SAMPLE CASE # 5 – EOBs/CARRIER LETTERS ATTACHED (3 pages)

Patient: "J.M."
Carrier: United HealthCare
Date(s) of service: 1/16/2013
Dx: uteric obstruction, kidney dysfunction, uterine leiomyosarcoma
CPT line items (# of procedures): 8
Total Claim(s) Amount : $99,518.05
Amount paid to provider: $73,453.73

Case summary: Elective sarcoma surgery, with obstruction

-Claim billed with detailed letter linking CPT codes to Dx codes for medical necessity
- modifiers appended in accordance with current CPT coding guidelines.

Result:

Every procedure billed was reimbursed at highest allowable benefit per plan.

Not a single code was denied or "bundled".

057ROVEA1D0685102

1D-10446*01*000001-PM-13057-120*C07ASOJPMCTOPS
STD - EOB

United HealthCare Services, Inc.
BUFFALO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-877-842-3210

UnitedHealthcare
A UnitedHealth Group Company

DATE: 02/26/13
TIN:
NPI:
GROUP NUMBER:
GROUP NAME:
CHECK NUMBER:
CHECK AMOUNT: $73,453.73

IN

PROVIDER EXPLANATION OF BENEFITS

PLEASE SEE NEXT PAGE FOR MORE INFORMATION

STD - EOB-133984313-95621169

United HealthCare Services, Inc.
BUFFALO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-877-842-3210

DATE: 02/26/13

JP Morgan Chase Bank N.A.
Syracuse, NY 13206

PLEASE PRESENT PROMPTLY FOR PAYMENT

1D-
CONTRACT

PAY: $*****73,453.73**

Seventy Three Thousand Four Hundred Fifty Three Dollars and Seventy Three Cents********

PAY
TO THE
ORDER OF

AUTHORIZED SIGNATURE

Void Void Void

Details on Back. Security Features Included

⑈008598439⑈ ⑆021309379⑆

1D-10446*01*00
STD - EOB

United HealthCare Services, Inc.
BUFFALO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-877-842-3210

UnitedHealthcare
A UnitedHealth Group Company

DATE: 02/26/13
TIN
NPI:
GROUP NUMBER: 07
GROUP NAME: KS
CHECK NUMBER:
CHECK AMOUNT: $73,453.73

:RY

PROVIDER EXPLANATION OF BENEFITS

MEMBER NAME:
MEMBER ID: A
PRODUCT: CHOICE
PATIENT ACCOUNT:

CONTROL NUMBER:
DATE RECEIVED: 01/28/13
PROVIDER OF SERVICE:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICES	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT	COPAY	PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP
[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]		[illegible]	[illegible]		
01/16/13	58240	$27,328.33			$27,328.33			100%	$27,328.33	S6	
[illegible]	[illegible]	[illegible]	[illegible]		[illegible]			[illegible]	[illegible]		
01/16/13	35221	$17,123.73			$17,123.73			100%	$17,123.73	EC	
[illegible]	[illegible]	[illegible]	[illegible]		[illegible]			[illegible]	[illegible]		

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BUFFALO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-877-842-3210

UnitedHealthcare
A UnitedHealth Group Company

FRY

DATE: 02/26/13
TIN:
NPI:
GROUP NUMBER:
GROUP NAME
CHECK NUMBER:
CHECK AMOUNT: $73,453.73

PROVIDER EXPLANATION OF BENEFITS

PATIENT:

MEMBER NAME:
MEMBER ID:
PRODUCT:
PATIENT ACCOUNT:
CONTROL NUMBER:
DATE RECEIVED: 01/28/13
PROVIDER OF SERVICE:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICES	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT	COPAY	PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP
01/16/13	44120	$9,700.60	$3,700.60		$6,000.00			100%	$6,000.00	EC	
01/16/13	50715	$10,233.60	$4,233.60		$6,000.00			100%	$6,000.00	EC	
CONTROL # SUBTOTAL:		$91,052.13	$19,478.40		$71,573.73	$5.00			$69,868.73	#	$21,183.40

MEMBER NAME:
MEMBER ID:
PRODUCT:
PATIENT ACCOUNT:
CONTROL NUMBER:
DATE RECEIVED: 01/28/13
PROVIDER OF SERVICE:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICES	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT	COPAY	PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP
01/16/13	44121	$4,425.20	$1,925.20		$2,500.00			100%	$2,500.00	29	
01/16/13	44139	$4,040.72	$2,955.72		$1,085.00			100%	$1,085.00	29	
CONTROL # SUBTOTAL:	02	$8,465.92	$4,880.92		$3,585.00				$3,585.00	#	$4,880.92
								TOTAL PAYABLE TO PROVIDER	$73,453.73		

REMARKS:

(29) YOUR PLAN COVERS THE ELIGIBLE EXPENSE AMOUNT REIMBURSABLE UNDER YOUR PLAN FOR COVERED OUT-OF-NETWORK HEALTH SERVICES. THE ELIGIBLE AMOUNT IS BASED ON A DATABASE OF COMPETITIVE FEES FOR SIMILAR SERVICES OR SUPPLIES IN YOUR AREA. BENEFITS ARE NOT AVAILABLE FOR THAT PORTION OF THE CHARGE THAT EXCEEDS THE ELIGIBLE AMOUNT DETERMINED FOR THIS SERVICE.

(EC) WE HAVE APPLIED THE MAXIMUM ALLOWED EXPENSE FOR THE PRIMARY PROCEDURE. STANDARD PAYMENT ADJUSTMENT (OR REDUCTION) RULES FOR MULTIPLE PROCEDURES HAVE BEEN APPLIED FOR THIS PROCEDURE.

(S6) ACCORDING TO OUR RECORDS, THE OUT OF POCKET MAXIMUM AMOUNT HAS BEEN REACHED FOR THIS PLAN YEAR.

(#) PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

THE MEMBER, PROVIDER, OR AN AUTHORIZED REPRESENTATIVE MAY REQUEST RECONSIDERATION OR APPEAL THE DECISION BY SUBMITTING COMMENTS, DOCUMENTS OR OTHER INFORMATION TO UNITEDHEALTHCARE. NETWORK PROVIDERS SHOULD REFER TO THE ADMINISTRATIVE GUIDE FOR CLAIM RECONSIDERATION OR APPEAL INFORMATION. IF YOU ARE A NETWORK PROVIDER APPEALING A CLINICAL OR COVERAGE DETERMINATION ON BEHALF OF A MEMBER, OR A NON-NETWORK PROVIDER APPEALING A DECISION ON BEHALF OF A MEMBER, FOLLOW THE PROCESS FOR APPEALS IN THE MEMBER'S BENEFIT PLAN DOCUMENT. DECISIONS ON APPEALS MADE ON BEHALF OF MEMBERS WILL BE COMPLETED IN 30 DAYS OF SUBMISSION OR WITHIN THE