

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

1017AI 030107-025146

3299777138

PROVIDER ID NO

000001048740

TAX ID NO XXXXX2508

DATE 10/17/23

Haladdlaaddaladdaladdaladdlaaddlaadd #BWNCQXF

#591999998740/DF1# MONITORING ASSOCIATES LLC PO BOX 29650 DEPT 880256 PHOENIX AZ 85038-9650

PAY EXACTLY *****1138 DOLLARS AND 30 CENTS

DEPOSITED TO:

ABA # ACC # EFT # 124001545 XXXXX7975 3223771844 ON 10/18/23

ACH DEPOSIT MADE - THIS IS NOT A CHECK

ANTHEM INSURANCE COMPANIES, INC.

1222 S PATTERSON BLVD DAYTON, OH 45402

ANTHEM. COM

DATE 10/17/23

PROVIDER NAME MONITORING ASSOCIATES LLC PO BOX 29650 DEPT 880256 ADDRESS

PHOENI X AZ 85038-9650

000001048740 PROVIDER-NPI IDS - 1174916522 XXXXX2508

TAX ID NO

CHECK NUMBER

PAYMENT SUMMARY

GROSS APPROVED CLAIM AMOUNT	1, 138. 30	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	1, 138. 30
NET AMOUNT DUE	1, 138. 30	□ 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.

PAYEE ENDORSEMENT ACKNOWLEDGEMENT: "I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION , OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. " (42 CFR 455.19)

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

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

® Registered Marks Blue Cross and Blue Shield Association

INDIANA HIP 2.0

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 MONI TORI NG ASSOCIATES LLC registered trademark of Anthem Insurance Companies, Inc.
PROVI DER ID NO: 000001048740

CHECK/EFT DT: CHECK/EFT:

10/17/23

0. 00												TOTAL NET PAID	
0 0 0				13, 490.00						13, 490. 00	_	i i	INTEREST
0 0		0 0	234 226	100.00		9 9	0.00	0 0	0 0	13 480 00	22	75799 TOTAL:	10/02/2023 10/02/2023
0.00		0.00			9 9	9 5	0.00	0.00	0.00	7, 014: 00	2 2	9586126, XU	
0.00		0.00			0 0	9 0	0.00	0.00	0.00	1, 614. 00	22 22		
0. 00		0.00			0. 00	0.00	0.00	0.00	0. 00	1, 755. 00	22	9595526	
0. 00		0.00			0. 00	0.00	0.00	0. 00	0. 00	3, 107. 00	22	9593826	
											_		
					PLAN TYPE			SURED:	RELATIONSHIP TO INSURED			OUT OF NETWORK	NETWORK: (
			·	EXPLCD	! : ! !		98423	DER ID: 1912298423	SERVICE PROVIDER ID	• •		THOMAS, GEORGE P.	
FOR INQUIRIES CALL: (844) 533-1995	FOR INC	Y, AARON 10/11/2023	LI NDSE	PATIENT NAME: RECEIVED DATE:			YRK120612747299 255995323700		INSURED'S ID CLAIM NUMBER			LI NDSEY, AARON P107249	
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	OVIDER RESP.	CONTRACTUAL PROVIDER RESP	CO-INSURANCE CON	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
0. 00												TOTAL NET PAID	
0. 00		_		_	_	_	_	_	_	_	_		INTEREST
0. 00		0. 00			0. 00	0.00	0. 00	0.00	0.00	18, 443. 00		TOTAL:	
0 0		0.00	Z33 226	7, 200. 00 Z	0.00	0.00	0.00	0.00	0.00	7, 200. 00	22	95999	01/13/2023 01/13/2023
9 9		9 9		972.00	9 9	9 9	0 .	9 9	0 0	2, 772, 00	2 1		01/13/2023 01/13/2023
0 0		0 0 00	733 226	437.00	o c 8 6	0 0	0.00	0 0	0.00	2 972 00	2 2 2	9590826	01/13/2023 01/13/2023
0.00		0.00			0. 00	0.00	0.00	0.00	0. 00	1, 755. 00	22	9595526	01/13/2023 01/13/2023
0. 00		0.00			0. 00	0.00	0.00	0.00	0.00	3, 107. 00	22	9593826	01/13/2023 01/13/2023
				_							_		
			<u>.</u>	EXPLCD	PLAN TYPE:		98423	SURED: 1912298423	RELATIONSHIP TO INSURED	REL		NETWORK: OUT OF NETWORK	NETWORK:
(844) 533-1995		10/10/2023	-	RECEIVED DATE:			255910674800		CLAIM NUMBER		3	36	
HIBIES CALL:	EOR IND	T DOB! M		PATIENT NAME			5606222100		INCLIBE		S	I EONO-DITT DODI	
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	OVIDER RESP.	CONTRACTUAL PROVIDER RESP	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
0. 00				-	-			_		-	-	TOTAL NET PAID	
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0 9		0 0	233 220	18 561 00	0 5	0 9	0.00	0.00	0.00	18 561 00	_	TOTAL:	01/11/2023 01/11/2023
o c.		0 0				9 5	0.00	0 0	0.00	2, 9/2, 00	2 2	9588626, XU	01/11/2023 01/11/2023
0.00		0.00		972.00	0. 00	0.00	0.00	0.00	0.00	2, 972. 00	21		01/11/2023 01/11/2023
0. 00		0.00			0. 00	0.00	0.00	0.00	0.00	555. 00	21	9590926	01/11/2023 01/11/2023
0. 00		0.00	Z33 226	1, 755. 00 Z:	0. 00	0.00	0.00	0. 00	0. 00	1, 755. 00	21	9595526	01/11/2023 01/11/2023
0. 00		0. 00			0. 00	0.00	0.00	0.00	0.00	3, 107. 00	21	9593826	01/11/2023 01/11/2023
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			<u>, , , , , , , , , , , , , , , , , , , </u>	EXPLOD	PLAN TYPE:		10536/9019		SERVICE PROVIDER ID	REL		NETWORK: OUT OF NETWORK	SERVICE PROVIDER NAME: NETWORK: (
FOR INQUIRIES CALL: (844) 533-1995	FOR INC	M,UDELL L 10/10/2023	MARKHA	PATIENT NAME: RECEIVED DATE:			YRK102176102699 255899291300		INSURED'S ID			MARKHAM, UDELL L 0.2855650	
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	AMOUNT	CONTRACTUAL PROVIDER RESP. DIFFERENCE AMOUNT	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos.	SERVICE CODES	SERVICE DATE(S)
	!	INSURED		1	2) 	

