax ID/NPI:

Check #:

Check Amount: 125.73

Servicing Provider Name: [redacted]

Payee Name: [redacted]

Patient and Services Information

Account Number: [redacted]

Patient Name: [redacted]

Subscriber #: [redacted]

AICI NV SmartValue Plus

Claim Id: [redacted]

Service Dates	Proc/Rev Code	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Plan Payment	Remark Codes
						Copay	Co Ins	Ded Amt	Non Cvrd		
03/12/09-03/12/09	96102	123.00	52.13	70.87	0.00	20.00	0.00	0.00	0.00	32.13	PDC
03/12/09-03/12/09	99214	231.00	93.60	137.40	0.00	0.00	0.00	0.00	0.00	93.60	PDC
ClaimTotals:		354.00	145.73	208.27	0.00	20.00	0.00	0.00	0.00	125.73	

Current Payment Amount: 125.73
Prior Paid Amount: 0.00
Interest Amount: 0.00
Net Payment Amount: 125.73

Provider total:

	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Plan Payment
					Copay	Co Ins	Ded Amt	Non Cvrd	
1407827850	354.00	145.73	208.27	0.00	20.00	0.00	0.00	0.00	125.73

PAYMENT SUMMARY

Payment Date: 03/19/2009
Check #: [redacted]
Paid To:
Tax ID/NPI:
Reference ID:

Total Charged:	354.00
Total Cons Charged [1]	354.00
Total Denied:	208.27
Total Allowed:	145.73
Non Paid [2]	20.00
Prior Paid:	0.00
Interest:	0.00
Total Paid:	125.73
Automatic Recovery:	0.00
Other Recoveries:	0.00
Net Check Amount:	125.73

1- **Larger of contracted amount and charges**
2- **Includes items such as COB and Patient Responsibility**

Explanation of Claims Handling

PDC The charge has been reduced based on a discount arrangement with the provider of service

Explanation of Payment

Vendor Number	Vendor Name	Date of Processing		Page
[redacted]	[redacted]	03/13/2009	THIS IS NOT A BILL - Retain for your records	1

Line	Procedure Date	Place of Svc	Diag Code	Procedure Code	Billed Amount	Allowed Amount	COB Amount	Non-Covered Amount	Deductible Amount	Coinsurance Amount	Copay Amount	Pre-paid Amount	Discount Amount	Withhold Amount	Paid Amount	Write-off Amount	Remark Codes
Provider Name: [redacted]						Provider #: 9997177											
LOB = Network																	
Member Name: [redacted]					Member #: [redacted]							Claim #: [redacted]		Date Received: 03/10/09		Pay Loc: [redacted]	
1	030509 030509	11	3468	0 94102	125.00	35.96	0.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00	25.96	87.04	100
2	030509 030509	11	311	99214	231.00	62.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	62.95	168.05	100
	Claim Totals:				354.00	98.91	0.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00	88.91	255.09	
	Provider Totals:				354.00	98.91	0.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00	88.91	255.09	
Vendor Totals - Line 1:					354.00		0.00		0.00		10.00		0.00		88.91		
Vendor Totals - Line 2:						98.91		0.00		0.00		0.00		0.00		255.09	

Remark Code Explanation

100 PAID ACCORDING TO THE MEMBER'S BENEFIT PLAN

Contact Information- refer to claim in question and Pay Loc

022 1.800.244.6224 4616 US HIGHWAY 75 SOUTH ; DENISON, TX 75020

eRemittance - PALMETTO GBA

Payee : [redacted]
[redacted]4
[redacted]

[redacted]
[redacted]
[redacted]
[redacted]

Payor : PALMETTO GBA (01302) , (01302) , ()
PO BOX 1416
AUGUSTA GA 309031416

Explanation of Payment

Claims: 1

(1)
Patient Name [redacted]F
Subscriber Name -
Provider Name

Patient ID [redacted]
Payer Claim ID [redacted]
Provider Claim ID [redacted]

Claim Status 19
Claim Amount $396.00
Paid Amount $124.02
Pt Responsibility $29.57

Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : **ANTHEM CENTRAL - FACETS : 30098**

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
03/23/2009 - 03/23/2009	1	HC>93000	$64.00	$17.10	$21.38	CO-45: $42.62 PR-2: $4.28
03/23/2009 - 03/23/2009	1	HC>99215	$312.00	$101.18	$126.47	CO-45: $185.53 PR-2: $25.29
03/23/2009 - 03/23/2009	1	HC>85610>QW	$20.00	$5.74	$5.74	CO-45: $14.26

