



P.O. BOX 14079  
LEXINGTON KY 40512-4079  
USA

## Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/23/2023  
Page: 1 of 3

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
NO PAY

PHYSICIAN OVERSIGHT, LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

### 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: LYNN M HARSCH (spouse)

Claim ID: EC368M8LF00 Recd: 10/16/23 Member ID: W252563719 Patient Account: 0.3086410

Member: SCOTT HARSCH

Group Name: RESINTECH, INC.

Product: Aetna Open Access® Elect Choice®

Contract State: NJ

DIAG: M4806/2, M5136

Group Number: 0108321-11-007 AC VB\*YS0

Network ID: 00000

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	PENDING	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/26/23	21	95999		7,200.00	0.00		7,200.00	1				0.00
07/26/23	21	9595526		1,755.00	0.00		1,755.00	1				0.00
07/26/23	21	95941		5,520.00	0.00		5,520.00	1				0.00
07/26/23	21	9593826		3,107.00	0.00		3,107.00	1				0.00
07/26/23	21	9592926		2,459.00	0.00		2,459.00	1				0.00
07/26/23	21	9590826		437.00	0.00		437.00	1				0.00
TOTALS				20,478.00			20,478.00					0.00

ISSUED AMT:

NO PAY

#### Remarks:

1 - To consider this charge, we need you to send us:

- Clinical documents that support medical necessity of the billed service. This includes drugs, medical equipment, and implants.
- The diagnosis and the expected time the patient will need the drug or equipment.
- Copies of the patient's current history and physical exam, office or nursing notes, operative report, photographs, lab or diagnostic testing results, or air ambulance records, if any of these apply. Please send copies since we won't return originals.

- A complete description of the service and the itemized bill if you billed an unlisted code.

You can find more details in our Clinical Policy Bulletins at this link:

<https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>

Don't resend the claim form. Attach the information to a copy of this statement along with the subscriber's full name, the patient's full name, and the subscriber's ID number.

You may send this to us by either:

- Fax: 859-455-8650 Attn: ICMN

- Mail: P.O. Box 14089, Attn: ICMN, Lexington, KY 40512

You have 45 days from the date of this statement to send us this information. When we get these details, we'll decide within 15 days. If we don't get it, we'll deny the claim. You will have a right to appeal the claim.

The following does not apply to Federal plans:

- For claims sent from NC: you have 90 days to send us the information. If we don't get it, we'll deny the claim.

- For claims sent from Texas: if we don't get the information, your claim may remain open.

In Texas, you can ask for a peer review with our medical director to discuss the medical necessity, appropriateness, and/or the experimental/investigational nature of this service. You must submit medical records to us prior to asking for a peer review. To schedule a peer review, please call

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PHYSICIAN OVERSIGHT, LLC

**Patient Name: LYNN M HARSCH** (spouse)

**Remarks (contd):**

866-225-8226 and leave the member's name, date of birth, and claim ID for the associated service.  
The peer review option expires 7 calendar days from the date you submit the medical records. If we don't receive the peer review request by the deadline, we will make our decision on this claim. A peer review call may not change our decision and isn't required to start an appeal. If we deny the service, we will send you a letter with the appeal rights and process. [U33]  
This claim is deficient in accordance with Texas legislation. 949  
Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

**For Questions Regarding This Claim**

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

**CALL (888) 632-3862 FOR ASSISTANCE**

Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: \$0.00  
Claim Payment: \$0.00

**Patient Name: NADINE E SWANGER** (self)

Claim ID: EQAC8Q03100 Recd: 10/13/23 Member ID: W261695620 Patient Account: 0.3083414

Member: NADINE E SWANGER

Group Name: CJKANTRG MANAGEMENT, LLC.

Product: Aetna Open Access® Managed Choice®

Contract State: PA

Aetna Life Insurance Company

DIAG: M5030, G89.4

Group Number: 0169789-11-001 AA PEW@~0

Network ID: 00000

Funding: Insured

Network Status: Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/QPA	COPAY AMOUNT	PENDING	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/25/23	22	95999		3,600.00	0.00		3,600.00	1				0.00
								2				
07/25/23	22	9595526		1,755.00	0.00		1,755.00	1				0.00
07/25/23	22	95941		2,760.00	0.00		2,760.00	1				0.00
07/25/23	22	9593926		3,814.00	0.00		3,814.00	1				0.00
								2				
07/25/23	22	9593826		3,107.00	0.00		3,107.00	1				0.00
								2				
07/25/23	22	9587026		1,166.00	0.00		1,166.00	1				0.00
		XU										
<b>TOTALS</b>				<b>16,202.00</b>			<b>16,202.00</b>					<b>0.00</b>

ISSUED AMT:

NO PAY

**Remarks:**

- 1 - To consider this charge, we need you to send us:
- Clinical documents that support medical necessity of the billed service. This includes drugs, medical equipment, and implants.
  - The diagnosis and the expected time the patient will need the drug or equipment.
  - Copies of the patient's current history and physical exam, office or nursing notes, operative report, photographs, lab or diagnostic testing results, or air ambulance records, if any of these apply. Please send copies since we won't return originals.
  - A complete description of the service and the itemized bill if you billed an unlisted code.
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*You have 45 days from the date of this statement to send us this information. When we get these details, we'll decide within 15 days. If we don't get it, we'll deny the claim. You will have a right to appeal the claim.*

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*In Texas, you can ask for a peer review with our medical director to discuss the medical necessity, appropriateness, and/or the experimental/investigational nature of this service. You must submit medical records to us prior to asking for a peer review. To schedule a peer review, please call 866-225-8226 and leave the member's name, date of birth, and claim ID for the associated service.*

*The peer review option expires 7 calendar days from the date you submit the medical records. If we don't receive the peer review request by the deadline, we will make our decision on this claim. A peer review call may not change our decision and isn't required to start an appeal. If we deny the service, we will send you a letter with the appeal rights and process. [U33]*

- 2 - *You are not part of our network. We applied the out-of-network benefit level to the covered services on this claim. If the member signed a consent form you gave them, the claim is correct and the member is responsible for any balance shown. If the member didn't sign a consent form, or you didn't give them a consent form, and you provided services per the Federal No Surprises Act, call us so we can reconsider the claim under the Act's requirements. [FDI]*

*This claim is deficient in accordance with Texas legislation. 949*

*Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)*

**For Questions Regarding This Claim**

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**CALL (888) 632-3862 FOR ASSISTANCE**

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Total Patient Responsibility:	\$0.00
Claim Payment:	\$0.00

If you are a licensed health care provider that treats our member, you have several ways to appeal claim determinations which are not clinical in nature. To obtain a provider dispute form please visit [http://www.aetna.com/provider/data/NJ\\_provider\\_claim\\_submission\\_form.pdf](http://www.aetna.com/provider/data/NJ_provider_claim_submission_form.pdf). For additional information, please visit [http://www.aetna.com/provider/medical/resource\\_med/coverage\\_med/payment\\_policy.html](http://www.aetna.com/provider/medical/resource_med/coverage_med/payment_policy.html).

P-TRA-NJ

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.