SAMPLE CASE # 1 – EOBs/CARRIER LETTERS ATTACHED (16 pages)

Patient: "L.S."

Carrier: Empire BCBS

Date(s) of service: 9/20/2011 (first surgery)

Dx: Uterine Leiomyosarcoma

CPT line items (# of procedures): 11 Total Claim(s) Amount: \$ 112,381.86

Amount paid to provider: \$ 112,381.86 – (100%)

Case summary: Patient admitted through ER, hence, cannot be held financially liable for out of network physician's fees once inpatient treatment started, as she had "no choice" over which doctor would render surgical services.

Note: Patient's malignant cancer recurred metastatic one year post initial treatment, requiring second surgery by same physician.

Second date of service: 8/8/2012

Dx: malignant neoplasm liver/bile ducts and retroperitoneum

CPT line items (# of procedures) 6

Total Claim amount: \$62,861.92 (surgery)

\$2,938.28 (Evaluation & Management – 10 day inpatient stay)

*Initial carrier decision - claim denied, resulting in zero reimbursement Carrier denial reason: "Contractual – subscriber's contract does not cover metastatic disease. (See BCBS denial letter attached dated 8/15/12)

Appeal/Re-submission date: 9/3/13 Claim settlement date: 9/18/13

Amount Paid: \$ 62,861.92 (100% - surgery)

\$ 2,938.28 (100% - E/M care)

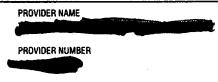
Page 1 of 7



Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans

Empire HealthChoice Assurance, Inc. 165 Broadway, New York, NY 10006

For Inquiry Contacts, Please See Back of This Page



SITE NUMBER 100

STATEMENT DATE 10/22/11

TAX ID

CHECK NUMBER 00000

Summary of Claims

Provider Service Unit codes are listed on the reverse side of this page. Please reference this list to obtain the correct address and phone number for each claim inquiry.

If you suspect illegal activities involving your patients' benefits, please contact us at 1-800-IC-FRAUD. When calling, you do not need to identify yourself.

You or your authorized representative may appeal or grieve our determination by writing to us at the address on page two that corresponds to the PSU code for the claim in question, or by calling our Provider Service Department. You must submit your appeal or grievance within 180 calendar days of this statement's distriff four appeal involves a medical necessity, experimental, or investigational denial, you may have the right to have it reviewed by an External Appeals Agency certified by the NYS Department of Insurance after Empire's final determination.

Total Number of Claims - 4 Total Charges	\$99,057.06
Total Allowed Amount	\$99,057.06
Empire Payment	\$99,057.06
Total Amount Paid by Check # 000001	\$99,057.06



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Provider Explanation of Benefits

Page 3 of 7

Empire • PROVIDER NAME PROVIDER NUMBER STATEMENT DATE TAX ID 10/22/11 SITE NUMBER **CHECK NUMBER** 100 000002 **Detail of Claims** PATIENT NAME PATIENT ACCOUNT NUMBER MEMBER ID **CONTRACT TYPE** YLK **PSU CODE 15** AUTH/REFERRAL Submitted ID Number No Change Not All re Cede: 49203 80 GE 09/20/11 - 09/20/11 \$13,324.80 \$0.00 \$13,324.80 Service Type/Place: 0 /IPC Schooltted Charge: \$0.00 Allowed Amount \$13,324.80 MESSAGE(S) SENT TO YOUR PATIENT: Plan Payment for this Service: \$13,324.80 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any Total Patient Responsibility: \$0.00 in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment **Total Payment for this Claim:** \$13,324.80 and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us. PATIENT ACCOUNT NUMBER MEMBER ID CONTRACT TYPE PSU CODE 15 AUTH/REFERRAL Submitted ID Number No Change n Bule: 99238 u± 09/28/11 - 09/28/11 \$366.08 \$0.00 \$366.08 e type/fees: 6/APC **14 :--:** \$0.00 **Allowed Amount** \$366.08 Plan Payment for this Service: Sisses nity to select on in-sempet provider for these work benefit level. You may bill the patient for any rance quantity. We sist that you accept this payme metronics amounts or payment in full. If you have

NON-NEGOTIABLE

Total Patient Responsibility.