---

(2)
Patient Name [redacted]
Subscriber Name -
Provider Name

Patient ID [redacted]
Payer Claim ID [redacted]
Provider Claim ID [redacted]

Claim Status 1
Claim Amount $418.00
Paid Amount $25.69
Pt Responsibility -

Claim Status Description : Processed as Primary

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
03/23/2009 - 03/23/2009	1	HC>99214	$231.00	$0.00	$93.60	CO-45: $137.40 PR-1: $93.60
03/23/2009 - 03/23/2009	1	HC>93000	$64.00	$0.00	$21.38	CO-45: $42.62 PR-1: $21.38
03/23/2009 - 03/23/2009	1	HC>96102	$123.00	$25.69	$52.13	CO-45: $70.87 PR-1: $20.02 , PR-2: $6.42

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
1 : Deductible Amount
2 : Coinsurance Amount
45 : Charges exceed your contracted/ legislsted fee arrangement.

eRemittance - PALMETTO GBA

Payee : [redacted]
[redacted]
[redacted]

Payor : PALMETTO GBA (01302) , (01302) , ()
PO BOX 1416
AUGUSTA GA 309031416

Explanation of Payment

Claims: 1

(1)
Patient Name [redacted] F
Subscriber Name -
Provider Name

Patient ID [redacted]
Payer Claim ID [redacted]
Provider Claim ID [redacted]

Claim Status 19
Claim Amount $396.00
Paid Amount $124.02
Pt Responsibility $29.57

Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : **ANTHEM CENTRAL - FACETS : 30098**

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
03/23/2009 - 03/23/2009	1	HC>93000	$64.00	$17.10	$21.38	CO-45: $42.62 PR-2: $4.28
03/23/2009 - 03/23/2009	1	HC>99215	$312.00	$101.18	$126.47	CO-45: $185.53 PR-2: $25.29
03/23/2009 - 03/23/2009	1	HC>85610>QW	$26.00	$5.74	$5.74	CO-45: $14.26

---

(2)
Patient Name [redacted]
Subscriber Name -
Provider Name

Patient ID [redacted]
Payer Claim ID [redacted]
Provider Claim ID [redacted]

Claim Status 1
Claim Amount $418.00
Paid Amount $25.69
Pt Responsibility -

Claim Status Description : Processed as Primary

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
03/23/2009 - 03/23/2009	1	HC>99214	$231.00	$0.00	$93.60	CO-45: $137.40 PR-1: $93.60
03/23/2009 - 03/23/2009	1	HC>93000	$64.00	$0.00	$21.38	CO-45: $42.62 PR-1: $21.38
03/23/2009 - 03/23/2009	1	HC>96102	$123.00	$25.69	$52.13	CO-45: $70.87 PR-1: $20.02 , PR-2: $5.67

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
1 : Deductible Amount
2 : Coinsurance Amount
45 : Charges exceed your contracted/ legislated fee arrangement.

eRemittance - PALMETTO GBA

Payee : [redacted]

Payor : PALMETTO GBA ([redacted]) , ([redacted]) , ()
PO BOX 1416
AUGUSTA GA 309031416

Explanation of Payment

Claims: 1

(1)
Patient Name [redacted]
Subscriber Name -
Provider Name
Patient ID [redacted]
Payer Claim ID [redacted]
Provider Claim ID [redacted]
Claim Status 1
Claim Amount $295.00
Paid Amount $91.98
Pt Responsibility -

Claim Status Description : Processed as Primary

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
03/20/2009 - 03/20/2009	1	HC>99214	$231.00	$74.88	$93.60	CO-45: $137.40 PR-2: $18.72
03/20/2009 - 03/20/2009	1	HC>93000	$64.00	$17.10	$21.38	CO-45: $42.62 PR-2: $4.28

(2)
Patient Name [redacted]
Subscriber Name -
Provider Name
Patient ID [redacted]
Payer Claim ID [redacted]
Provider Claim ID [redacted]
Claim Status 1
Claim Amount $231.00
Paid Amount $74.88
Pt Responsibility -

Claim Status Description : Processed as Primary

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
03/23/2009 - 03/23/2009	1	HC>99214	$231.00	$74.88	$93.60	CO-45: $137.40 PR-2: $18.72