10/17/23

INDIANA HIP 2.0

TOTAL APPROVED AMOUNT
TOTAL INTEREST
TOTAL NET AMOUNT DUE: INDIANA HIP 2.0

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0. 00											TOTAL NET PAID	
0.00	_		_			_		_		_		INTEREST
0.00	0.00		24, 728.00	0. 00	0.00	0.00	0.00	0.00	24, 728. 00		TOTAL:	
0. 00	0.00	226	7, 200. 00 Z33	0. 00	0.00	0.00	0.00	0.00	7, 200. 00	22	95999	01/12/2023 01/12/2023
0. 00	0.00	226	1, 310. 00 Z33	0. 00	0.00	0.00	0.00	0.00	1, 310. 00	22	9586826, XU	01/12/2023 01/12/2023
0. 00	0.00	226	1, 310. 00 Z33	0. 00	0.00	0.00	0.00	0.00	1, 310. 00	22	9586826, XU	01/12/2023 01/12/2023
0. 00	0.00	226	1, 502. 00 Z33	0. 00	0.00	0.00	0.00	0.00	1, 502. 00	22	9586526	01/12/2023 01/12/2023
0. 00	0.00	226	1, 502. 00 Z33	0. 00	0.00	0.00	0.00	0.00	1, 502. 00	22	9586526, XU	01/12/2023 01/12/2023
0. 00	0.00	226	1, 614. 00 Z33	0. 00	0.00	0.00	0.00	0.00	1, 614. 00	22	9586126, XU	01/12/2023 01/12/2023
0. 00	0.00	226	1, 614. 00 Z33	0. 00	0.00	0.00	0.00	0.00	1, 614. 00	22	9586126	01/12/2023 01/12/2023
0. 00	0.00	226	1, 755. 00 Z33	0. 00	0.00	0.00	0.00	0.00	1, 755. 00	22	9595526	01/12/2023 01/12/2023
0. 00	0.00	226	3, 107. 00 Z33	0. 00	0.00	0.00	0.00	0.00	3, 107. 00	22	9593826	01/12/2023 01/12/2023
0.00	0.00	226	3, 814. 00 Z33	0. 00	0.00	0.00	0.00	0. 00	3, 814. 00	22	9593926	01/12/2023 01/12/2023
										_		
				PLAN TYPE:			RED	RELATIONSHIP TO INSURED	REL		NETWORK: OUT OF NETWORK	NETWORK: (
			EXPL CD:			1053679019	•	SERVICE PROVIDER ID:			JATH, AUDREY R.	SERVICE PROVIDER NAME: NATH, AUDREY R.
(844) 284-1798	10/10/2023	10/10	RECEIVED DATE:			255909458200		CLAIM NUMBER). 2857558	PATIENT ACCOUNT#: 0.2857558
FOR INQUIRIES CALL:	BETH A	RI CH, ELI ZABETH A	PATIENT NAME:			YRH100399086699		INSURED'S ID:			INSURED'S NAME: RICH, ELIZABETH A	INSURED'S NAME: F
EXPL/ANSI WHAT WE WILL PAY	INSURED RESPONSIBILITY EXPL AMOUNT COL	EXPL/ANSI CODE(S)	RACTUAL PROVIDER RESP. ERENCE AMOUNT	E CONTRACTUAL P	CO-INSURANCE CONT	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
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TOTAL APPROVED AMOUNT
TOTAL INTEREST
TOTAL NET AMOUNT DUE: INDIANA HOOSIERS AND ABD

