P8438028001

20230105012S

aetna®

P.O. BOX 14079
LEXINGTON KY 40512-4079
USA

*006833*J280DUB1*009282*

Explanation Of Benefits

Please Retain for Future Reference

Printed: 01/04/2023
Page: 1 of 1

PIN:
TIN:

NO PAY

3 OF 5 F

ENV 18853

Medical providers: sign up before it's your turn

Enroll for directly deposited payments. Just go to **PayerEnrollServices.com**. If you don't enroll to receive payments by direct deposit, you may receive future payments by virtual credit card. You can get electronic Explanation of Benefits (EOB) statements from our provider portal on Availity®. To do so, go to **Availity.com** and register.

Patient Name:

Claim ID: Recd: **12/12/22** Member ID. Patient Account:
Member: DIAG:
Group Name: Group Number:
Product: **Aetna Open Access® Managed Choice®** Network ID: **00000**
Aetna Life Insurance Company Network Status: **Out-of-Network**

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/QPA	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/03/22	24	3099959	1.0	875.00	437.50		437.50	1	437.50		875.00	0.00
								2				
								3				
12/03/22	24		1.0					4				0.00
								2				
								3				
12/03/22	24		1.0					4				0.00
								2				
								3				
12/03/22	24		1.0					4				0.00
								2				
								3				
TOTALS												**0.00**

F006833000001000001000J280DUB1460F

ISSUED AMT: **NO PAY**

Remarks:

1 - *We paid for these for services in accordance with the Member's benefit plan. Allowed amount is standardly 50% of billed, however, depending on the Member's plan; the allowed amount can be up to 100%. [O51]*
2 - *[ON6]*
3 - *You are not part of our network. We applied the out-of-network benefit level to the covered services on this claim. If the member signed a consent form you gave them, the claim is correct and the member is responsible for any balance shown. If the member didn't sign a consent form, or you didn't give them a consent form, and you provided services per the Federal No Surprises Act, call us so we can reconsider the claim under the Act's requirements. [FDI]*
4 - *Member's plan allows up to 140% of the Medicare Allowable Rate for charges covered by their plan. G07*

For Questions Regarding This Claim PO 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:
Claim Payment: $0.00

Protecting the privacy of member health information is a top priority. When contacting us about this statement or for help with other questions, please be prepared to provide your provider number, tax identification number (TIN), or Social Security number (SSN), in addition to the member's ID number.

P8438028001

202302230132

aetna®

P.O. BOX 14079
LEXINGTON KY 40512-4079
USA

*008541*J280DUB1*011233*

Explanation Of Benefits

Please Retain for Future Reference

Printed: 02/22/2023
Page: 1 of 2

PIN:
TIN:

3 OF 3 F

ENV 22452

Medical providers: sign up before it's your turn

Enroll for directly deposited payments. Just go to **PayerEnrollServices.com**. If you don't enroll to receive payments by direct deposit, you may receive future payments by virtual credit card. You can get electronic Explanation of Benefits (EOB) statements from our provider portal on Availity®. To do so, go to **Availity.com** and register.

Patient Name:

Claim ID: Recd: **02/03/23** Member ID: Patient Account:
Member: DIAG:
Group Name: Group Number:
Product: Network ID:
Aetna Life Insurance Company Network Status:

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/QPA	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
05/05/22	24	3099959	1.0	875.00	437.50		437.50	1		131.25	568.75	306.25
								2				
								3				
05/05/22	24	30520	1.0					4				
								2				
								3				
05/05/22	24	30130LT	1.0					4				
								2				
								3				
05/05/22	24	30130RT	1.0					4				
								2				
								3				
TOTALS												

F00854100000100000100GJ280DUB1880F

Adjusted Payment Made to Member

ISSUED AMT:

Remarks:

1 - *We paid for these for services in accordance with the Member's benefit plan. Allowed amount is standardly 50% of billed, however, depending on the Member's plan; the allowed amount can be up to 100%. [O51]*
2 - *[ON6]*
3 - *You are not part of our network. We applied the out-of-network benefit level to the covered services on this claim. If the member signed a consent form you gave them, the claim is correct and the member is responsible for any balance shown. If the member didn't sign a consent form, or you didn't give them a consent form, and you provided services per the Federal No Surprises Act, call us so we can reconsider the claim under the Act's requirements. [FDI]*
4 - *Member's plan allows up to 140% of the Medicare Allowable Rate for charges covered by their plan. G07*

For Questions Regarding This Claim PO 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:
Claim Payment:

Continued on Next Page

DMSVTP4H COMB 20230209BOE J8CF
20230206 003619 Env [17,241] 2 of 2

08626

Anthem BlueCross

PROVIDER ID NO:

CHECK/EFT DT: 02/07/23
CHECK/EFT:

PPO PB INCNTV HOSP/PROF

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME:				INSURED'S ID:					PATIENT NAME:				FOR INQUIRIES CALL:
PATIENT ACCOUNT#:				CLAIM NUMBER:					RECEIVED DATE:		01/18/2023		(800) 284-1110
SERVICE PROVIDER NAME:				SERVICE PROVIDER ID:					EXPL CD:		APPEALS CODE:		
NETWORK: OUT OF NETWORK				RELATIONSHIP TO INSURED:				PLAN TYPE: PPO	DRG RCVD:				
12/19/2022 12/19/2022	30520	24			0.00	0.00	0.00	0.00	0.00				
12/19/2022 12/19/2022	30130	24			0.00	0.00	0.00	0.00	0.00				
12/19/2022 12/19/2022	30130	24			0.00	0.00	0.00	0.00	0.00				
12/29/2022 12/29/2022	30999	24	875.00	875.00	0.00	0.00	0.00	0.00	0.00		0.00		875.00
	TOTAL:				0.00	0.00	0.00	0.00	0.00				
	TOTAL NET PAID												

TOTAL APPROVED AMOUNT
TOTAL INTEREST
TOTAL NET AMOUNT DUE: PPO PB INCNTV HOSP/PROF

GROSS APPROVED CLAIM AMOUNT
NET AMOUNT DUE

EXPL CODES	EXPLANATION
AUZ	We paid the member for this claim because the doctor/facility is not in the plan's network. The member is responsible for paying the bill they receive from the doctor/facility.
015	This was processed, and as an out of network provider, the maximum amount has been paid. The remaining balance can be billed to the member only if it was non-emergent or was not authorized.
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION.

APPEALS CODE	APPEALS
DMHC	Explanation of claims review procedures If you believe that your claim is wrongfully in whole or in part, rejected or denied you may request a review from the Department of Managed Health Care at the following address and phone number: Department of Managed Health Care Help Center: 1-888-HMO-2219 980 Ninth Street, Suite 500, Sacramento, California 95814-2725 If you have questions regarding this Remittance Advice, please contact our Custom Service Department. Provider dispute resolution mechanism for Providers: If you are a contracting provider with Anthem Blue Cross (Anthem) you are required to follow dispute resolution process in your contract. If you have a dispute with Anthem Blue Cross regarding your contract, you may ask for a "meet and confer" unless your contract specifies otherwise. If the "meet and confer" does not resolve the issue, you may request binding arbitration as specified in your provider contract. See your contract for more detailed information, or contact the Custom Service Department at the telephone number shown on the member's ID card. If you disagree with an Anthem Blue Cross claim or billing determination, or Anthem Blue Cross request for reimbursement of an overpayment, or if you have a contract dispute, you may submit a provider by mailing a written notice to us at P.O. Box 60007, Los Angeles, CA 90060-0007. The written notice must include the provider name, tax identification number, patient name, health plan identification number, description of the dispute, and whether this is a single dispute or a substantially similar multiple claims dispute. Disputes involving a claim, or billing or overpayment must also