(3)
Patient Name [redacted]
Subscriber Name -
Provider Name
Patient ID [redacted]
Payer Claim ID [redacted]
Provider Claim ID [redacted]
Claim Status 19
Claim Amount $354.00
Paid Amount $116.58
Pt Responsibility $29.15

Claim Status Description : Processed as Primary, Forwarded to Additional Payer(s). Forwarded to : **NEVADA-DHCFP : 70030**

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
03/23/2009 - 03/23/2009	1	HC>99214	$231.00	$74.88	$93.60	CO-45: $137.40 PR-2: $18.72
03/23/2009 - 03/23/2009	1	HC>96102	$123.00	$41.70	$52.13	CO-45: $70.87 PR-2: $10.43

(4)
Patient Name [redacted]
Subscriber Name -
Patient ID [redacted]
Payer Claim ID [redacted]
Claim Status 19
Claim Amount $375.00

[redacted] CARDIOLOGY P C
PROVIDER : [redacted]
CHECK/EFT: [redacted] 04/22/09

[redacted] GEA
-- MEDICARE REMITTANCE NOTICE --
NPI: 1[redacted]

Rend Prov	Serv Date	POS	NOs	Proc	Mods	Billed	Allowed	Deduct	Coins	StatGroup	RC-Amt	Prov Paid
Name: [redacted]										ASG: Y	MOA: MA01 MA18	
[redacted]	2009-03-26	11	1	[redacted]		[redacted]	[redacted]	0.00	[redacted]	CO-45	[redacted]	[redacted]
[redacted]	2009-03-26	11	0	[redacted]		0.00	[redacted]	0.00	0.00			0.00
	Sub NOs:	1		REM:N365								
[redacted]	2009-03-26	11	1	96102		75.00	52.13	0.00	10.43	CO-45	22.87	41.70
PT RESP	22.86		CLAIM TOTALS			[redacted]						
ADJ TO TOTALS:	PREV PD				INTEREST	0.00		LATE FILING CHARGE		0.00	NET	[redacted]

CLAIM INFORMATION FORWARDED TO: ANTHEM FEP NEVADA

MESSAGES/REASONS:

2	Coinsurance Amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
CO	Contractual Obligation
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA18	Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
PR	Patient Responsibility

41.70

Attn: [redacted]

Provider Explanation of Medical Payment Report

CIGNA HealthCare

004415

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
[redacted]	[redacted]	04/10/2009		1

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Non-Covered Charges	Deductible/Copay Amount	Coinsurance Amount	DRG/ Per Diem Type	DRG/ Per Diem Number	DRG/ Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	Exc Note
PATIENT NAME: [redacted]									OPERATION LOCATION/GROUP#: [redacted] RECEIVE DATE: 04/06/2009 PROCESS DATE: 04/10 CHECK#: [redacted] REF#: [redacted]						
2	[redacted]	[redacted]		[redacted]		[redacted]	[redacted]	[redacted]							A
															S
3	03232009	96102		75.00		35.96	39.04						0.00	0.00	35.96 A
	TOTAL			[redacted]		[redacted]	[redacted]	[redacted]							[redacted]

BALANCE..... $30.00

WHY WAIT FOR THE MAIL? VIEW ELIGIBILITY, BENEFITS OR CLAIM DETAILS ONLINE ANYTIME AT HTTP://WWW.CIGNA.COM/HEALTH/PROVIDER/

PAYMENT OF $43.96 TO [redacted] NB

SYS BS5

A) THANK YOU FOR USING THE MANAGED CARE CONSULTANTS - HEALTH ALLIANCE NETWORK. THIS REPRESENTS YOUR SAVINGS, SO YOU ARE NOT REQUIRED TO PAY THIS AMOUNT. THIS PROVIDER IS PROHIBITED FROM BILLING THE PATIENT FOR THE DIFFERENCE. IF YOU HAVE ALREADY PAID THE FULL AMOUNT, PLEASE REQUEST REIMBURSEMENT FROM YOUR PROVIDER.

B) IT IS IMPORTANT FOR US TO KNOW WHETHER YOU OR YOUR DEPENDENT(S) HAVE OTHER MEDICAL OR DENTAL INSURANCE. PLEASE UPDATE YOUR OTHER INSURANCE INFORMATION BY CONTACTING OUR MEMBER SERVICES AT THE ABOVE ADDRESS OR AT WWW.CIGNA.COM. WHEN OTHER INSURANCE EXISTS, WE NEED THE OTHER INSURANCE PLAN'S DETAILED PAYMENT INFORMATION OR EXPLANATION OF BENEFITS (EOB) TO PROCESS THE CLAIM.