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INDIANA MEDICARE WLP

FOR INQUIRIES CALL: (800) 676-2583 0.00 0.00	MA	CK, ANNE 08/31/2023 APPEALS CODE: MA 0.00 0.00	EBUCK	PATIENT NAME: RO RECEIVED DATE: EXPL CD: YPE: 0.00 3,814.00- 1,755.00- M45 252 0.00 1,755.00- M45 252	PLAN TYPE:	2 o o o o o o o o o o o o o o o o o o o	0K041W04707 253244907600 053679019 00 00 00 00 00 00 00 00 00 00 00 00 00	000	CLAIM NUMBER: SERVICE PROVIDER ID: RELATIONSHIP TO INSURED: 0- 0- 0- 0- 0- 0- 0- 0- 0- 0- 0- 0- 0-	REL 3, 814. 00- 1, 755. 00-	22	ED'S NAME: ROEBUCK, ANNE ACCOUNT#: 0.3064224 DER NAME: NATH, AUDREY R. NETWORK: OUT OF NETWORK NETWORK: 0UT OF NETWORK 07/07/2023 9593926 07/07/2023 9582226	INSURED'S NAME: ROEBUCK, ANNE PATIENT ACCOUNT# 0.3064224 SERVICE PROVIDER NAME: NATH, AUDREY R NETWORK: OUT OF NETWORK 07/07/2023 07/07/2023 9593926 07/07/2023 07/07/2023 9593926 07/07/2023 07/07/2023 9593926
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)		CO-INSURANCE CONTRACTUAL PROVIDER RESP	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)



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PROVIDER ID NO: 000001048740

CHECK/EFT DT: CHECK/EFT:

10/17/23

0. 00												TOTAL NET PAID	
0.00		_			_						_		INTEREST
0.00		0.00			8	0.00	0.00	0.00	0.00	16, 643. 00-		TOTAL:	
0. 00		0.00		400.00-	0. 00	0. 00	0.00	0. 00	0.00	5, 400. 00-	21	95999	09/09/2022 09/09/2022
0. 00		0.00	5 252	2, 972. 00- M45	0.00	0.00	0.00	0.00	0.00	2, 972. 00-	21	9588626, XU	09/09/2022 09/09/2022
0. 00		0.00	5 252	2, 972. 00- M45	0. 00	0.00	0.00	0.00	0.00	2, 972. 00-	21	9588626	09/09/2022 09/09/2022
0. 00		0.00	5 252	437.00- M45	0. 00	0. 00	0.00	0.00	0. 00	437. 00-	21	9590826	09/09/2022 09/09/2022
0. 00		0.00	5 252	3, 107. 00- M45	0. 00	0. 00	0.00	0.00	0.00	3, 107. 00-	21	9593826	09/09/2022 09/09/2022
0. 00		0.00		1, 755.00- M45	0. 00	0. 00	0.00	0. 00	0.00	1, 755. 00-	21	9582226	09/09/2022 09/09/2022
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		-	_	-		-	-	-	-	-			
	5			[]	PLAN TYPE:		0		RELATIONSHIP TO INSURED	RELA		OUT OF NETWORK	
(000) 070-2000	MA	ABBEALS CODE:		באם טטיני			12208422	10	CERVICE DROVIDER ID:			HOMAS GEORGE D	
FOR INQUIRIES CALL:	FOR INC	SEPH K	WALTER	PATIENT NAME:			XPG101M71617	¥	INSURED'S ID:			WALTERS, JOSEPH K	INSURED'S NAME: W
		AMOUNI	1										
WHAT WE WILL PAY	EXPL/ANSI	INSURED RESPONSIBILITY	EXPL/ANSI F	OVIDER RESP.	CO-INSURANCE CONTRACTUAL PROVIDER RESP	CO-INSURANCE (CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
4/0.09												TOTAL NET PAID	
0.00		_	_	_	_	_	_	_	_	_	_		INTEREST
4/0.09		7, 200.00		14, 053. 91	0. 00	0.00	0.00	0.00	4/9. /1	21, /24. 00		TOTAL:	
0.00	GYB 256			0.00	8 8	0.00	0.00	0.00	0.00	7, 200. 00	22	45444	0//0//2023 0//0//2023
57.66	9		N 45 LS5 253	1, 252. 34 PXN		0.00	0.00	0.00	58. 84	1, 310. 00	22	9586826, XU	07/07/2023 07/07/2023
57.00		0.00	10 LS3	202.34	9 .	9 0	0.00	0.00	00.04	1, 310.00	2 2	9280820	0//0//2023 0//0//2023
/5. 24 E7 <i>6</i>		0 0	45 LS5	538. /6	9 5	9 5	0 0	0 0	76. 78	1, 614. 00	3 2	9586126, XU	07/07/2023 07/07/2023
75. 24		0.00	45 LS5		9 0	0 .	0.00	0.00	70.78	1, 614. 00	2 2	9580120	07/01/2023 01/01/2023
11 . 07		0 0	45 1.55		9 5	9 5	0 0	0.00	42.75	3, 107. 00	2 2	9593826	07/01/2023 01/01/2023
52. 83		0.00	45 LS5			9 5	0 0	0 0	53. 9 I	3 107 00	2 2	9582226	07/07/2023 07/07/2023
109.57		0.00	45 LV5		9 0	9 0	0.00	0.00		3, 814. 00	2 2	9593926	07/07/2023 07/07/2023
100 57		9	- 60	704		3	8	9	0	2	ა ა	050000	07 /07 /0000 07 /07 /0000
		-		-	-	-	-	- 	-	-	-		
	į			!	PLAN TYPE				RELATIONSHIP TO INSURED	RELA		NETWORK: OUT OF NETWORK	NETWORK: 0
(000) 070-2003	MA	ALS CODE:	000	EXPL CD:			79019	1	SERVICE PROVIDER ID:			NATH AHDREY R	
FOR INQUIRIES CALL:	FOR INC)SO222	ROEBUCK, ANNE	PATIENT NAME:			VOKO41WO47O7	6	INSURED'S ID:			ROEBUCK, ANNE	INSURED'S NAME: R
		CALCONI											
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY	EXPL/ANSI F	OVIDER RESP.	CONTRACTUAL PROVIDER RESP	CO-INSURANCE C	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
0. 00												TOTAL NET PAID	
0. 00		_	_	_	_		_	_	_		_		INTEREST
0. 00		0.00		21, 724.00-	8	0.00	0.00	0.00	0.00	21, 724. 00-		TOTAL:	
0. 00		0.00	5 252		0. 00	0.00	0. 00	0.00	0.00	7, 200. 00-	22	95999	07/07/2023 07/07/2023
0. 00		0.00	5 252		0. 00	0.00	0.00	0.00	0.00	1, 310. 00-	22	9586826, XU	07/07/2023 07/07/2023
0. 00		0.00			0. 00	0.00	0.00	0.00	0.00	1, 310. 00-	22	9586826	07/07/2023 07/07/2023
0. 00		0.00	5 252	1, 614. 00- M45	0. 00	0.00	0.00	0.00	0.00	1, 614. 00-	22	9586126, XU	07/07/2023 07/07/2023
0. 00		0.00	5 252	1, 614. 00- M45	0. 00	0. 00	0.00	0.00	0.00	1, 614. 00-	22	9586126	07/07/2023 07/07/2023
											_		
					PLAN TYPE:			URED:	RELATIONSHIP TO INSURED:	RELA		NETWORK: OUT OF NETWORK	NETWORK: C
	MA	APPEALS CODE:		EXPL CD:			79019		SERVICE PROVIDER ID:			NATH, AUDREY R.	SERVICE PROVIDER NAME: N
(800) 676-2583	008)	ŕ		RECEIVED DATE:			253244907600		CLAIM NUMBER:			0. 3064224	
DI IIRIES CALL:	FOR INC	ñ	ROFRIICK ANNE	PATIENT NAME			VOKO41WO47O7		INSURED			ROERIICK ANNE	INSTIRED'S NAME: R
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI F	OVIDER RESP. AMOUNT	CO-INSURANCE CONTRACTUAL PROVIDER RESP	CO-INSURANCE (CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
				CHECK/ EF 1:									

