

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. ANTHEM INSURANCE COMPANIES, INC.
DBA ANTHEM BLUE CROSS AND BLUE SHIELD
3075 VANDERCAR WAY
CINCINNATI, OH 45209

1018AI 030107-072309

PROVIDER ID NO

XXXXX9794

TAX ID NO

DATE

10/18/23

XXXXX9794

||...|.|.||....||.||...||...||...||...||...||...||| #BWNCQXF #025416770////DF8# M001 TCM HEALTHCARE LLC PO BOX 29650

DEPT 880396 PHOENIX AZ 85038-9650

ZERO AMOUNT -- THIS IS NOT A CHECK

ANTHEM INSURANCE COMPANIES, INC.

DATE 10/18/23

P. O. BOX 105187 ATLANTA, GA 30348-5187

PROVIDER NAME	TCM HEALTHCARE LLC
ADDRESS	PO BOX 29650
ADDKE22	DEPT 880396
	PHOENI X AZ 85038-9650
PROVIDER-NPI IDS	XXXXX9794 - 1336746122
TAX ID NO	XXXXX9794
CHECK NUMBER:	9022333351

PAYMENT SUMMARY

GROSS APPROVED CLAIM AMOUNT	0.00	r> IRS WITHHELD	0.00
INTEREST	0.00	STATE WITHHELD	0.00
PENALTY	0.00	AMOUNT PREVIOUSLY OVERPAID	0.00
LEVY/GARNISHMENT	0.00	AMOUNT DISBURSED	0.00
NET AMOUNT DUE	0.00	RECOUPMENT BALANCE	0.00

TO AVOID ANY UNNECESSARY DELAYS IN CLAIMS PROCESSING, PLEASE INCLUDE CURRENT COORDINATION OF BENEFITS (COB) INFORMATION WHEN SUBMITTING CLAIMS TO ANTHEM.

IMPORTANT NOTE: YOU ARE NOT PERMITTED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ABOUT INDIVIDUALS THAT YOU ARE NOT CURRENTLY TREATING. THIS APPLIES TO PROTECTED HEALTH INFORMATION ACCESSIBLE IN ANY ANTHEM ONLINE TOOL, OR SENT IN ANY OTHER MEDIUM INCLUDING MAIL, EMAIL, FAX, OR OTHER ELECTRONIC TRANSMISSION.

Health Insurance fraud hurts us all. You can assist us in fighting health insurance fraud by carefully examining the information presented on the other side of this form.

Health Insurance fraud often involves the collection of fees for services never rendered, the payment of claims filed on ineligible patients, and claims filed for services different than those actually received. If after reviewing this Explanation of Benefits, you believe that medical insurance fraud may have occurred, please contact our Special Investigations department at the number below using your toll free hotline. Callers will remain anonymous if they so choose. For anything other than suspected fraud, including questions regarding your coverage or questions about this Explanation of Benefits form, contact your Customer Service unit directly, using the phone number on the front of this form.

SPECIAL INVESTIGATIONS TOLL-FREE HOTLINE 1-877-283-1524

An independent licensee of the Blue Cross and Blue Shield Association

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® Registered Marks Blue Cross and Blue Shield Association

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Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a TCM HEALTHCARE LLC registered trademark of Anthem Insurance Companies, Inc.

PROVIDER ID NO: 853229794

CHECK/EFT DT: CHECK/EFT:

10/18/23 9022333351

BLUE ACCESS PPO

	INTEREST		09/11/2023	09/11/2023	09/11/2023	09/11/2023	09/11/202:	09/11/2023	09/11/2023	09/11/2023	09/11/202	09/11/202	00 /1 1 /2022		PATIEN SERVICE PRO	SERVIC		INTEREST		09/11/202:	09/11/2023	09/11/2023	09/11/2023	09/11/2023	09/11/2023	09/11/2023	09/11/2023	09/11/2023	09/11/2023		SERVICE PRO	PATIEN	INSL	0EX VIC
			09/11/2023 09/11/2023	09/11/2023 09/11/2023	3 09/11/2023	3 09/11/2023	09/11/2023 09/11/2023	3 09/11/2023		3 09/11/2023	09/11/2023 09/11/2023	09/11/2023 09/11/2023	00/11/2023		INSURED'S NAME: PATIENT ACCOUNT#: SERVICE PROVIDER NAME:					09/11/2023 09/11/2023	3 09/11/2023	09/11/2023 09/11/2023	3 09/11/2023	3 09/11/2023	09/11/2023 09/11/2023	3 09/11/2023	3 09/11/2023	09/11/2023 09/11/2023	09/11/2023 09/11/2023	NET WORK:	SEXVICE PROVIDER NAME: ICM HEALTHCARE	PATIENT ACCOUNT#:		SERVICE DATE(S)
TOTAL NET PAID	_	TOTAL:	A4556	A4215	95999	95868 , XU	95868	95861 , XU	95861				0 7 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	NETWORK: OUT OF NETWORK	GRI FFI TH, JEFFREY O. 3135847 TCM HEALTHCARE LLC	CODES	TOTAL NET PAID		TOTAL:	A4556	A4215	95999	95868 , XU	95868	95861 , XU	95861	95955	95938	95940	NET WORK: OUT OF NETWORK	I CM HEALIHO	0. 3135847	GRI FFI TH, JEFFREY	CODES
PAI D	_		15	15	15					15	1 0	15	<u>,</u>	ORK	ARE LLC	S POS	PALD	_		15	15	15		15		15	15	15	15	ORK	ARE LLC		FFREY	8
		31, 940. 00	36. 00	200. 00	5, 400. 00	2, 904. 00	2, 904. 00	3, 139. 00	3, 139. 00	5, 225. 00	4, 103.00	4, 830. 00	4 830 00	72		CHARGE			31, 940. 00	36. 00	200. 00-	5, 400. 00	2, 904. 00	2, 904. 00-	3, 139. 00-	3, 139. 00	5, 225. 00	4, 163. 00	4, 830. 00		,			CESTO
		380. 19	0.00	0.00	0.00	0.00	32. 73	0. 00	34. 85	93. 33	219.20	210.00	0	RELATIONSHIP TO INSURED	INSURED'S ID: CLAIM NUMBER: SERVICE PROVIDER ID:	ALLOWED			616. 19-	36.00-	200.00-	0.00	0.00	32. 73-	0.00	34.85-	93. 33-	219. 28-	0.00	RELATIONSHIP TO INSURED	WEXVICE TXCVIDEX ID:	CLAIM NUMBER	INSUR	0
		380. 19	0.00	0.00	0.00	0.00	32.73	0.00	34. 85	93. 33	219.20	210.00	9		16 AM	5		_	- 380. 19-						0.00	34.85-	93.33-	- 219. 28-	0.00	ASURED: SUBSCRIBER			Ą	000
	_	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0 0	0	RI BER	AMF677W16293 2023277EN5818 1619608866	CO-PAY		_	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0. 00	KI BER	08866	2023277EN5818	AMF677W16293	
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		10, 873. 00	0. 00	0. 00	0. 00	2, 904. 00		3, 139. 00	0. 00	0.00	0 0	4, 830.00		PLAN TYPE: PPO		DIFFERENCE			16, 273. 00-	0. 00	0. 00	5, 400. 00-	2, 904. 00-	0. 00	3, 139. 00-	0. 00	0. 00	0. 00	4, 830. 00-	PLAN TYPE: PPO				DIFFERENCE AMOUNT
		_		200. 00 1	0.00	2, 904. 00 7	0.00	3, 139. 00 7	0.00	0.00	0		830 00		PATIENT NAME: RECEIVED DATE: EXPL CD:	ERENCE AMOUNT		_	16, 509. 00-	36.00- 164 97	200.00- 164 97	5, 400. 00- 933 252	2, 904. 00- 7	0.00	3, 139. 00-	0. 00	0. 00	0.00	4, 830. 00- 7	DRG RCVD:		RECEIVED DATE:	PATIENT NAME:	AMOUNI
			164 97	164 97		777 119		777 119				//5 9/		D: N/A	GRI + F	ا ر				64 97	64 97	33 252	777 119		777 119				775 97	D: N/A			E: GRIFFITH, JEFFREY	CODE(S)
		20, 831. 00	0.00	0.00	5, 400.00	0.00	2, 904. 00	0.00	3, 139.00	5, 225.00	1, 103.00	1 163 00	0		1H, JEFFREY 10/04/2023	RESPONSIBILITY AMOUNT	INSURED	_	15, 431.00-	0.00	0.00	0.00	0.00	2, 904. 00-	0.00	3, 139. 00-	5, 225.00-	4, 163.00-	0. 00			10/04/2023	JEFFREY	AMOUNT
	_				015 45		015 45 038 1		015 45 038 1	45 038	40 030	ī		-	T CZ	CODE		_						015 45 038 1		015 45 038 1	015 45 038 1	015 45 038 1					FOR IN	CODE(S)
	0.00	0.00	0. 00	0. 00	0.00	0. 00		0. 00	0.00	0.00	0.00				FOR INQUIRIES CALL: (833) 578-4439	WHAT WE WILL PAY	0. 00	0.00	0. 00	0. 00	0.00	0. 00	0. 00	0. 00	0. 00	0. 00	0. 00	0.00	0.00			(833) 578-4439	FOR INQUIRIES CALL:	

