aetna®

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Summary of Claim Payment

Please Retain for Future Reference

Printed: 10/07/2023
Page: 1 of 22

Monitoring Associates LLC
TIN: XXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Notes: Enclosed is a group payment to the XXXXXXX2508. Below is a itemization of the check. Please refer to the attached statements of details.

Breakdown of Payment(s) Issued:

NAME	PIN	ISSUED AMT
Kevin S Mochizuki	0005579791	$220.58
Audrey R Nath	0006483171	$633.34
Maria A De Jesus	0007051585	$0.00
Matthew B McAuliffe	0007066969	$711.07

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P.O. BOX 981106
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ID No: XXXXXXX2508
Seq No: 000000004

Trace No: 901003734
Acct: 09146
51 - 44
119 CT

10-07-2023

NON-NEGOTIABLE NON-NEGOTIABLE

VOID AFTER ONE YEAR

PAY ***Four Thousand One Hundred Eleven Dollars and 53/100*** ******$4,111.53**

TO THE ORDER OF

MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Bank of America

VOID VOID

766 (10-02)

Payment was made via Electronic Funds Transfer

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Summary of Claim Payment

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Printed: 10/07/2023
Page: 2 of 22

Monitoring Associates LLC
TIN: XXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

NAME	PIN	ISSUED AMT
George P Thomas	0009038504	$942.46
Jonathan D Burns	0009730214	$1,604.08
TOTAL ISSUED AMOUNT		$4,111.53

TOTAL TRACE AMOUNT:	**$4,111.53**

Explanation Of Benefits

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USA

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Printed: 10/07/2023
Page: 3 of 22

Kevin S Mochizuki
PIN: 0005579791
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Kevin S Mochizuki
PO Box 29650
Phoenix AZ 85038

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: CONSTANCE M SAVOIE (self)

Claim ID: **E3TX6VQ9K03** Recd: **10/03/23** Member ID: **101453570400** Patient Account: **0.2820012**
Member: **CONSTANCE M SAVOIE** DIAG: **M54.16**
Group Name: **Aetna Medicare Explorer Plan (PPO)** Group Number: **000003-RI00 0001**
Product: **PPO - Medicare (Aetna)**
Contract State: **RI** Funding: **Insured**
First Health Life & Health 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
12/09/22	22	9593826	1.0	3,107.00			0.57	1		18.94	18.94	27.83
							3,059.66	2				
12/09/22	22	9595526	1.0	1,755.00			0.67	1		22.22	22.22	32.65
							1,699.46	2				
12/09/22	22	9590926	1.0	1,755.00			1.00	1		33.18	33.18	48.76
							1,672.06	2				
12/09/22	22	9588626	2.0	2,972.00			1.14	1		37.87	37.87	55.67
							2,877.32	2				
12/09/22	22	9588626	2.0	2,972.00			1.14	1		37.87	37.87	55.67
		XU					2,877.32	2				
12/09/22	22	95999		5,400.00			5,400.00	3				0.00
TOTALS				**17,961.00**			**17,590.34**			**150.08**	**150.08**	**220.58**

ISSUED AMT: $220.58

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

Continued on Next Page

P.O. BOX 981106
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Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/07/2023
Page: 4 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Kevin S Mochizuki
PIN: 0005579791
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: CONSTANCE M SAVOIE (self)

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$150.08
Claim Payment:	$220.58

Total Payment to: Kevin S Mochizuki ***$220.58***

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

Explanation Of Benefits

Please Retain for Future Reference

P.O. BOX 981106
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USA

Printed: 10/07/2023
Page: 5 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Audrey R Nath
PO Box 29650
Phoenix AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

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Patient Name: LINDA J Mcdonald *(self)*

