Forwarding Service Requested

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

HOMETOWN CLINIC
2795 OAK DRIVE
HOMETOWN, OK 98749

1 Customer Service

Group Name: HEALTHCARE USA

Patient #: 105555555
Patient: JOHN SMITH

Provider: HOMETOWN CLINIC
Employee: JOHN SMITH
Claim #: 001USA123456789

2 Treatment Dates	3 Service Code	4 Procedure Code	5 Billed Amount	6 Not Covered	7 Reason Code	8 Exceeds R&C	9 PPO Discount	10 Covered Amount	11 Deductible Amount	12 Co-pay Amount	13 Paid At	14 Payment Amount
10/24-10/24/2013	750	98940	$45.00	$8.52	47 FH	$0.00	$6.48	$30.00	$0.00	$0.00	80%	$24.00
	Column Totals		$45.00	$8.52		$0.00	$6.48	$30.00	$0.00	$0.00		$24.00
											Other Insurance Credits or Adjustments	$0.00
											15 Total Payment Amount	$24.00

16 Patient Responsibility Summary

Coinsurance Total	$6.00
Co-pay Total	$0.00
Deductible Total	$0.00
Not Covered Total	$8.52
Patient Responsibility Total	**$14.52**

17 Service Code/Description

750 CHIROPRACTIC SERVICES

18 Reason Code/Description

47 EXCEEDS CHIROPRACTIC LIMITATIONS
FH FIRST HEALTH NETWORK DISCOUNT.

19 Payment Details

Paid To	Check No.	Amount
HOMETOWN CLINIC	123456	$24.00

20 Comments

FIRST HEALTH NETWORK DISCOUNT PATIENT ISNOT LIABLE FOR THIS AMOUNT.

CHIROPRACTIC BENEFITS APPLIED. SEE PAGE 20 OF THE PLAN DOCUMENT.

21 Appeal Rights

You have the right to appeal this benefit decision. Please refer to you Plan Document for a full description of the Appeal Process.

Information About Appeals

Please refer to your Master Plan Document &/or Summary Plan Description for further explanation of the terms, conditions, limitations, and exclusions applicable to your benefits.

You have the right to appeal this decision within 180 days. For a full description of the Appeal Process, please refer to your Master Plan Document &/or Summary Plan Description. If you wish to appeal, please send your written request to:

The written request should include the name of the Member, the Member identification number, the Patient name, the nature of the complaint, the facts upon which the complaint is based, and the resolution you are seeking. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You and/or your Provider should include any documentation, including medical records, that you want to become a part of the review file. The Plan may request further information if necessary.

If your benefit determination involved a rule or guideline or a medical necessity or experimental/investigational treatment decision, you may receive upon request, free of charge, a copy of the rule or guideline or an explanation of the decision.

If your benefit plan is governed by ERISA, you may have the right to take legal actions under Sec. 502 (a) of ERISA if the benefit decision is upheld on appeal.

You Should Know

1. Customer Service: If you have questions, please call us at the toll free number listed at the top of your Explanation of Benefits. Our friendly and knowledgeable representatives are here to assist you.
2. Treatment Dates: Represents the date in which the patient was treated and the date in which you are submitting charges.
3. Service Code: This section is to determine what service was performed.
4. Procedure Code: This section is to determine what procedure was performed.
5. Billed Amount: This is the billed amount before any negotiated adjustments, co-pays, deductibles or any ineligible amount.
6. Not Covered: Any specific amount that was determined to be ineligible for payment by the plan.
7. Reason Code: Please reference the Reason code section of this document to determine why a specific code was ineligible for payment or whether the code represents a savings or negotiated adjustment.
8. Exceeds R&C: Any charges that exceed any reasonable and customary charges, which are not reimbursed by the plan.
9. PPO Discount: This amount represents the "write off" or contractual amount agreed upon based on your contract or fee schedule with the re-pricing network.
10. Covered Amount: Amount that has been accepted to pay according to your plan.
11. Deductible Amount: This amount reflects the deductible requirement at the time charges were processed. If you see an amount in the deductible column, the patient would be responsible for these amounts and you would simply balance bill the patient.
12. Co-Pay Amount: Represents amounts responsible to the patient. Copays- Typically office visits, emergency room and in-patient facility charge.
13. Paid At: This is the percentage services are covered at after any deductions are taken from the billed amount. This amount is reflected in the plan benefits.
14. Payment Amount: This amount represents the plan payment after any ineligible charges, co-pays, deductibles, negotiated adjustments and patient's coinsurance is determined.
15. Total Payment Amount: This will be the actual payment amount made to the provider or insured.
16. Patient Responsibility Summary: This section contains the totals for the coinsurance, co-pay and decuctible amounts, as well as the patient responsibility.
17. Service Code/Description: This will be the procedure (CPT) code or dental (ADA) code for the services provided to the patient.
18. Reason Code/Description: This code is used to explain the reason something is not covered or is discounted from the billed amount.
19. Payment Details: This section determines who is receiving the payment and the payment check number and total.
20. Comments: This section includes any additional notes or information as to what was covered or not covered.
21. Appeal Rights: This will be the procedure and information needed to file a formal review for any denied claim.