[redacted]

Attn: [redacted]

Provider Explanation of Medical Payment Report

CIGNA HealthCare

004415

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
[redacted]	[redacted]	04/10/2009		1

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Non-Covered Charges	Deductible/Copay Amount	Coinsurance Amount	DRG/ Per Diem Type	DRG/ Per Diem Number	DRG/ Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	Exc Note
PATIENT NAME: [redacted]									OPERATION LOCATION/GROUP#: [redacted] RECEIVE DATE: 04/06/2009 PROCESS DATE: 04/10 CHECK#: [redacted] REF#: [redacted]						
2	[redacted]	[redacted]		[redacted]		[redacted]	[redacted]	[redacted]							A
															S
3	03232009	96102		75.00		35.96	39.04						0.00	0.00	35.96 A
	TOTAL			[redacted]		[redacted]	[redacted]	[redacted]							[redacted]

BALANCE..... $30.00

WHY WAIT FOR THE MAIL? VIEW ELIGIBILITY, BENEFITS OR CLAIM DETAILS ONLINE ANYTIME AT HTTP://WWW.CIGNA.COM/HEALTH/PROVIDER/

PAYMENT OF $43.96 TO [redacted] NB

SYS BS5

A) THANK YOU FOR USING THE MANAGED CARE CONSULTANTS - HEALTH ALLIANCE NETWORK. THIS REPRESENTS YOUR SAVINGS, SO YOU ARE NOT REQUIRED TO PAY THIS AMOUNT. THIS PROVIDER IS PROHIBITED FROM BILLING THE PATIENT FOR THE DIFFERENCE. IF YOU HAVE ALREADY PAID THE FULL AMOUNT, PLEASE REQUEST REIMBURSEMENT FROM YOUR PROVIDER.

B) IT IS IMPORTANT FOR US TO KNOW WHETHER YOU OR YOUR DEPENDENT(S) HAVE OTHER MEDICAL OR DENTAL INSURANCE. PLEASE UPDATE YOUR OTHER INSURANCE INFORMATION BY CONTACTING OUR MEMBER SERVICES AT THE ABOVE ADDRESS OR AT WWW.CIGNA.COM. WHEN OTHER INSURANCE EXISTS, WE NEED THE OTHER INSURANCE PLAN'S DETAILED PAYMENT INFORMATION OR EXPLANATION OF BENEFITS (EOB) TO PROCESS THE CLAIM.

[redacted]

1

planation of Medical Benefits Report

CIGNA HealthCare

er | Provider Name [redacted] | Date through which claims were processed 03/21/2009 | THIS IS NOT A BILL Retain for Your Records | Page 1

lDate	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem Type	DRG / Per Diem Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
NAME: [redacted]				PATIENT#: [redacted]				OPERATION LOCATION/GROUP# [redacted]			RECEIVE DATE: [redacted]		PROCESS DATE: 03/21	
NAME: [redacted]				SUBSCRIBER#: [redacted]				REF#: [redacted]						
	96102		123.00		35.96	87.04	35.96				0.00	0.00	0.00	C
TOTAL			123.00		35.96	87.04	35.96						0.00	

BALANCE..... $35.96

IN BENEFIT DETERMINATION:
EXPENSE HAS BEEN APPLIED TO PLAN DEDUCTIBLE OR COPAY
CORRECTION OF A PREVIOUSLY PROCESSED CLAIM.
E ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE
NUMBER ON INQUIRIES.

[redacted]

OR THE MAIL? VIEW ELIGIBILITY, BENEFITS OR CLAIM DETAILS ONLINE
HTTP://WWW.CIGNA.COM/HEALTH/PROVIDER/

XPENSES ARE DUPLICATES AND HAVE BEEN PREVIOUSLY
ED.
RVICE HAS BEEN IDENTIFIED AS EITHER A DUPLICATE
RVICE CURRENTLY BEING CONSIDERED UNDER ANOTHER
R A DUPLICATE OF A SERVICE PREVIOUSLY FINALIZED
NOTHER CLAIM.
OU FOR USING A MANAGED CARE CONSULTANTS
PATING PROVIDER. THIS REPRESENTS YOUR SAVINGS,
ARE NOT REQUIRED TO PAY THIS AMOUNT. THIS
R IS PROHIBITED FROM BILLING THE PATIENT FOR THE
NCE. IF YOU HAVE ALREADY PAID THE FULL AMOUNT,
REQUEST REIMBURSEMENT FROM YOUR PROVIDER.