Claim ID: **EWFC6V6TH02** Recd: **09/28/23** Member ID: **101132040700** Patient Account: **0.3013427**
Member: **LINDA J Mcdonald** DIAG: **M43.16, M48.062**
Group Name: **Aetna Medicare Freedom Plan (PPO)** Group Number: **000003-TX00 0047**
Product: **PPO - Medicare (Aetna)**
Contract State: **TX** Funding: **Insured**
CVS - Silver Script 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
05/23/23	21	9582226	1.0	1,755.00			0.55	1		27.50	27.50	29.66
							1,699.99	2				
								3				
05/23/23	21	9593826	1.0	3,107.00			0.44	1		21.84	21.84	21.41
							3,063.31	3				
05/23/23	21	9590926	1.0	555.00			0.77	1		38.26	38.26	37.49
							478.48	3				
05/23/23	21	9588626	2.0	2,972.00			0.88	1		44.01	44.01	43.13
							2,883.98	3				
05/23/23	21	9588626	2.0	2,972.00			0.88	1		44.01	44.01	43.13
		XU					2,883.98	3				
05/23/23	21	95999		7,200.00			7,200.00	4				0.00
TOTALS				**18,561.00**			**18,213.26**			**175.62**	**175.62**	**174.82**

ISSUED AMT: $174.82

Remarks:

1 - *This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]*
2 - *The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]*
3 - *Payment made according to Medicare allowable rate. [P49]*
4 - *We need more details to complete our review. Please send us:*

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process,

Continued on Next Page

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Explanation Of Benefits

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Printed: 10/07/2023
Page: 6 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: LINDA J Mcdonald (self)

Remarks (contd):

you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$175.62
Claim Payment:	$174.82

Patient Name: Donald K Moretti (self)

Claim ID: **E1TX6YFH403** Recd: **10/02/23** Member ID: **101384016800** Patient Account: **0.2814351**
Member: **Donald K Moretti** DIAG: **M48.062**
Group Name: **Medicare (C04) ESA PPO** Group Number: **200-EGS0000 0177**
Product: **ESA - Medicare (Aetna)**
Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/06/22	22	9593926	1.0	3,814.00			2.38	1				116.84
							3,694.78	2				
12/06/22	22	9593826	1.0	3,107.00			0.91	1				44.81
							3,061.28	2				
12/06/22	22	9590826	1.0	437.00			1.33	1				65.21
							370.46	2				
12/06/22	22	9595526	1.0	1,755.00			1.07	1				52.44
							1,701.49	2				
12/06/22	22	9588626	2.0	2,972.00			1.83	1				89.61
		XU					2,880.56	2				
12/06/22	22	9588626	2.0	2,972.00			1.83	1				89.61
							2,880.56	2				
12/06/22	22	95999		9,000.00			9,000.00	3				0.00
TOTALS				**24,057.00**			**23,598.48**					**458.52**

ISSUED AMT: $458.52

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]
2 - Payment made according to Medicare allowable rate. [P49]
3 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies

Continued on Next Page

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Printed: 10/07/2023
Page: 7 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: Donald K Moretti (self)

Remarks (contd):

3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$458.52

[redacted] Total Payment to: Audrey R Nath ***$633.34***

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

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- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

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Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

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USA

Printed: 10/07/2023
Page: 8 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Maria A De Jesus
PO Box 29650
Phoenix AZ 85038

Maria A De Jesus
PIN: 0007051585
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

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Patient Name: CHERIE A NAZZAL (self)

Claim ID: **EDPC8C64204** Recd: **10/02/23** Member ID: **101138031500** Patient Account: **0.2850084**
Member: **CHERIE A NAZZAL** DIAG: **M41.85**
Group Name: **Aetna Medicare Choice Plan (PPO)** Group Number: **000003-TX00 0008**
Product: **PPO - Medicare (Aetna)**
Contract State: **TX** Funding: **Insured**
Aetna Health and 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
01/05/23	21	9593926	1.0	3,814.00			2.28	1				111.95
							3,699.77	2				
01/05/23	21	9593826	1.0	3,107.00			0.87	1				42.82
							3,063.31	2				
01/05/23	21	9595526	1.0	1,755.00			1.03	1				50.32
							1,703.65	2				
01/05/23	21	9586126	1.0	1,614.00			1.57	1				76.88
							1,535.55	2				
01/05/23	21	9586126	1.0	1,614.00			1.57	1				76.88
		XU					1,535.55	2				
01/05/23	21	95999		1,800.00			1,800.00	3				0.00
TOTALS				**13,704.00**			**13,345.15**					**358.85**

