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)

Provider Explanation of Benefits

Empire BlueCross BlueShield

PROVIDER NAME
[redacted]

PROVIDER NUMBER
[redacted]

SITE NUMBER
100

STATEMENT DATE
10/22/11

TAX ID
[redacted]

CHECK NUMBER
00000[redacted]

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

For Inquiry Contacts, Please See Back of This Page

.0025828050200.

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 - 4

Total Charges	$99,057.06	
Total Allowed Amount		$99,057.06
Empire Payment		**$99,057.06**
Total Amount Paid by Check # 00000[redacted]		**$99,057.06**

NYCS8040 COMB
20111024 025882 Env [1,280] 2 of 8

Provider Explanation of Benefits

PROVIDER NAME [redacted]

PROVIDER NUMBER [redacted]

STATEMENT DATE 10/22/11

TAX ID [redacted]

Empire BlueCross BlueShield

SITE NUMBER 100

CHECK NUMBER 000002[redacted]

Detail of Claims

PATIENT NAME [redacted]

PATIENT ACCOUNT NUMBER [redacted]

MEMBER ID YLK[redacted]

CONTRACT TYPE [redacted]

AUTH/REFERRAL 000[redacted]

PSU CODE 15

Submitted ID Number
No Change

			Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure Code: 49203 80 Service Type/Place: 0 /IPC	Date(s): 09/20/11 - 09/20/11 No. of Units: 1	$13,324.80	$0.00	$13,324.80
			Submitted Charge: $0.00		

Payment Calculation	Allowed Amount	$13,324.80

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, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.*

Plan Payment for this Service:	**$13,324.80**
Total Patient Responsibility:	***$0.00***
Total Payment for this Claim:	***$13,324.80***

PATIENT NAME [redacted]

PATIENT ACCOUNT NUMBER [redacted]

MEMBER ID YLK[redacted]

CONTRACT TYPE [redacted]

AUTH/REFERRAL [redacted]

PSU CODE 15

Submitted ID Number
No Change

			Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure Code: 99238 Service Type/Place: 6 /IPC	Date(s): 09/28/11 - 09/28/11 No. of Units: 1	$366.08	$0.00	$366.08
			Submitted Charge: $0.00		

Payment Calculation	Allowed Amount	$366.08

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:	**$366.08**
Total Patient Responsibility:	***$0.00***
Total Payment for this Claim:	***$366.08***

Provider Explanation of Benefits

PROVIDER NAME [redacted]

PROVIDER NUMBER [redacted]

STATEMENT DATE 10/22/11

TAX ID [redacted]

SITE NUMBER 100

CHECK NUMBER [redacted]

Empire BlueCross BlueShield

PATIENT NAME [redacted]

PATIENT ACCOUNT NUMBER [redacted]

MEMBER ID YLK[redacted]

CONTRACT TYPE

CLAIM NUMBER [redacted]

AUTH/REFERRAL [redacted]

PSU CODE 15

Submitted ID Number
No Change

			Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure Code: 58240 Service Type/Place: 2 /IPC	Date(s): 09/20/11 - 09/20/11 No. of Units: 1	$33,763.60	$0.00	$33,763.60
			Submitted Charge: $0.00		
Payment Calculation	Allowed Amount				$33,763.60

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: $33,763.60

			Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure Code: 38765 Service Type/Place: 2 /IPC	Date(s): 09/20/11 - 09/20/11 No. of Units: 1	$11,679.20	$0.00	$11,679.20
	Submitted Procedure Code: No Change	Submitted Date(s): No Change		Submitted Charge: No Change	
Payment Calculation	Allowed Amount				$11,679.20

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: $11,679.20

			Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure Code: 50715 Service Type/Place: 2 /IPC	Date(s): 09/20/11 - 09/20/11 No. of Units: 1	$10,233.60	$0.00	$10,233.60
	Submitted Procedure Code: No Change	Submitted Date(s): No Change		Submitted Charge: No Change	

[redacted]