TOTAL APPROVED AMOUNT
TOTAL INTEREST
TOTAL NET AMOUNT DUE: BLUE ACCESS PPO

o. o. o. o. o. o.

CHECK/EFT:	CHECK/EFT DT:
9022333351	10/18/23

0. 00													TOTAL NET PAID	
0. 00		_		_								_		INTEREST
0. 00		1.00	15, 481. 00		0.00	0. 00	0.00	0.00	0.00	0.00	15, 481. 00		TOTAL:	
0. 00	243	255	48		0.00	0. 00	0.00	0.00	0.00	0.00	48. 00	15	A4556	07/25/2023 07/25/2023
0. 00	243	255	70		0.00	0. 00	0.00	0.00	0.00	0.00	70. 00	15	A4215	07/25/2023 07/25/2023
0. 00	243	255	3, 600		0.00	0. 00	0.00	0.00	0.00	0.00	3, 600. 00	15	95999	07/25/2023 07/25/2023
0. 00	243	255	3, 107. 00		0.00	0. 00	0.00	0.00	0.00	0.00	3, 107. 00	15	95938	07/25/2023 07/25/2023
0. 00	243	255	4, 516.00		0.00	0. 00	0.00	0.00	0.00	0.00	4, 516. 00	15	95822	07/25/2023 07/25/2023
0. 00	243	255	4, 140. 00		0. 00	0. 00	0.00	0.00	0.00	0. 00	4, 140. 00	15	95940	07/25/2023 07/25/2023
		_												
			Α	RCVD: N/A	IMO DRG RCVD:	PLAN TYPE: HMO		MALE SUBSCRI BER		RELATIONSHIP TO INSURED	REI		NETWORK: OUT OF NETWORK	NETWORK: 0
(833) 434-1219			09/27/2023	EXPL CD:	RECEIVED DATE: EXPL CD:			2023270EK7978 1265737498	12	CLAIM NUMBER SERVICE PROVIDER ID		C	.3083268 CM HEALTHCARE LLC	PATIENT ACCOUNT#: 0.3083268 SERVICE PROVIDER NAME: TCM HEALTHCARE
FOR INQUIRIES CALL:	FOR INQL		MATHI SON, CRAIG		PATIENT NAME:			E7B704M56183		INSURED'S ID			ATHI SON, CRAI G	INSURED'S NAME: MATHI SON, CRAI G
WHAT WE WILL PAY	EXPL/ANSI CODE(S)		EXPL/ANSI RESPONSIBILITY CODE(S) AMOUNT		PROVIDER RES	CO-INSURANCE CONTRACTUAL PROVIDER RESP. AMOUNT	CO-INSURANC	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
													1	PATHWAY X HMO
0. 00							JE: IN HSA	TOTAL NET AMOUNT DUE:	TOTAL NET AMOU					
0 0 00							ΝT	TOTAL APPROVED AMOUNT	TOTAL AP					
0. 00													TOTAL NET PAID	
0. 00		_	_	_							_	_		INTEREST
0. 00		6.00	27, 226. 00		4, 427.00	0. 00	0.00	0.00	1, 943. 93	1, 943. 93	31, 653. 00		TOTAL:	
0. 00		0.00		164 97	48.00	0. 00	0.00	0.00	0.00	0.00	48. 00	15	A4556	
0. 00				164 97	200.00	0. 00	0.00	0.00	0.00	0.00	200.00	15	A4215	
0. 00	1 015 45	400.00 038 1	5, 40		0.00	0. 00	0. 00	0.00	210. 24	210. 24	5, 400. 00	15		
0. 00				777 119	1, 779.00	0. 00	0.00	0.00	0.00	0.00	1, 779. 00	15	95868 , XU	
0. 00	1 015 45	038	1, 779		0.00	0. 00	0.00	0.00	87.59	87. 59	1, 779. 00	15	-	
0. 00				777 119	2, 400.00	0. 00	0.00	0.00	0.00	0.00	2, 400. 00	15	95861 , XU	
0. 00			2, 400.00		0.00	0. 00	0.00	0.00	90. 21	90. 21	2, 400. 00	15	95861	06/09/2023 06/09/2023
0. 00		038	3, 107. 00		0.00	0.00	0. 00	0.00	356. 36	356. 36	3, 107. 00	15	95938	06/09/2023 06/09/2023
0. 00			4, 516. 00		0. 00	0. 00	0. 00	0.00	401.47	401.47	4, 516. 00	15	95822	06/09/2023 06/09/2023
0. 00	1 015 45		3, 814. 00		0.00	0. 00	0.00	0.00	479.37	479. 37	3, 814. 00	15	95939	06/09/2023 06/09/2023
0.00	1 015 45	0.00 038	6, 210. 00		0. 00	0. 00	0.00	0.00	318. 69	318. 69	6. 210. 00	15	95940	06/09/2023 06/09/2023