0. 00												TOTAL NET PAID	
0. 00		_		_		_		_	_	_	_		INTEREST
0. 00		0.00		18, 561.00-	0. 00	0.00	0.00	0.00	0.00	18, 561. 00-		TOTAL:	
0. 00		0.00	252	7, 200. 00- M45 252	0. 00	0.00	0.00	0.00	0.00	7, 200. 00-	21	95999	05/01/2023 05/01/2023
0. 00		0.00	5 252	2, 972. 00- M45	0. 00		0.00	0.00	0.00	2, 972. 00-	21	9588626, XU	05/01/2023 05/01/2023
0. 00		0.00	252	2, 972.00- M45 252	0. 00	0.00	0.00	0.00	0.00	2, 972. 00-	21	9588626	05/01/2023 05/01/2023
0. 00		0.00	252	555. 00- M45	0. 00	0.00	0.00	0.00	0.00	555.00-	21	9590926	05/01/2023 05/01/2023 9590926
0. 00		0.00	5 252	3, 107. 00- M45	0. 00	0.00	0.00	0.00	0.00	3, 107. 00-	21	9593826	05/01/2023 05/01/2023
0. 00		0.00	252	1, 755.00- M45	0. 00	0.00	0.00	0.00	0. 00	1, 755. 00-	21	9582226	05/01/2023 05/01/2023
_	5	- ATT			PLAN TYPE	-	70307	'' '	RELATIONSHIP TO INSURED	REL	-	NETWORK: OUT OF NETWORK	NETWORK:
(833) 812-1797	MA	08/29/2023 ADDEALS CODE: MA	08/	RECEIVED DATE:			253095444000 36176387	7	CLAIM NUMBER:). 2985848 DE JESTIS MARLA A	SERVICE PROVIDER NAME: DE JESTIS MARIA A
FOR INQUIRIES CALL:	FOR II	BYRNS EARLE, TERRY L	BYRNS EAR	PATIENT NAME:			ZVR349W14700		INSURED'S ID:		Г	INSURED'S NAME: BYRNS EARLE, TERRY L	INSURED'S NAME: I
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	FERENCE AMOUNT	CONTRACTUAL P	CO-INSURANCE CONT	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
												CARE -	OHIO GROUP MEDICARE
801. 33)I CARE WLP	UE: INDIANA MEDICARE WLP	TOTAL NET AMOUNT DUE:	TOTAL NET					
0.00							TEREST	TOTAL INTEREST					
801. 33						JNT	TOTAL APPROVED AMOUNT	TOTAL APF					

09/09/2022 09/09/2022 09/09/2022 09/09/2022 09/09/2022 09/09/2022

9593826

1, 755. 3, 107. 437. 2, 972. 2, 972. 5, 400. 16, 643.