Total Payment for this Claim.

		STATEMENT DATE TA	Empi	HOSS BLUESHIELD
in the North State of the State	SITE NUMBER 100	CHECK NUMBER	a die	
PATIENT NAME	PATIENT ACCOUNT NUMBER	MEMBER ID	CONTRACT TYPE	CLAID NUMBER
	At a special	YLK	AUTH/REFERRAL	PSU CODE 15
		Submitted ID Number No Change Charges	Charges Het Allewed	Allewed Amount
Service Precedure Code: 58240	Date(s): 09/20/11 - 09/20/11	\$33,763.60	\$0.00	\$33,763.60
Information Service Type/Place: 2 /IPC	No. of Units: 1	Submitted C	harge: \$0.00	\$1.4\$\text{3.5}
Payment Allowed Amount				\$33,763.60
MESSAGE(S) SENT TO YOUR PATIENT:		Plan P	ayment for this Service	: \$33,763.60
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in-network co-pay, deductible and coinsu and the in-network co-pay, deductible, coi any questions regarding this, please contac	rance amounts. We ask that you accept th insurance amounts as payment in full. If y	is payment		
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Provider Explanation of Benefits

Page 5 of 7

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 10/22/11

TAX ID



SITE NUMBER

CHECK NUMBER

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Payment Allowed Amount Calculation

\$10,233.60

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any questions regarding this, please contact us.

Since this patient did not have the opportunity to select an in-network provider for these
services, we are paying them at the in-network benefit level. You may bill the patient for any
in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment
and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have

Plan Payment for this Service: \$10,233.60

Service Information	Presentare Gode: 49255 59 Barries Type/Pines: 2/IPC	Bado(c): 09/20/11 - 09/20/11 No. of Malic: 1	\$6,854.40 \$0.00	\$6,854.40
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Payment Calculation	Allowed Amount			\$6,854.40
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With the

PATIENT MODIFIED MUNICER

MEMBER 10

Seeks: 44850.59 Pariet: 09/20/11 - 09/20/11 \$6.586.58 \$0.00 \$6.586.58

CONTRACT TYPE

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Submitted ID Named

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\$5,434.00

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 10/22/11

TAX ID



SITE NUMBER 100

CHECK NUMBER 0000 Tall

CLAIM NUMBER

CONTINUED

Payment

Calculation

Allowed Amount

\$5,434.00

MESSAGE(S) SENT TO YOUR PATIENT:

• Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.

Plan Payment for this Service: \$5,434.00

			Charges	Charges Not Allowed	Allowed Amount
Service Information	Precedure Code: 49419 RT Service Type/Place: 2 /IPC	Date(s): 09/20/11 - 09/20/11 Se. of Units: 1	\$4,599.40	\$0.00	\$4,599.40
Submitted Precede	ure Code: No Change	Submitted Date(s): No Change	Submitted Char	e: No Change	
Payment Calculation	Allowed Amount				\$4,599.40

MESSAGE(S) SENT TO YOUR PATIENT:

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Plan Payment for this Service: \$4,599.40

Service Procedure Code: 49419 LT Date(s): 09/20/11 - 09/20/11 \$4,599.40 \$0.00 \$4,599.40 Information Service Type/Place: 2 /IPC No. of Units: 1 Submitted Procedure Code: No Change Submitted Date(s): No Change Submitted Charge: No Change **Payment** Allowed Amount \$4,599.40 Calculation

MESSAGE(S) SENT TO YOUR PATIENT:

 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.

Plan Payment for this Service:

\$4,599,40

Precedure Code: 49080 Information Service Type/Place: 2/IPC

Date(s): 09/20/11 - 09/20/11 No. of Units: 1

\$1,616.00

\$0.00

\$1,616.00

Submitted Procedure Code: No Change

Submitted Date(s): No Change

Submitted Charge: No Change

Page 7 of 7

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 10/22/11

TAX ID



SITE NUMBER 100

CHECK NUMBER

CONTINUED

Allowed Amount

Plan Payment for this Service: \$1.616.00

\$1,616.00

MESSAGE(S) SENT TO YOUR PATIENT:

Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.

