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

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/21/2023
Page: 1 of 4

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
NO PAY

Omar J Moore
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: PATRIA M CRUZ (self)

Claim ID: **EPAC8S18T00** Recd: **10/19/23** Member ID: **101642048600** Patient Account: **0.2871998**
Member: **PATRIA M CRUZ** DIAG: **M43.16**
Group Name: **Medicare (C01) ESA PPO** Group Number: **200-EGS0000 0696**
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
01/25/23	21	9593826		3,107.00			3,107.00	1 2				0.00
01/25/23	21	9595526		1,755.00			1,755.00	1 2				0.00
01/25/23	21	9586126		1,614.00			1,614.00	1 2				0.00
01/25/23	21	9586126 XU		1,614.00			1,614.00	1 2				0.00
01/25/23	21	95999		5,400.00			5,400.00	2				0.00
TOTALS				**13,490.00**			**13,490.00**					**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
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

Continued on Next Page

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

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/21/2023
Page: 2 of 4

Mailing Address:
Omar J Moore
PO BOX 29650
PHOENIX AZ 85038

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
NO PAY

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
USA

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/21/2023
Page: 3 of 4

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
NO PAY

Matthew B McAuliffe
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: SHELLEY E STEPANEK (self)

Claim ID: **ENY18L1PX04** Recd: **10/12/23** Member ID: **101129302500** Patient Account: **0.2801283**
Member: **SHELLEY E STEPANEK** DIAG: **G06.1**
Group Name: **Aetna Medicare Premier Plan (HMO-POS)** Group Number: **000003-NV00 0009**
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
11/25/22	21	9593926		3,814.00			3,814.00	1				0.00
11/25/22	21	9593826		3,107.00			3,107.00	1				0.00
11/25/22	21	9595526		1,755.00			1,755.00	1				0.00
11/25/22	21	9586126		1,614.00			1,614.00	2				0.00
11/25/22	21	9586126		1,614.00			1,614.00	2				0.00
		XU										
11/25/22	21	9586526		1,502.00			1,502.00	2				0.00
11/25/22	21	9586526		1,502.00			1,502.00	2				0.00
		XU										
11/25/22	21	9586826		1,310.00			1,310.00	2				0.00
		XU										
11/25/22	21	9586826		1,310.00			1,310.00	2				0.00
		XU										
11/25/22	21	95999		5,400.00			5,400.00	3				0.00
TOTALS				**22,928.00**			**22,928.00**					**0.00**

ISSUED AMT: NO PAY

Remarks:

1 - *Charges for or in connection with services or supplies that are, as determined by us, considered to be experimental or investigational are excluded from coverage under the member's plan. The member is not responsible for this charge, unless they agreed to be responsible for this charge in writing before the service or supply was given. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, the Code Edit Lookup tools. [777]*

2 - *This service does not meet the coverage requirements in the applicable Local Coverage Determination (LCD) or National Coverage Determination (NCD). Related services performed in connection with the denied procedure are also not covered. The member is not responsible for this charge. [D0F]*

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

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

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/21/2023
Page: 4 of 4

Mailing Address:
Matthew B McAuliffe
PO BOX 29650
PHOENIX AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
NO PAY

Patient Name: SHELLEY E STEPANEK (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:	$0.00

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.