Provider Explanation of Benefits

PROVIDER NAME	PROVIDER NUMBER	STATEMENT DATE	TAX ID
[redacted]	[redacted]	10/22/11	[redacted]
	SITE NUMBER	CHECK NUMBER	
	100	000002[redacted]	

Empire BlueCross BlueShield

[redacted] - CLAIM NUMBER [redacted] *CONTINUED*

Payment Calculation Allowed Amount $10,233.60

MESSAGE(S) SENT TO YOUR PATIENT:

Plan Payment for this Service: **$10,233.60**

- *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 Not Allowed	Allowed Amount
Service Information	**Procedure Code:** 49255 59 **Service Type/Place:** 2 /IPC	**Date(s):** 09/20/11 - 09/20/11 **No. of Units:** 1	$6,854.40	$0.00	$6,854.40

Submitted Procedure Code: No Change **Submitted Date(s):** No Change **Submitted Charge:** No Change

Payment Calculation Allowed Amount $6,854.40

MESSAGE(S) SENT TO YOUR PATIENT:

Plan Payment for this Service: **$6,854.40**

- *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 Not Allowed	Allowed Amount
Service Information	**Procedure Code:** 44850 59 **Service Type/Place:** 2 /IPC	**Date(s):** 09/20/11 - 09/20/11 **No. of Units:** 1	$6,586.58	$0.00	$6,586.58

Submitted Procedure Code: No Change **Submitted Date(s):** No Change **Submitted Charge:** No Change

Payment Calculation Allowed Amount $6,586.58

MESSAGE(S) SENT TO YOUR PATIENT:

Plan Payment for this Service: **$6,586.58**

- *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: ***$0.00***

Total Payment for this Claim: ***$69,117.38***

PATIENT NAME	PATIENT ACCOUNT NUMBER	MEMBER ID	CONTRACT TYPE	
[redacted]	[redacted]	YLK[redacted]		[redacted]
		Submitted ID Number: No Change	AUTH/REFERRAL 000[redacted]	PSU CODE 15

			Charges	Charges Not Allowed	Allowed Amount
Service Information	**Procedure Code:** 22900 **Service Type/Place:** [illegible]	**Date(s):** 09/20/11 - 09/20/11 **No. of Units:** 1	$5,434.00	$0.00	$5,434.00

Submitted Charge: $0.00

NON-NEGOTIABLE

Provider Explanation of Benefits

PROVIDER NAME	PROVIDER NUMBER	STATEMENT DATE	TAX ID
[redacted]	[redacted]	10/22/11	[redacted]

Empire BlueCross BlueShield

SITE NUMBER	CHECK NUMBER
100	0000[redacted]

[redacted] - CLAIM NUMBER [redacted] 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	Procedure Code: 49419 RT Service Type/Place: 2 /IPC Date(s): 09/20/11 - 09/20/11 No. of Units: 1	$4,599.40	$0.00	$4,599.40
Submitted Procedure Code: No Change	Submitted Date(s): No Change	Submitted Charge: No Change		

Payment Calculation Allowed Amount $4,599.40

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.*

Plan Payment for this Service: **$4,599.40**

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

Payment Calculation Allowed Amount $4,599.40

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.*

Plan Payment for this Service: **$4,599.40**

Service Information	Procedure Code: 49080 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		

Provider Explanation of Benefits

PROVIDER NAME	PROVIDER NUMBER	STATEMENT DATE	TAX ID
[redacted]	[redacted]	10/22/11	[redacted]

Empire BlueCross BlueShield

SITE NUMBER: 100

CHECK NUMBER: [redacted]

[redacted] - CLAIM NUMBER [redacted] CONTINUED

Payment Calculation	Allowed Amount	$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.*

Plan Payment for this Service:	**$1,616.00**
Total Patient Responsibility:	***$0.00***
Total Payment for this Claim:	***$16,248.80***

Empire BLUECROSS BLUESHIELD

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

August 15, 2012

[redacted]