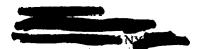
Total Patient Responsibility: Total Payment for this Claim: \$0.00

\$16,248.80



P.O. Box 1407, Church Street Station New York NY 10008-1407 www.empireblue.com

August 15, 2012



RE: date of service 8/8/12

. Note for Spanish-speaking recipients: -Si necesita ayuda en espanoi para entender este documento, puede solicitaria sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

IDENT. NUMBER:

PATIENT:

REFERENCE NO:

CONTRACT:

DENIAL REASON:

PROVIDER: FACILITY:

CONTRACTUAL

Hospital

Dear Lynda Spina:

Diagnosis code and description: ICD-9-CM 179 Malignant neoplasm of uterus, part unspecified

The Medical Management Department is in receipt of the request for inpatient hospital services to be provided to the Hospital Center under the care of Dr. We are unable to authorize this request for the following reason(s):

1						
	REFERENCE #	· SERVICE CODE	OTY	START DATE	END DATE	
ļ		Inpatient Flospital-Additional Provider	23 inpatient			
ı		1.444444		08/07/12	08/29/12	/
٠			days		│	_

*No benefits are available under the member's contract for the requested service(s), when an out-of- network provider is utilized. Please refer to the exclusion section of your contract or your member benefit materials.

The member or the member's designee may request, free of charge, reasonable access to and copies of all documents, records and other information, including the clinical guidelines, relevant to the member's or the member's designee's benefit request.

We have denied this request, there could be significant additional financial responsibility for you. Please call the customer service number on your health plan identification card. Customer service can determine what your financial responsibility may be if you proceed with receiving the above service.

Please note that this is not a medical necessity determination of your proposed medical services.

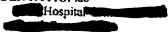
If you, your provider, or your representative disagrees with this decision, please see the attached information for additional rights.

Sincerely,

The Medical Management Department

VD0001 CON-DEN NYFIG: lac

CC:



Page 1 of 5



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Empire HealthChoice Assurance, Inc. 165 Broadway, New York, NY 10006

For Inquiry Contacts, Please See Back of This Page

PROVIDER NAME PROVIDER NUMBER

Total Amount Paid by Check # 00000

SITE NUMBER 100

STATEMENT DATE 09/18/12

TAX ID

CHECK NUMBER

\$62,861.92

Summary of Claims

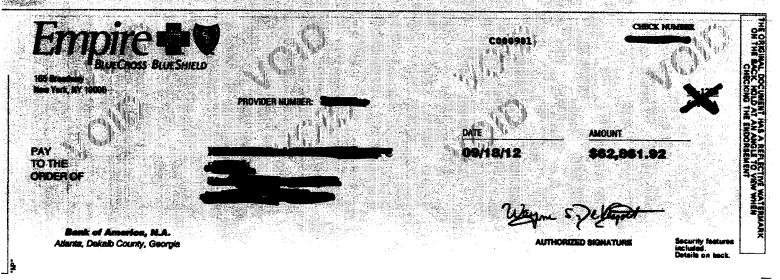
Provider Service Unit codes are listed on the reverse side of this page. Please reference this list to obtain the correct address and phone number for each claim inquiry.

If you suspect illegal activities involving your patients' benefits, please contact us at 1-800-IC-FRAUD. When calling, you do not need to identify yourself.

You or your authorized representative may appeal or grieve our determination by writing to us at the address on page two that corresponds to the PSU code for the claim in question, or by calling our Provider Service Department. You must submit your appeal or grievance within 180-calendar days of this statement's date. If your appeal involves a medical necessity, experimental, or investigational denial, you may have the right to have it reviewed by an External Appeals Agency certified by the NYS Department of Insurance after Empire's final determination.