IN HSA

INSURED'S NAME: ENGIBOUS, CHRI STOPHER M
PATIENT ACCOUNT#: 0.3034840
SERVICE PROVIDER NAME: TCM HEALTHCARE LLC

INSURED'S ID:
CLAIM NUMBER:
SERVICE PROVIDER ID:
RELATIONSHIP TO INSURED:

X6B961W10823 2023258DI 2066 1891424503 SUBSCRI BER

PLAN TYPE: PPO

DRG RCVD: N/A

PATIENT NAME: RECEIVED DATE: EXPL CD:

NETWORK: OUT OF NETWORK

SERVICE DATE(S)

SERVICE CODES

Pos

CHARGE

ALLOWED

DEDUCTIBLE

CO-PAY

CO-INSURANCE CONTRACTUAL PROVIDER RESP.
AMOUNT

EXPL/ANSI CODE(S)

INSURED RESPONSIBILITY AMOUNT

EXPL/ANSI CODE(S)

WHAT WE WILL PAY

FOR INQUIRIES CALL:

(844) 441-1463

ENGI BOUS, CHRI STOPHER M

09/15/2023

Anthem. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a TOM HEALTHCARE LLC registered trademark of Anthem Insurance Companies, Inc.
PROVIDER ID NO: 853

PROVIDER ID NO: 853229794 CHECK/EFT DT:

CHECK/EFT: 9022333351 10/18/23

PATHWAY X HMO

TOTAL INTEREST TOTAL APPROVED AMOUNT

o. o. o. o. o. o.

000 888

GROSS APPROVED CLAIM AMOUNT TOTAL NET AMOUNT DUE: PATHWAY X HMO

TOTAL INTEREST

EXPL CODES 775 **EXPLANATION** NET AMOUNT DUE

015 777 038 THIS AMOUNT IF THEY CHOSE TO RECEIVE CARE FROM A DOCTOR/FACILITY NOT IN THEIR PLAN'S THEREFORE, THE MEMBER'S PLAN DOESN'T PAY FOR IT. THE MEMBER MIGHT BE RESPONSIBLE FOR THE DOCTOR/FACILITY BILLED FOR THIS CARE MORE TIMES THAN OUR GUIDELINES ALLOW. access Eligibility and Benefits Inquiry. The member is responsible for the unpaid to check a member's benefits, from Availity.com use the Patient Registration tab to This amount was applied to the member's deductible. For the quickest and easiest way or was not authorized. paid. The remaining balance can be billed to the member only if it was non-emergent This was processed, and as an out of network provider, the maximum amount has been unless they chose to receive care from a doctor or facility not in their plan's medical procedure. As a reminder, the member is not responsible for the balance policies, located on our public website, for additional information about this This was denied because it was covered as part of another service. Review our medical

send the requested documentation. to submit the requested documentation, from Availity.com use the Claims & Payments tab to access Claim Status. Find this claim and use the Send Attachments button to be made based upon the information available to us. For the quickest and easiest way the claim. If the requested information is not provided, a benefit determination will This was denied because we have not received the requested medical records to process NETWORK

unless they chose to receive care from a doctor or facility not in their plan's medical procedure. As a reminder, the member is not responsible for the balance policies, located on our public website, for additional information about this This was denied because it was covered as part of another service. Review our medical