RE: date of service 8/8/12

Note for Spanish-speaking recipients: -Si necesita ayuda en espanol para entender este documento, puede solicitarla 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: [redacted]
PATIENT: [redacted]
REFERENCE NO: [redacted]
CONTRACT: EPO
DENIAL REASON: CONTRACTUAL
PROVIDER: [redacted]
FACILITY: [redacted] Hospital [redacted]

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 [redacted] at [redacted] Hospital Center [redacted] under the care of Dr. [redacted] We are unable to authorize this request for the following reason(s):

REFERENCE #	SERVICE CODE	QTY	START DATE	END DATE
[redacted]	Inpatient Hospital-Additional Provider	23 inpatient days	08/07/12	08/29/12

*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: [redacted] Hospital [redacted]

Provider Explanation of Benefits

Empire BlueCross BlueShield

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 [redacted]

PROVIDER NUMBER [redacted]

SITE NUMBER
100

STATEMENT DATE
09/18/12

TAX ID [redacted]

CHECK NUMBER [redacted]

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.

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Total Number of Claims - 1

Total Charges	$62,861.92
Total Allowed Amount	$62,861.92
Empire Payment	**$62,861.92**
Total Amount Paid by Check # 0000[redacted]	**$62,861.92**

NYCCS034 COMB 20120920802 1960 Env [2,921] 5 of 7 0000 0001 0000 09/20/2012

DETACH AT PERFORATION

Empire BlueCross BlueShield
165 Broadway
New York, NY 10006

PROVIDER NUMBER: [redacted]

C000901

CHECK NUMBER [redacted]

PAY TO THE ORDER OF [redacted]

DATE
09/18/12

AMOUNT
$62,861.92

Bank of America, N.A.
Atlanta, Dekalb County, Georgia

AUTHORIZED SIGNATURE

Security features included. Details on back.

THE ORIGINAL DOCUMENT WAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT

⑈0027288234⑈ ⑆061112788⑆ 329 905 1583⑈

Provider Explanation of Benefits

PROVIDER NAME [redacted]

PROVIDER NUMBER [redacted]

STATEMENT DATE 09/18/12

TAX ID

SITE NUMBER 100

CHECK NUMBER

Empire BlueCross BlueShield

Detail of Claims

PATIENT NAME [redacted]

PATIENT ACCOUNT NUMBER [redacted]

MEMBER ID YL[redacted]

CONTRACT TYPE [redacted]

AUTH/REFERRAL [redacted]

PSU CODE 15

Submitted ID Number No Change

			Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure Code: 49205 Service Type/Place: 2 /IPC	Date(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, coinsurance amounts as payment in full. If you have any questions regarding this, please contact us.*

Plan Payment for this Service: $26,124.80

Service Information	Procedure Code: 76998 26 Service Type/Place: P /IPC	Date(s): 08/08/12 - 08/08/12 No. of Units: 1	$2,502.50	$0.00	$2,502.50
Submitted Procedure Code: No Change		Submitted Date(s): No Change	Submitted Charge: No Change		
Payment Calculation	Allowed Amount				$2,502.50

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: $2,502.50

Service Information	Procedure Code: 47120 59 Service Type/Place: 2 /IPC	Date(s): 08/08/12 - 08/08/12 No. of Units: 1	$14,944.02	$0.00	$14,944.02
Submitted Procedure Code: No Change		Submitted Date(s): No Change	Submitted Charge: No Change		

Provider Explanation of Benefits

PROVIDER NAME [redacted]

PROVIDER NUMBER [redacted]

STATEMENT DATE 09/18/12

TAX ID [redacted]

Empire BlueCross BlueShield

SITE NUMBER 100

CHECK NUMBER [redacted]

[redacted] - CLAIM NUMBER 22[redacted] CONTINUED

Payment Calculation Allowed Amount $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 any questions regarding this, please contact us.*

Plan Payment for this Service: **$14,944.02**

	Charges	Charges Not Allowed	Allowed Amount
Service Information Procedure Code: 38564 59 Date(s): 08/08/12 - 08/08/12 Service Type/Place: 2 /IPC No. of Units: 1	$8,881.60	$0.00	$8,881.60