Total Number of Claims - 1 Total Charges	\$62,861.92	
Total Allowed Amount		\$62,861.92
Empire Payment		\$62,861.92

DETACH AT PERFORATION



Page 3 of 5

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 09/18/12

TAX ID



SITE NUMBER 100

CHECK NUMBER

Detail of Claims

PATIENT NAME

PATIENT ACCOUNT NUMBER

MEMBER ID YLER

CONTRACT TYPE

PSU CODE 15

AUTH/REFERRAL

Submitted ID Number

Change				
		-	: Ch	arge

re Cede: 49205 formetion Service Type/Place: 2/IPC

Batu(s): 08/08/12 - 08/08/12 No. of Units: 1

\$26,124.80

\$0.00

\$26,124.80

Submitted Charge: \$0.00

Payment Calculation

Allowed Amount

\$26,124.80

MESSAGE(S) SENT TO YOUR PATIENT:

 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, communance amounts as payment in full. If you have any questions regarding this, please contact us.

Plan Payment for this Service:

\$26,124.80

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Service	Precedere Code: 76998 26	Patental: 08/08/12 - 0	18/08/12	\$2,502,50	S0.0	- Filter Pr. Collection - City
Information		He of his 1		Ψ Δ, Ο 0 Δ.Ο	90.0	0 \$2,502.50
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		SECTION SERVICES	Springer and the state of		(2003)	CONTROL OF A STATE OF THE PARTY
Payment	Allowed Amount		2. (Table 1 - 1.53 FTL 国际			
Calculation				NOTED 新工作的		\$2,502.50

MESSAGE(S) SENT TO YOUR PATIENT:

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Plea Payment for this Service:

re Code: 47120 59

08/08/12 - 08/08/12

\$14,944.02

50.00

x No Change

: No Change

Mary No Change

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 09/18/12

TAX ID



SITE NUMBER 100

CHECK NUMBER

CLAIM NUMBER 22

CONTINUED

Payment Allowed Amount Calculation

\$14,944.02

Plan Payment for this Service:

\$14,944.02

MESSAGE(S) SENT TO YOUR PATIENT:

 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have

			Charges	Charges Not Allewed	Allewor Ameun
Service Information	Precedere Gede: 38564 59 Service Type/Place: 2 /IPC	Date(s): 08/08/12 - 08/08/12 No. of Units: 1	\$8,881.60	\$0.00	\$8,881.60
	ure Code: No Change	Submitted Outs(s): No Change	Submitted Char	e: No Change	
Payment Calculation	Allowed Amount				\$8,881.60
MESSAGE(S)	SENT TO YOUR PATIENT:		Pian Pay	ment for this Service:	\$8,881.60
services, we a in-network c and the in-n	are paying them at the in-netw co-pay, deductible and coinsure	ity to select an in—network provider for these ork benefit level. You may bill the patient for any ance amounts. We ask that you accept this payment nsurance amounts as payment in full. If you have			

Service Information	Procedero Gode: 47600 59 Service Type/Place: 2 /IPC	Bate(s): 08/08/12 - 08/08/12	\$8,793.00	\$0.00	\$8,793.00
	ure Gode: No Change	Submitted Date(s): No Change	Submitted Cha	rge: No Change	
Payment Calculation	Allowed Amount				\$8,793.00
MESSAGE(S) SENT TO YOUR PATIENT:			Pian Pay	ment for this Service:	\$8,793.00
Since this pat	tient did not have the opportun	ity to select an in-network provider for these	•		

services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.

Service Information

Precedure Code: 49082 59 Service Type/Place: 2 /IPC

Bate(s): 08/08/12 - 08/08/12 No. of Units: 1

\$1,616.00

\$0.00

\$1,616.00

Submitted Procedure Code: No Change

Submitted Date(s): No Change

Submitted Charge: No Change



Page 5 of 5

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 09/18/12

Empire 4.7

SITE NUMBER 100

CHECK NUMBER

CLAIM NUMBER 220

Allowed Amount

CONTINUED

\$1,616.00

MESSAGE(S) SENT TO YOUR PATIENT:

Calculation

 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.