1

planation of Medical Benefits Report

CIGNA HealthCare

er | Provider Name [redacted] | Date through which claims were processed 03/21/2009 | THIS IS NOT A BILL Retain for Your Records | Page 1

lDate	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem Type	DRG / Per Diem Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
NAME: [redacted]				PATIENT#: [redacted]				OPERATION LOCATION/GROUP# [redacted]			RECEIVE DATE: [redacted]		PROCESS DATE: 03/21	
NAME: [redacted]				SUBSCRIBER#: [redacted]				REF#: [redacted]						
	96102		123.00		35.96	87.04	35.96				0.00	0.00	0.00	C
TOTAL			123.00		35.96	87.04	35.96						0.00	

BALANCE..... $35.96

IN BENEFIT DETERMINATION:
EXPENSE HAS BEEN APPLIED TO PLAN DEDUCTIBLE OR COPAY
CORRECTION OF A PREVIOUSLY PROCESSED CLAIM.
E ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE
NUMBER ON INQUIRIES.

[redacted]

OR THE MAIL? VIEW ELIGIBILITY, BENEFITS OR CLAIM DETAILS ONLINE
HTTP://WWW.CIGNA.COM/HEALTH/PROVIDER/

XPENSES ARE DUPLICATES AND HAVE BEEN PREVIOUSLY
ED.
RVICE HAS BEEN IDENTIFIED AS EITHER A DUPLICATE
RVICE CURRENTLY BEING CONSIDERED UNDER ANOTHER
R A DUPLICATE OF A SERVICE PREVIOUSLY FINALIZED
NOTHER CLAIM.
OU FOR USING A MANAGED CARE CONSULTANTS
PATING PROVIDER. THIS REPRESENTS YOUR SAVINGS,
ARE NOT REQUIRED TO PAY THIS AMOUNT. THIS
R IS PROHIBITED FROM BILLING THE PATIENT FOR THE
NCE. IF YOU HAVE ALREADY PAID THE FULL AMOUNT,
REQUEST REIMBURSEMENT FROM YOUR PROVIDER.

Anthem

700 BROADWAY
DENVER, CO 80273-0002

[redacted]

EXPLANATION OF BENEFITS

001834

ISSUE DATE	PAGE
March 19, 2009	00002 OF 00003

C000661

[redacted]

Sequence Number: 1568711659 200900000
Provider ID: [redacted]
NETWORK PROVIDER: Y
FOUNDATION PHYSICIAN: N

Patient Name: [redacted] ID#: [redacted] Acct Nbr: [redacted] Group#: [redacted]
Claim ID: [redacted] Claim Received Date: 03/12/09 PARTICIPATING PROVIDER

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
03/06/09	96102	001	123.00	52.89	123.00/01			0.00
03/06/09	99214	001	231.00	47.37	183.63/03		20.00/02	27.37
TOTAL THIS CLAIM			354.00	100.06	306.63	0.00	20.00	27.37

FOR INFORMATION CALL: 866-817-3717

MESSAGES:

01 - This is not a covered expense of the patient's plan.
02 - This amount is the member's copayment responsibility.
03 - This is the amount in excess of the allowed expense for a participating provider. The member, therefore, is not responsible for this amount.

PAYMENT SUMMARY

CLAIMS PAYMENT/ADJUSTMENTS	PROCESSED	PAID AMOUNT
Total Claims	27.37	27.37
Adjustments Payable Provider	0.00	0.00
Deferred Adjustments Due	0.00	0.00
Sub Total		27.37

CHECK AMOUNT (CHK # [redacted]) $27.37

Anthem

Anthem
PO Box 795180
San Antonio, TX 78279

Return Service Requested

[redacted]

3972 2.2232 MB D-619

[redacted] C 207

[redacted]

Payment Date: 03/19/09

Reference ID: [redacted]

For Customer Service Call
1-866-364-2374
TTY for the hearing impaired
1-800-425-5705

PAYMENT SUMMARY

Group Name: Smart Value-NV

Paid To: [redacted]

Tax ID/NPI: [redacted]

Check #: [redacted]

Check Amount: [redacted]

Servicing Provider Name: [redacted] Payee Name: [redacted]

Patient and Services Information

Account Number: [redacted] Subscriber #: [redacted] AICI NV SmartValue Plus

Patient Name: [redacted] Claim Id: [redacted]