Submitted Procedure Code: No Change Submitted Date(s): No Change Submitted Charge: No Change

Payment Calculation Allowed Amount $8,881.60

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: **$8,881.60**

Service Information Procedure Code: 47600 59 Date(s): 08/08/12 - 08/08/12 Service Type/Place: 2 /IPC No. of Units: 1	$8,793.00	$0.00	$8,793.00

Submitted Procedure Code: No Change Submitted Date(s): No Change Submitted Charge: No Change

Payment Calculation Allowed Amount $8,793.00

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: **$8,793.00**

Service Information Procedure Code: 49082 59 Date(s): 08/08/12 - 08/08/12 Service Type/Place: 2 /IPC 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

[redacted]

Provider Explanation of Benefits

PROVIDER NAME [redacted]C

PROVIDER NUMBER [redacted]

STATEMENT DATE 09/18/12

TAX ID [redacted]

Empire BlueCross BlueShield

SITE NUMBER 100

CHECK NUMBER [redacted]

[redacted] - CLAIM NUMBER 22[redacted] *CONTINUED*

Payment Calculation	Allowed Amount	$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.***

Plan Payment for this Service:	**$1,616.00**
Total Patient Responsibility:	***$0.00***
Total Payment for this Claim:	***$62,861.92***

Provider Explanation of Benefits

Empire BlueCross BlueShield

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 [redacted]

PROVIDER NUMBER [redacted]

SITE NUMBER
100

STATEMENT DATE
08/25/12

TAX ID [redacted]

CHECK NUMBER [redacted]

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.

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Total Number of Claims - 2

Total Charges	$2,938.28	
Total Allowed Amount		$2,938.28
Empire Payment		**$2,938.28**
Total Amount Paid by Check # 000002[redacted]		**$2,938.28**

DETACH AT PERFORATION

Empire BlueCross BlueShield

165 Broadway
New York, NY 10006

PROVIDER NUMBER: [redacted]

C006652

CHECK NUMBER [redacted]

64-1278
611 GA

PAY TO THE ORDER OF [redacted]

DATE 08/25/12

AMOUNT $2,938.28

Bank of America, N.A.
Atlanta, Dekalb County, Georgia

AUTHORIZED SIGNATURE

Security features included. Details on back.

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHILE CHECKING THE ENDORSEMENT

⑈00269644 2⑈ ⑆061112788⑆ 329 905 1583⑈

Provider Explanation of Benefits

PROVIDER NAME [redacted]

PROVIDER NUMBER [redacted]

STATEMENT DATE 08/25/12

TAX ID [redacted]

Empire BlueCross BlueShield

SITE NUMBER 100

CHECK NUMBER [redacted]

Detail of Claims

PATIENT NAME [redacted]

PATIENT ACCOUNT NUMBER [redacted]

MEMBER ID YLK [redacted]

CONTRACT TYPE [redacted]

PSU CODE 15

AUTH/REFERRAL [redacted]

Submitted ID Number
No Change

		Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure Code: 99255 57 Service Type/Place: 9 /IPC Date(s): 08/07/12 - 08/07/12 No. of Units: 1	$825.00	$0.00	$825.00
	Submitted Charge: $0.00			
Payment Calculation	Allowed Amount			$825.00
	Plan Payment for this Service:			$825.00

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.*

Service Information	Procedure Code: 99231 Service Type/Place: 6 /IPC Date(s): 08/08/12 - 08/08/12 No. of Units: 1	$218.40	$0.00	$218.40
	Submitted Procedure Code: No Change Submitted Date(s): No Change Submitted Charge: No Change			
Payment Calculation	Allowed Amount			$218.40
	Plan Payment for this Service:			$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.*

Service Information	Procedure Code: 99231 Service Type/Place: 6 /IPC Date(s): 08/09/12 - 08/09/12 No. of Units: 1	$218.40	$0.00	$218.40
	Submitted Procedure Code: No Change Submitted Date(s): No Change Submitted Charge: No Change			

Provider Explanation of Benefits

PROVIDER NAME [redacted]

PROVIDER NUMBER [redacted]