Plan Payment for this Service:

\$1,616.00

Total Patient Responsibility: Total Payment for this Claim: \$0.00

\$62,861.92





Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans

Empire HealthChoice Assurance, Inc. 165 Broadway, New York, NY 10006

For Inquiry Contacts, Please See Back of This Page

PROVIDER NAME PROVIDER NUMBER

SITE NUMBER

STATEMENT DATE 08/25/12

TAX ID

CHECK NUMBER

Summary of Claims

Provider Service Unit codes are listed on the reverse side of this page. Please reference this list to obtain the correct address and phone number for each claim inquiry.

If you suspect illegal activities involving your patients' benefits, please contact us at 1-800-IC-FRAUD. When calling, you do not need to identify yourself.

You or your authorized representative may appeal or grieve our determination by writing to us at the address on page two that corresponds to the PSU code for the claim in question, or by calling our Provider Service Department. You must submit your appeal or grievance within 180 calendar days of this statement's date. If your appeal involves a medical necessity, experimental, or investigational denial, you may have the right to have it reviewed by an External Appeals Agency certified by the NYS Department of Insurance after Empire's final determination.

Total Number of Gla Total Charges	ims - 2		\$2,931	3.28	i d	
Total Allowed Amount	-				 \$2,93	38.28
Empire Payment	g and the pa	C Marie Ch	After a Control of the Control of th	36775-13-ii	\$2,9	8.28
Total Amount Paid by	Check # 0	000020	1.00 TEST	11.0	\$2,93	8.28

DETACH AT PERFORATION

TOTAL STATE STATE OF THE STATE

Page 3 of 6

PROVIDER NAME

PROVIDER-NUMBER 🎎 💉 STATEMENT DATE 🐗 🐗 TAX ID 08/25/12

Empire 📲 🗸

SITE NUMBER 100

CHECK NUMBER

Detail of Claims

PATIENT NAME

PATIENT ACCOUNT NUMBER

CONTRACT TYPE

YLK 886

PSU CODE 15

Submitted ID Number No Change

me Code: 99255 57 tervice Type/Piece: 9 /IPC

Dete(a): 08/07/12 - 08/07/12

\$825.00

\$0.00

AUTH/REFERRAL

d Charge: \$0.00

Allowed Amount

\$825.00

MESSAGE(8) SENT TO YOUR PATIENT:

Plan Payment for this Service:

9825.00

 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and communance amounts. We ask that you accept this paym and the in-network co-pay, deductible, communance amounts as payment in full. If you have ony questions regarding this, please contact us.

ro Codo: 99231 • Type/Phone: 6 /IPC Data(de: 08/08/12 - 08/08/12

\$218.40

\$0.00

\$218.40

e tiste: No Change

and house No Change

ed Charge: No Change

Allowed Amount

\$218.40

SAGE(S) SENT TO YOUR PATIENT:

08/09/12-08/09/12

\$218.40

\$0,00

No Change

\$218.40

\$218.40

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 08/25/12





SITE NUMBER 100

CHECK NUMBER

Payment Calculation Allowed Amount

Plan Payment for this Service:

MESSAGE(S) SENT TO YOUR PATIENT:

 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment

	twork co-pay, deductible, coins regarding this, please contact	surance amounts as payment in full. If you have us.	•		
··· .			Charges	Charges Not Allowed	Allewed Ameunt
Service Information	Precedure Code: 99231 Service Type/Place: 6 /IPC	Date(e): 08/10/12 - 08/10/12 No. of Units: 1	\$218.40	\$0.00	\$218.40
abadited Precedi	ere Code: No Change	Submitted Date(s): No Change	Submitte	d Charge: No Change	
Payment Calculation	Allowed Amount				\$218.40 \$218.40
 Since this pat services, we do in-network of and the in-network 	are paying them at the in-netwo o-pay, deductible and coinsura	ty to select an in-network provider for these ork benefit level. You may bill the patient for an unce amounts. We ask that you accept this paym surance amounts as payment in full. If you have us.	y sent	Payment for this Service:	
Service Information	Precedure Code: 99231 Service Type/Ptace: 6 /IPC	Date(s): 08/11/12 - 08/11/12 No. of Units: 1	\$218.40	\$0.00	\$218.40
Submitted Procedure Code: No Change Submitted Cate(s): No Change		Submitte	Submitted Charge: No Change		
Payment Calculation	Allowed Amount				\$218.40
	SENT TO YOUR PATIENT:	<u> </u>	Pla	n Payment for this Service:	\$218.40
services, we in-network o and the in-n	are paying them at the in-netw co-pay, deductible and coinsur	ity to select an in-network provider for these ork benefit level. You may bill the patient for an ance amounts. We ask that you accept this pays nsurance amounts as payment in full. If you hav t us.	nent Tota	al Patient Responsibility: I Payment for this Claim:	\$0.00 \$1,698.60
PATIENT NAME		PATIENT ACCOUNT NUMBER MEI	MBER ID	CONTRACT TYPE	CLAIM NUMBE