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55. 00 43. 80 64. 00 87. 60 87. 60 0. 00 338. 00

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PXN P X N

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LS5 LS5 LS5

253 253 253 253 253

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1, 701. 10 3, 064. 08 374. 28

2, 886. 15 2, 886. 15 0. 00 10, 911. 76

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GYB 256

53. 90 42. 92 62. 72 85. 85 85. 85 0. 00 331. 24 0. 00 331. 24

09/09/2022 09/09/2022 09/09/2022 09/09/2022

95999 9588626, XU 9588626 9590826

TOTAL:

TOTAL NET PAID

NTEREST

09/09/2022 09/09/2022

INSURED'S NAME: WALTERS, JOSEPH K
PATIENT ACCOUNT#: 0. 2705474
SERVICE PROVIDER NAME: THOMAS, GEORGE P.

NETWORK: OUT OF NETWORK

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

PLAN TYPE

PATIENT NAME: RECEIVED DATE: EXPL CD:

SERVICE DATE(S)

SERVICE CODES

g

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:

(800) 676-2583

WALTERS, JOSEPH K

09/05/2023

APPEALS CODE: MA

XPG101M71617 253481221401 1912298423

INDIANA MEDICARE WLP

OHIO GROUP MEDICARE

336. 97												TOTAL NET PAID	
0. 00		_		_	_						_		INTEREST
336. 97		7, 200. 00		11, 017. 15	0. 00	0.00	0.00	0.00	343.85	18, 561. 00		TOTAL:	
0. 00	GYB 256	7, 200. 00 GY		0.00	0. 00	0.00	0.00	0.00	0.00	7, 200. 00	21	95999	05/01/2023 05/01/2023
84. 40		0.00	45 PXN 45	2, 885. 88 GB1 45	0. 00	0.00	0.00	0.00	86. 12	2, 972. 00	21	9588626, XU	05/01/2023 05/01/2023
84. 40		0.00	45 PXN 45	2, 885. 88 GB1 45	0. 00	0.00	0.00	0.00	86. 12	2, 972. 00	21	9588626	05/01/2023 05/01/2023
73. 45		0.00	45 PXN 45	480. 05 GB1 45	0. 00	0.00	0.00	0.00	74.95	555. 00	21	9590926	05/01/2023 05/01/2023
41. 89		0.00	45 PXN 45	3, 064. 25 GB1 45	0. 00	0.00	0.00	0.00	42. 75	3, 107. 00	21	9593826	05/01/2023 05/01/2023
52. 83		0. 00	45 PXN 45	1, 701. 09 GB1 45	0. 00	0.00	0.00	0.00	53. 91	1, 755. 00	21	9582226	05/01/2023 05/01/2023
					PLAN TYPE:			URED:	RELATIONSHIP TO INSURED	REL		NETWORK: OUT OF NETWORK	NETWORK: (
	MA	APPEALS CODE: MA		EXPL CD:			1336176387		SERVICE PROVIDER ID:		,P	DE JESUS, MARIA	SERVICE PROVIDER NAME: DE JESUS, MARIA A.
(833) 812-1797		2023	08/29/2023	RECEIVED DATE:			253095444001		CLAIM NUMBER:). 2985848	PATIENT ACCOUNT#: 0.2985848
FOR INQUIRIES CALL:	FOR IN	TERRY L	BYRNS EARLE, TERRY L	PATIENT NAME:			ZVR349W14700		INSURED'S ID:		≺	NSURED'S NAME: BYRNS EARLE, TERRY	INSURED'S NAME: E
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI RE		CO-INSURANCE CONTRACTUAL PROVIDER RESP. AMOUNT	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pg.	SERVICE CODES	SERVICE DATE(S)

NET AMOUNT DUE	TOTAL INTEREST	GROSS APPROVED CLAIM AMOUNT	TOTAL NET AMOUNT DUE: OHIO GROUP MEDICARE	TOTAL INTEREST	TOTAL APPROVED AMOUNT
1, 138. 30	0. 00	1, 138. 30	336. 97	0. 00	336. 97