Less Amount Already Paid $358.85

ISSUED AMT: NO PAY

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
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3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

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Continued on Next Page

P.O. BOX 981106
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Explanation Of Benefits

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Printed: 10/07/2023
Page: 9 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Maria A De Jesus
PIN: 0007051585
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: CHERIE A NAZZAL (self)

Remarks (contd):
to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$0.00

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- A signed waiver of liability form http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

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Fax: 860-900-7995

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USA

Printed: 10/07/2023
Page: 10 of 22

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Matthew B McAuliffe
PO Box 29650
Phoenix AZ 85038

Medical providers: sign up before it's your turn

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Patient Name: Charlene H Kelly (self)

Claim ID: **E7JM6ZML703** Recd: **10/04/23** Member ID: **101133142500** Patient Account: **0.2829727**
Member: **Charlene H Kelly** DIAG: **M48.02, M48.061**
Group Name: **Aetna Medicare Platinum Plan (PPO)** Group Number: **000003-AZ00 0026**
Product: **PPO - Medicare (Aetna)**
Contract State: **AZ** Funding: **Insured**
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
12/16/22	22	9593926	1.0	3,814.00			1.41	1		47.08	47.08	69.20
							3,696.31	2				
12/16/22	22	9593826	1.0	3,107.00			0.54	1		18.04	18.04	26.52
							3,061.90	2				
12/16/22	22	9595526	1.0	1,755.00			0.64	1		21.17	21.17	31.11
							1,702.08	2				
12/16/22	22	9586126	1.0	1,614.00			0.97	1		32.40	32.40	47.64
							1,532.99	2				
12/16/22	22	9586126	1.0	1,614.00			0.97	1		32.40	32.40	47.64
		XU					1,532.99	2				
12/16/22	22	9586826		1,310.00			1,310.00	3				0.00
12/16/22	22	9586826	1.0	1,310.00			0.74	1		24.82	24.82	36.50
		XU					1,247.94	2				
12/16/22	22	95999		7,200.00			7,200.00	4				0.00
TOTALS				**21,724.00**			**21,289.48**			**175.91**	**175.91**	**258.61**

ISSUED AMT: $258.61

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - Procedures designated as bilateral should not be billed with multiple units. Payment has been based on one unit. [DXT]

4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name,

Continued on Next Page

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/07/2023
Page: 11 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: Charlene H Kelly (self)

Remarks (contd):

patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $175.91
Claim Payment: $258.61

Patient Name: KAREN A YOUNG (self)

Claim ID: **E1JM6X8R705** Recd: **10/02/23** Member ID: **101520183600** Patient Account: **0.2813445**
Member: **KAREN A YOUNG** DIAG: **M48.02**
Group Name: **Aetna Medicare Eagle Plan (PPO)** Group Number: **000003-CS00 0032**
Product: **PPO - Medicare - MA (Aetna)**
Contract State: **UT** Funding: **Insured**
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
12/06/22	21	9593926	1.0	3,814.00			2.33	1				113.92
							3,697.75	2				
12/06/22	21	9593826	1.0	3,107.00			0.89	1				43.65
							3,062.46	2				
12/06/22	21	9595526	1.0	1,755.00			1.05	1				56.35
							1,702.72	3				
								2				
12/06/22	21	9586126	1.0	1,614.00			1.60	1				86.23
							1,534.01	3				
								2				
12/06/22	21	9586126	1.0	1,614.00			1.60	1				86.23
		XU					1,534.01	3				
								2				
12/06/22	21	9586826		1,310.00			1,310.00	4				0.00
12/06/22	21	9586826	1.0	1,310.00			1.23	1				66.08
		XU					1,248.70	3				
								2				
12/06/22	21	95999		5,400.00			5,400.00	5				0.00
TOTALS				**19,924.00**			**19,498.35**					**452.46**