AUTH/REFERRAL

PSU CODE 15

Submitted ID Number

No Change

\$218.40

Service Information

Procedure Code: 99231 Service Type/Place: 6 /IPC

Date(s): 08/12/12 - 08/12/12 No. of Units: 1

\$218.40

\$0.00

Submitted Charge: \$0.00

Page 5 of 6

\$218.40

\$218.40

PROVIDER NAME

Paymont

Celoulation

PROVIDER NUMBER

STATEMENT DATE 08/25/12

TAX ID



SITE NUMBER 100

CHECK NUMBER

CLAIM NUMBER 223

Allowed Amount

CONTINUED

\$218.40

Plan Payment for this Service:

MESSAGE(S) SENT TO YOUR PATIENT:

. Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.

				Charges	Charges Bot Allered	All parting and a second
Service Present	Cude: 99231 Date	n(a): 08/13/12 - 08/13 of Unite: 1	3/1 2	\$218.40	\$0.00	\$218.40
Salushind Procedure Code: 3	The process of the state of the	Sub-Mind Datable: N	o Change		d Change: No Change	
						100 / 100 /

MESSAGE(S) SENT TO YOUR PATIENT:

Allowed Amount

 Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.

Plan Payment for this Service: \$218.40

tur bate: 9923) • Japantae, 6/IPC \$218.40 **68:** 08/14/12 - 08/14/12 \$0.00 \$218.40 w tests: No Change Change No Change and betrick No Change

Allowed Amount \$218.40

E) SENT TO YOUR PARTIES.

Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any is-network on pay, dedictible and consurance amounts. We ask that you accept this payment ert et pay actuelle, commente a

Plea Payment for the Service:

50.00

• Change

No Change

ne: No Change

PROVIDER NAME

PROVIDER NUMBER

STATEMENT DATE 08/25/12

TAX ID



SITE NUMBER

CHECK NUMBER

- CLAI	M NUM	BER 22	C

CONTINUED

Payment Calculation

Allowed Amount

any questions regarding this, please contact us.

Plan Payment for this Service:

\$218.40 \$218.40

MESSAGE(S) SENT TO YOUR PATIENT:

Since this patient did not have the opportunity to select an in-network provider for these
services, we are paying them at the in-network benefit level. You may bill the patient for any
in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment
and the in-network co-pay, deductible, coinsurance amounts as payment in full. If you have
any questions regarding this, please contact us.

			Charges	Charges Het Allewed	Allewed Amount
Service Information	Precedure Code: 99238 Service Type/Place: 6 /IPC	Date(s): 08/16/12 - 08/16/12 No. of Units: 1	\$366.08	\$0.00	\$366.08
Submitted Precedure Code: No Change Submitted Bate(s): No Change			Submitted Ch	Submitted Charge: No Change	
Payment Calculation	Allowed Amount				\$366.08
MESSAGE(S) SENT TO YOUR PATIENT:			Plan Pa	yment for this Service:	\$366.08
• Since this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefit level. You may bill the patient for any in-network co-pay, deductible and coinsurance amounts. We ask that you accept this payment and the in-network co-pay, deductible coinsurance amounts as payment in full. If you have				atient Responsibility: yment for this Claim:	\$0.00 \$1,239.68