YOUR BENEFITS DON'T COVER CARE YOU GET FROM DOCTORS AND FACILITIES THAT AREN'T IN

POLICY IDENTIFICATION SEGMENT, IF PRESENT. PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/

45

97

255

164

933

DEDUCTI BLE AMOUNT THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGI SLATED FEE ARRANGEMENT.

119 252 243

TCM HEALTHCARE LLC
PROVIDER ID NO: 853229794

CHECK/EFT DT: CHECK/EFT:

10/18/23 9022333351

BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.
SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.

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RECOUPMENT NOTIFICATION

CHECK AMT:	DATE:	NEG BAL REF #:	PAYEE ID:	PROVIDER:	
0.00	10/18/23		853229794	TCM HEALTHCARE LLC	

THIS IS A DETAILED NOTIFICATION OF THE RECOUPMENT PROCESSED BY ANTHEM FOR OVERPAYMENTS MADE TO YOUR ACCOUNT AS INDICATED ON THE ENCLOSED REMITTANCE ADVICE.

THE 'NEGATIVE BALANCE DEFERRED' SECTION SHOWS DEFERRED (FUTURE) RECOUPMENTS WHERE REFUNDS ARE DUE. THESE ARE NOT REFLECTED ON THIS REMITTANCE ADVICE. A SEPERATE LETTER HAS BEEN SENT WITH FURTHER DETAILS AND OVERPAYMENT RECOVERY WILL COMMEMCE FOLLOWING EXISTING PROCESSES IF A REFUND IS NOT RECEIVED. IF YOU HAVE QUESTIONS REGARDING A RECOUPMENT, PLEASE CONTACT PROVIDER SERVICE AT NUMBER NOTED ON REMITTANCE ADVICE. THE "ORIGINAL NEGATIVE CLAIM NUMBER" COLUMN CONTAINS THE ORIGINAL CLAIM ID THAT CREATED THE NEGATIVE BALANCE. THE CORRESPONDING PRIOR AND CURRENT RECOUPMENT SECTIONS BELOW SHOW THE RECOUPMENT DETAILS FOR EACH ORIGINAL NEGATIVE CLAIM LISTED IN THE NEGATIVE BALANCE HISTORY.

DATE DATANCE LISTORY.	PATIENT ACCT	SUBSCRIBER ID	CLAIM NUMBER/ REFUND ID	DATE OF SERVICE	CLAIM NUMBER/ DATE OF ORIGINAL NEGATIVE REFUND ID SERVICE CLAIM NUMBER	CLAIM AMOUNT	CREDITS ADJICD CHARGE RECOVERED AMT	ADJ CD	CHARGE AMT	RECOVERY LETTER ID	
NEGATI VE BALANCE HI STORY:											

PRI OR RECOUPMENT:

CURRENT RECOUPMENT:

DATE				REFUND ID	SERVICE	SERVICE CLAIM NUMBER	RECOUP DATE	AMT	LETTER ID
REMIT.	PATIENT NAME	PATIENT ACCT	SUBSCRIBER ID	CLAIM NUMBER/ DATE OF ORIGINAL NEGATIVE	DATE OF	m	CLAIM AMOUNT EXPECTED ADJ CD	CHARGE RECOVER	RECOVERY

NEGATI VE BALANCE DEFERRED:

	10/17/23 KRATZ
	MI CHAEL
	MI CHAEL 0. 2913388
TOTAL NEGATI VE BALANCE DEFERRED	406M68935
ALANCE DEFERRED	2023117DY334498 03/01/23 2023117DY334498
1, 599.09-	1, 599. 09- 12/31/99
	22, 847. 00 15524688

RECOUPMENT NOTIFICATION

PAGE

TOTAL PRI OR RECOUPMENT
TOTAL CURRENT RECOUPMENT
TOTAL OUTSTANDI NG NEGATI VE BAL
TOTAL DEFERRED
OUTSTANDI NG NEGBAL WI TH DI FER

0.00 0.00 0.00 1,599.09-1,599.09-