ISSUED AMT: $452.46

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the

Continued on Next Page

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Explanation Of Benefits

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Printed: 10/07/2023
Page: 12 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: KAREN A YOUNG (self)

Remarks (contd):

sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]

4 - Procedures designated as bilateral should not be billed with multiple units. Payment has been based on one unit. [DXT]

5 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$452.46

Total Payment to: Matthew B McAuliffe ***$711.07***

Continued on Next Page

P.O. BOX 981106
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Explanation Of Benefits

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Printed: 10/07/2023
Page: 13 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

P.O. BOX 981106
EL PASO TX 79998-1106
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Explanation Of Benefits

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Printed: 10/07/2023
Page: 14 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
George P Thomas
PO Box 29650
Phoenix AZ 85038

George P Thomas
PIN: 0009038504
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

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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: Henry I Ker JR (self)

Claim ID: **EGTX8JNXS02** Recd: **10/03/23** Member ID: **101073484600** Patient Account: **0.2801318**
Member: **Henry I Ker JR** DIAG: **I65.1**
Group Name: **Aetna Medicare Dual Preferred Plan (HMO D-SNP)** Group Number: **000003-LA00 0006**
Product: **VBID DSNP Direct Access HMO - Medicare (Aetna)**
Contract State: **LA** Funding: **Insured**
Aetna Better Health, Inc. - Louisiana 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
11/25/22	22	9593826	1.0	1,800.00			0.74	1		9.22	9.22	36.16
							1,753.88	2				
								3				
								4				
11/25/22	22	9595526	1.0	1,755.00			0.86	1		10.79	10.79	42.30
							1,701.05	2				
								3				
								4				
11/25/22	22	95999	2.0	3,600.00			2,520.00	3		216.00	216.00	864.00
								5				
TOTALS				**7,155.00**			**5,976.53**			**236.01**	**236.01**	**942.46**

ISSUED AMT: $942.46

Remarks:

1 - *This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]*
2 - *We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]*
3 - *You cannot collect the coinsurance amount since the patient is a Medicaid / Qualified Medicare Beneficiary. Review your records to ensure you didn't collect the coinsurance from the patient. [BZI]*
4 - *Payment made according to Medicare allowable rate. [P49]*
5 - *This charge is paid at a percentage of billed, according to the default value on the Aetna Fee Schedule. Pharmacy J drug codes will still be at 60%. [PH5]*

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $236.01
Claim Payment: $942.46

Continued on Next Page

P.O. BOX 981106
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USA

Explanation Of Benefits

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Printed: 10/07/2023
Page: 15 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

George P Thomas
PIN: 0009038504
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: DARLENE G KWARTA (self)

Claim ID: **EAJM8KVVH00** Recd: **10/05/23** Member ID: **101635775200** Patient Account: **0.2898847**
Member: **DARLENE G KWARTA** DIAG: **M40.203**
Group Name: **Medicare (C05) ESA PPO** Group Number: **200-EGS0000 0698**
Product: **ESA - Medicare (Aetna)**
Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
02/17/23	21	9593926		3,814.00			3,814.00	1				0.00
								2				
02/17/23	21	9593826		3,107.00			3,107.00	1				0.00
								2				
02/17/23	21	9595526		1,755.00			1,755.00	1				0.00
								2				
02/17/23	21	9586126		1,614.00			1,614.00	1				0.00
								2				
02/17/23	21	9586126		1,614.00			1,614.00	1				0.00
		XU						2				
02/17/23	21	9586826		1,310.00			1,310.00	1				0.00
								2				
02/17/23	21	9586826		1,310.00			1,310.00	1				0.00
		XU						2				
02/17/23	21	95999		7,200.00			7,200.00	2				0.00
TOTALS				**21,724.00**			**21,724.00**					**0.00**