EXPL CODES EXPLANATION

Z33

This was denied because the billing provider NPI is not registered with the state. If you disagree with our decision, and have documents to support the claim, the fastest and easiest way to dispute a claim button function is not available, refer to your provider manual for additional information about how to file a claims dispute. As a is through Availity.com. Log onto Availity.com and use the Claims & Payments tab to access Claims Status. Find the claim, select the with the state. If you disagree with our decision, and have documents This was denied because the rendering provider NPI is not registered reminder, the member is not responsible for the unpaid amount. additional information about how to file a claims dispute. As a button function is not available, refer to your provider manual for Dispute button, and attach supporting documentation. If the Dispute Submit medical records for review reminder, the member is not responsible for the unpaid amount. Dispute button, and attach supporting documentation. If the Dispute to support the claim, the fastest and easiest way to dispute a claim Payments tab to access Claims Status. Find the claim, select the is through Availity.com. Log onto Availity.com and use the Claims &

Z34

OHIO GROUP MEDICARE

253 256 GYB GB1 252 45 226 PXN AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. 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. and Benefits Inquiry. SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT. SEQUESTRATION - REDUCTION IN FEDERAL PAYMENT. OR NOT PROVIDED TIMELY OR WAS INSUFFICIENT/INCOMPLETE. INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED Availity.com use the Patient Registration tab to access Eligibility quickest and easiest way to check a member's benefits, from Claim paid, the plan out of pocket maximum has been reached. For the This was not paid because it is not reimbursable. additional information related to this amount, consult Medicare. This is a reduction in payment due to Federal Sequestration. For contract. rates. For additional information related to this amount, consult your This was paid in accordance with your contracted or out of network

LS5

APPEALS CODE

M

Non-Contracted Medicare Provider Appeal - Medicare Advantage/Medicare Medicaid Plans

If a claim is partially or fully denied for payment, the non-contracted provider must request an appeal of the denial within 60 calendar days from the remittance notification. When submitting the appeal, a signed Waiver of Liability form must be included. To obtain this form, please go to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zlp. The purpose of the Waiver of Liability form is to hold the enrollee harmless regardless of the outcome of the appeal

With the appeal, the non-contracted provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. The appeal must be in writing and mailed.

Please mail the appeal to this address:

Mailstop: 0H0205-A537 Gri evances and Appeals

4361 Irwin Simpson Rd

Mason, OH 45040-9398

Non-Contracted Medicare Provider Payment Disputes - Medicare Advantage/Medicare Medicaid Plans

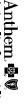
A payment dispute is when you believe the amount we paid is different than what Original Medicare would have paid. If you disagree with the payment amount, you may file a non-contracted Medicare provider payment dispute in writing within 120 calendar days.

Your payment dispute should be sent to:

Provider Payment Disputes

P. 0. Box 61599

Virginia Beach, VA 23466-1599



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RECOUPMENT NOTIFICATION

PROVIDER: PAYEE ID: CHECK AMT: MONITORING ASSOCIATES LLC 000001048740

10/17/23 1,138.30

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.

NEGATI VE BALANCE HI STORY:

PRI OR RECOUPMENT:

CURRENT RECOUPMENT:

REMIT		PATIENT NAME	PATIENT ACCT	SUBSCRIBER ID	CLAIM NUMBER/	DATE OF	CLAIM NUMBER/ DATE OF ORIGINAL NEGATIVE	CLAIM AMOUNT EXPECTED ADJ CD	ADJ CD	CHARGE	RECOVERY	
DATE	H				REFUND ID	SERVICE	SERVICE CLAIM NUMBER	RECOUP DAT	m	AMT	LETTER ID	
		NITO ATT 101 101 101 101 101 101 101 101 101 1										

NEGATI VE BALANCE DEFERRED:

	387.08-	ALANCE DEFERRED	TOTAL NEGATI VE BALANCE DEFERREI			
14, 699. 00 15126680	98. 77- 12/31/99 1	2022034DT243898 06/04/21 2022034DT243898	363M99926	0. 2171874	SHEILAH 0.217187. PAULETTE 1945879 GEORGANNA 0.209037	10/16/23 KEEFER
13, 304. 00 12936090	45. 82- 12/31/99 1	20212230A186896 05/19/21 20212230A186896	359M54867	1945879		10/16/23 REI LLY
14, 328. 00 12482503	242. 49- 12/31/99 1	2021152EP429896 03/31/21 2021152EP429896	007M72156	0. 2090377		10/16/23 STEWART

RECOUPMENT NOTIFICATION

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

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