STATEMENT DATE 08/25/12

TAX ID [redacted]

Empire BlueCross BlueShield

SITE NUMBER 100

CHECK NUMBER [redacted]

[redacted] - CLAIM NUMBER 22[redacted] CONTINUED

Payment Calculation Allowed Amount $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.*

Plan Payment for this Service: $218.40

	Charges	Charges Not Allowed	Allowed Amount
Service Information Procedure Code: 99231 Service Type/Place: 6 /IPC Date(s): 08/10/12 - 08/10/12 No. of Units: 1	$218.40	$0.00	$218.40
Submitted Procedure Code: No Change Submitted Date(s): No Change Submitted Charge: No Change			

Payment Calculation Allowed Amount $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.*

Plan Payment for this Service: $218.40

Service Information Procedure Code: 99231 Service Type/Place: 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 Date(s): No Change Submitted Charge: No Change			

Payment Calculation Allowed Amount $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.*

Plan Payment for this Service: $218.40

Total Patient Responsibility: ***$0.00***

Total Payment for this Claim: ***$1,698.60***

PATIENT NAME [redacted]

PATIENT ACCOUNT NUMBER [redacted]

MEMBER ID YLK [redacted]

CONTRACT TYPE

AUTH/REFERRAL [redacted]

CLAIM NUMBER [redacted]

PSU CODE 15

Submitted ID Number **No Change**

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	$218.40
Submitted Charge: $0.00			

Provider Explanation of Benefits

PROVIDER NAME [redacted]

PROVIDER NUMBER [redacted]

STATEMENT DATE 08/25/12

TAX ID [redacted]

Empire BlueCross BlueShield

SITE NUMBER 100

CHECK NUMBER [redacted]

[redacted] - CLAIM NUMBER 22[redacted] CONTINUED

Payment Calculation Allowed Amount $218.40

MESSAGE(S) SENT TO YOUR PATIENT: **Plan Payment for this Service: $218.40**

- *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 Not Allowed	Allowed Amount
Service Information	Procedure Code: 99231 Service Type/Place: 6 /IPC Date(s): 08/13/12 - 08/13/12 No. of Units: 1	$218.40	$0.00	$218.40
Submitted Procedure Code: No Change	Submitted Date(s): No Change	Submitted Charge: No Change		

Payment Calculation Allowed Amount $218.40

MESSAGE(S) SENT TO YOUR PATIENT: **Plan Payment for this Service: $218.40**

- *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.*

Service Information	Procedure Code: 99231 Service Type/Place: 6 /IPC Date(s): 08/14/12 - 08/14/12 No. of Units: 1	$218.40	$0.00	$218.40
Submitted Procedure Code: No Change	Submitted Date(s): No Change	Submitted Charge: No Change		

Payment Calculation Allowed Amount $218.40

MESSAGE(S) SENT TO YOUR PATIENT: **Plan Payment for this Service: $218.40**

- *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.*

Service Information	Procedure Code: 99231 Service Type/Place: 6 /IPC Date(s): 08/15/12 - 08/15/12 No. of Units: 1	$218.40	$0.00	$218.40
Submitted Procedure Code: No Change	Submitted Date(s): No Change	Submitted Charge: No Change		

Provider Explanation of Benefits

PROVIDER NAME	PROVIDER NUMBER	STATEMENT DATE	TAX ID
[redacted]	[redacted]	08/25/12	[redacted]

Empire BlueCross BlueShield

SITE NUMBER: 100

CHECK NUMBER: [redacted]

[redacted] - CLAIM NUMBER 22[redacted] CONTINUED

Payment Calculation Allowed Amount $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.*

Plan Payment for this Service: **$218.40**

		Charges	Charges Not Allowed	Allowed Amount
Service Information	Procedure 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 Procedure Code: No Change	Submitted Date(s): No Change	Submitted Charge: No Change		

Payment Calculation Allowed Amount $366.08

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: **$366.08**

Total Patient Responsibility: ***$0.00***

Total Payment for this Claim: ***$1,239.68***