ISSUED AMT: **NO PAY**

Remarks:
1 - We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]
2 - The member is not responsible for this charge, because the claim was not filed within the required time limit. U19

For Questions Regarding This Claim
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USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $0.00

Total Payment to: George P Thomas ***$942.46***

Continued on Next Page

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Explanation Of Benefits

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Printed: 10/07/2023
Page: 16 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

George P Thomas
PIN: 0009038504
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

Explanation Of Benefits

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Printed: 10/07/2023
Page: 17 of 22

Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Jonathan D Burns
PO Box 29650
Phoenix AZ 85038

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: SCOTT J CORNETT (self)

Claim ID: **ELFC8JL7W03** Recd: **10/03/23** Member ID: **101549918600** Patient Account: **0.3069470**
Member: **SCOTT J CORNETT** DIAG: **M43.16**
Group Name: **Aetna Medicare Value Plan (PPO)** Group Number: **000003-TX00 0020**
Product: **PPO - Medicare (Aetna)**
Contract State: **TX** Funding: **Insured**
Aetna Health and 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
07/12/23	22	9593826	1.0	3,107.00			0.46	1		22.92	22.92	22.46
							3,061.16	2				
07/12/23	22	9595526	1.0	1,755.00			0.54	1		26.89	26.89	26.36
							1,701.21	2				
07/12/23	22	9590826	1.0	437.00			0.67	1		33.29	33.29	32.63
							370.41	2				
07/12/23	22	9588626	2.0	5,944.00			0.92	1		46.18	46.18	45.26
							5,851.64	2				
07/12/23	22	9588626	2.0	5,944.00			0.92	1		46.18	46.18	45.26
		XU					5,851.64	2				
07/12/23	22	95999		7,200.00			7,200.00	3				0.00
TOTALS				**24,387.00**			**24,039.57**			**175.46**	**175.46**	**171.97**

ISSUED AMT: $171.97

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

Continued on Next Page

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Explanation Of Benefits

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Printed: 10/07/2023
Page: 18 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: SCOTT J CORNETT (self)

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $175.46
Claim Payment: $171.97

Patient Name: Stephen D Gill (self)

Claim ID: **ER588J6MR03** Recd: **10/04/23** Member ID: **101303082500** Patient Account: **0.2828910**
Member: **Stephen D Gill** DIAG: **M43.16**
Group Name: **Aetna Medicare Select Plan (PPO)** Group Number: **000003-NV00 0014**
Product: **PPO - Medicare (Aetna)**
Contract State: **NV** Funding: **Insured**
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
12/15/22	22	9593926	1.0	3,814.00			1.46	1		48.68	48.68	71.55
							3,692.31	2				
12/15/22	22	9593826	1.0	3,107.00			0.56	1		18.66	18.66	27.44
							3,060.34	2				
12/15/22	22	9595526	1.0	1,755.00			0.66	1		21.86	21.86	35.34
		XU					1,700.35	3				
								2				
12/15/22	22	5178526	1.0	2,799.00			1.21	1		40.18	40.18	64.97
							2,698.55	3				
								2				
12/15/22	22	5178526	1.0	2,799.00			0.60	1		20.09	20.09	32.49
		XU					2,748.77	3				
								2				
12/15/22	22	9586126	1.0	1,614.00			1.01	1		33.58	33.58	54.30
		XU					1,530.05	3				
								2				
12/15/22	22	9586126	1.0	1,614.00			1.01	1		33.58	33.58	54.30
		XU					1,530.05	3				
								2				
12/15/22	22	95999		7,200.00			7,200.00	4				0.00
TOTALS				**24,702.00**			**24,166.93**			**216.63**	**216.63**	**340.39**

ISSUED AMT: $340.39

Remarks:
1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]
2 - Payment made according to Medicare allowable rate. [P49]
3 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional

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Explanation Of Benefits

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Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Patient Name: Stephen D Gill (self)

Remarks (contd):
Shortage Areas (HPSA) bonus program. [MI7]
4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$216.63
Claim Payment:	$340.39

Patient Name: SHARON L GLICKMAN (self)

Claim ID: **EG368DGYZ03** Recd: **10/02/23** Member ID: **101195678700** Patient Account: **0.2812997**
Member: **SHARON L GLICKMAN** DIAG: **M51.27**
Group Name: **Aetna Medicare Prime Plan (HMO-POS)** Group Number: **000003-NV00 0010**
Product: **Direct Access POS - Medicare (Aetna)**
Contract State: **NV** Funding: **Insured**
Coventry Health Care of Nebraska, Inc. 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
12/05/22	21	9593826	1.0	3,107.00			0.93	1				45.73
							3,060.34	2				
12/05/22	21	9595526	1.0	1,755.00			1.09	1				58.92
							1,700.35	3				
								2				
12/05/22	21	9586126	1.0	1,614.00			1.68	1				90.50
							1,530.05	3				
								2				
12/05/22	21	9586126 XU	1.0	1,614.00			1.68	1				90.50
							1,530.05	3				
								2				
12/05/22	21	95999		5,400.00			5,400.00	4				0.00
TOTALS				**13,490.00**			**13,226.17**					**285.65**

Continued on Next Page

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Explanation Of Benefits

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Printed: 10/07/2023
Page: 20 of 22

Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Patient Name: SHARON L GLICKMAN (self)

ISSUED AMT: $285.65

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]

4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $285.65

Patient Name: REBECCA R ROBERTS-PRESLEY (self)

Claim ID: **EFPC8HZF303** Recd: **10/02/23** Member ID: **101474350900** Patient Account: **0.2814828**
Member: **REBECCA R ROBERTS-PRESLEY** DIAG: **M54.50**
Group Name: **Aetna Medicare Elite Plan (PPO)** Group Number: **000003-AZ00 0027**
Product: **PPO - Medicare (Aetna)**
Contract State: **AZ** Funding: **Insured**
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
12/06/22	21	9593926	1.0	3,814.00			2.43	1				119.26
							3,692.31	2				
12/06/22	21	9593826	1.0	3,107.00			0.93	1				45.73
							3,060.34	2				
12/06/22	21	9595526	1.0	1,755.00			1.09	1				58.92
		XU					1,700.35	3				

Continued on Next Page

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Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/07/2023
Page: 21 of 22

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Patient Name: REBECCA R ROBERTS-PRESLEY (self)

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
								2				
12/06/22	21	9591026	1.0	780.00			2.18	1				106.88
		XU					670.94	2				
12/06/22	21	5178526	1.0	2,799.00			2.01	1				108.28
							2,698.55	3				
								2				
12/06/22	21	5178526	1.0	2,799.00			2.01	1				108.28
		XU					2,698.55	3				
								2				
12/06/22	21	9588626	2.0	2,972.00			1.87	1				91.45
							2,878.68	2				
12/06/22	21	9588626	2.0	2,972.00			1.87	1				91.45
		XU					2,878.68	2				
12/06/22	21	9588726	1.0	583.00			0.77	1				37.91
		XU					544.32	2				
12/06/22	21	9588726	1.0	583.00			0.77	1				37.91
		XU					544.32	2				
12/06/22	21	95999		9,000.00			9,000.00	4				0.00
TOTALS				**31,164.00**			**30,382.97**					**806.07**

ISSUED AMT: $806.07

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]

4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
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3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

Continued on Next Page

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Printed: 10/07/2023
Page: 22 of 22

Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882327901003734
Trace Amount: $4,111.53

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Patient Name: REBECCA R ROBERTS-PRESLEY (self)

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$806.07

Total Payment to: Jonathan D Burns ***$1,604.08***

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

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.