Service Dates	Proc/Rev Code	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Plan Payment	Remark Codes
						Copay	Co Ins	Ded Amt	Non Cvrd		
03/12/09-03/12/09	96102	123.00	52.13	70.87	0.00	20.00	0.00	0.00	0.00	32.13	PDC
03/12/09-03/12/09	99214	231.00	93.60	137.40	0.00	0.00	0.00	0.00	0.00	93.60	PDC
ClaimTotals:		354.00	145.73	208.27	0.00	20.00	0.00	0.00	0.00	125.73	

Current Payment Amount: 125.73
Prior Paid Amount: 0.00
Interest Amount: 0.00
Net Payment Amount: 125.73

Provider total:

	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Plan Payment
					Copay	Co Ins	Ded Amt	Non Cvrd	
1407827850	354.00	145.73	208.27	0.00	20.00	0.00	0.00	0.00	125.73

PAYMENT SUMMARY

Payment Date: [redacted]
Check #: [redacted]
Paid To: [redacted]
Tax ID/NPI: [redacted]
Reference ID: [redacted]

1- Larger of contracted amount and charges
2- Includes Items such as COB and Patient Responsibility

Total Charged:	354.00
Total Cons Charged [1]	354.00
Total Denied:	208.27
Total Allowed:	145.73
Non Paid [2]	20.00
Prior Paid:	0.00
Interest:	0.00
Total Paid:	125.73
Automatic Recovery:	0.00
Other Recoveries:	0.00
Net Check Amount:	125.73

Explanation of Claims Handling

PDC The charge has been reduced based on a discount arrangement with the provider of service

Anthem

700 BROADWAY
DENVER, CO 80273-0002

[redacted]

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE
April 14, 2009	00002 OF 00004

[redacted]
HENDERSON, NV [redacted]

Sequence Number: [redacted]
Provider ID: [redacted]
NETWORK PROVIDER: Y
FOUNDATION PHYSICIAN: N

Patient Name: [redacted] Claim Received Date: 04/[redacted] PARTICIPATING PROVIDER Group#: [redacted]

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
[redacted]		001	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
03/25/09	96102	001	75.00	49.04	25.96/01			49.04
TOTAL THIS CLAIM			[redacted]	[redacted]	[redacted]	0.00	[redacted]	[redacted]

FOR INFORMATION CALL: 877-833-5742

[redacted] ID#: [redacted] A[redacted] Claim Received Date: 04/08/09 PARTICIPATING PROVIDER [redacted]

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
[redacted]	[redacted]	001	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	001	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
TOTAL THIS CLAIM			[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

FOR INFORMATION CALL: 866-817-3717

MESSAGES:

01 - This is the amount in excess of the allowed expense for a participating provider. The member, therefore, is not responsible for this amount.
02 - This amount is the member's copayment responsibility.

THIS IS NOT A BILL

R6-00250*01*00069 [redacted] 110

UNITEDHEALTHCARE INSURANCE COMPANY
SPRINGFIELD SERVICE CENTER
P O BOX 30555
SALT LAKE CITY, UT 84130-0555
[redacted]

UnitedHealthcare
A UnitedHealth Group Company

DATE: [redacted]
TIN [redacted]
NPI: [redacted]
GROUP #: [redacted]
GROUP NAME: [redacted]
CHECK NUMBER: [redacted]
CHECK AMOUNT: [redacted]

[redacted] MD
[redacted] 6

PROVIDER EXPLANATION OF BENEFITS

PATIENT DETAIL

MEM. ID	PATIENT NAME	PAT REL	PATIENT ACCOUNT	MEMBER NAME	CONTROL NUMBER	DATE RECEIVED	PROVIDER OF SERVICE
[redacted]		EE	[redacted]	[redacted]	[redacted]	03/31/09	[redacted]
		EE				03/31/09	

SERVICE DETAIL

T	DATES OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT/ COPAY	PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP.
	03/24/09	99214	231.00		155.88	75.12	15.00	100%	60.12	D1	
		SUBTOTAL	231.00		155.88	75.12	15.00		60.12#		15.00
	03/24/09	96102	123.00		81.17	41.83	5.00	100%	36.83	D1	
		SUBTOTAL	123.00		81.17	41.83	5.00		36.83#		5.00

TOTAL PAID TO PROVIDER $96.95

HANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED F
ATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE
ROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT
OR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.

AYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

ach Check

Detach Ch