Check Summary **Transaction Date:** October 06, 2023

MOLINA HEALTHCARE TEXAS	**Payee Tax ID:**	850542512	**Payee Name:**	PHYSICIAN OVERSIGHT LLC
200 OCEANGATE	**Payee ID:**	1770111452	**Payee Address:**	PO BOX 29650
6TH FLOOR	**Check/EFT Trace Number:**	CHKHST41163518		DEPT 880359
LONG BEACH, CA 90802	**Payment Amount:**	0.00		PHOENIX, AZ 850389650
	Check/EFT Date:	10/06/2023		
	Production End Cycle Date:	01/01/0001		

Patient Name: ESPINOZA, FRANCISCO ABEL **Claim Number:** 23276529521 **Claim Date:** 06/04/2021-06/04/2021 **Claim Status Code:** 1

Patient ID: 0009620212	**Group / Policy:**	**Facility Type:**		**Claim Charge:**	$17,381.00
Patient Ctrl Nmbr: 1923784	**Contract Hdr:** 45786TX0020007	**Claim Frequency:**		**Claim Payment:**	$0.00
Rendering Prvd: FERENZ, GREGORY J	**Rendering Prv ID:**	**Claim Received Date:**	10/02/2023	**Patient Resp:**	$0.00
Original Ref Nmbr:					

Line Details **Results:** 7

Line Ctrl Nmbr	Dates of Service	Rend Prov ID	Rev	Sub Proc / Modifier / Units	Adjud Proc / Modifier / Units	Remark / Payer Code	Supp Info (AMT)	Charge	Adjustments (Qty)	Adj Amount	Payment
DK000001793964177-01	06/04/2021 - 06/04/2021				HC:95939 / 26 / 1	M47		$3,814.00	CO-16	$3,814.00	$0.00
DK000001793964177-02	06/04/2021 - 06/04/2021				HC:51785 / 26 / 1	M47		$1,071.00	CO-16	$1,071.00	$0.00
DK000001793964177-03	06/04/2021 - 06/04/2021				HC:95938 / 26 / 1	M47		$3,107.00	CO-16	$3,107.00	$0.00
DK000001793964177-04	06/04/2021 - 06/04/2021				HC:95955 / 26 / 1	M47		$1,755.00	CO-16	$1,755.00	$0.00
DK000001793964177-05	06/04/2021 - 06/04/2021				HC:95861 / 26,XU / 1	M47		$1,614.00	CO-16	$1,614.00	$0.00
DK000001793964177-06	06/04/2021 - 06/04/2021				HC:95937 / 26,XU / 1	M47		$500.00	CO-16	$500.00	$0.00
DK000001793964177-07	06/04/2021 - 06/04/2021				HC:95941 / / 2	M47		$5,520.00	CO-16	$5,520.00	$0.00

Payer: MOLINA HEALTHCARE TEXAS	Check/EFT Trace Number: CHKHST41163518	Check/EFT Date: 10/06/2023	Total Paid: $0.00

Patient Name: SALINAS, VERONICA G **Claim Number:** 23278337803 **Claim Date:** 08/19/2022-08/19/2022 **Claim Status Code:** 1

Patient ID: 0003853771	**Group / Policy:**	**Facility Type:**		**Claim Charge:**	$45,401.00
Patient Ctrl Nmbr: 0.2683264	**Contract Hdr:** 45786TX0020009	**Claim Frequency:**		**Claim Payment:**	$0.00
Rendering Prvd: DEJESUS, MARIA A	**Rendering Prv ID:**	**Claim Received Date:**	10/04/2023	**Patient Resp:**	$0.00
Original Ref Nmbr:					

Line Details **Results:** 9

Line Ctrl Nmbr	Dates of Service	Rend Prov ID	Rev	Sub Proc / Modifier / Units	Adjud Proc / Modifier / Units	Remark / Payer Code	Supp Info (AMT)	Charge	Adjustments (Qty)	Adj Amount	Payment
7371296916Z1	08/19/2022 - 08/19/2022				HC:95941 / / 7	MA66		$19,320.00	CO-16	$19,320.00	$0.00
7371296916Z2	08/19/2022 - 08/19/2022				HC:95939 / 26 / 1	" "		$7,500.00	CO-29	$7,500.00	$0.00
7371296916Z3	08/19/2022 - 08/19/2022				HC:95822 / 26 / 1	" "		$1,755.00	CO-29	$1,755.00	$0.00
7371296916Z4	08/19/2022 - 08/19/2022				HC:95938 / 26 / 1	" "		$2,943.00	CO-29	$2,943.00	$0.00
7371296916Z5	08/19/2022 - 08/19/2022				HC:95861 / 26 / 1	M15		$1,614.00	CO-234	$1,614.00	$0.00
7371296916Z6	08/19/2022 - 08/19/2022				HC:95861 / 26,XU / 1	M15		$1,614.00	CO-234	$1,614.00	$0.00
7371296916Z7	08/19/2022 - 08/19/2022				HC:95865 / 26 / 1	M15		$1,953.00	CO-234	$1,953.00	$0.00
7371296916Z8	08/19/2022 - 08/19/2022				HC:95865 / 26,XU / 1	M15		$1,502.00	CO-234	$1,502.00	$0.00
7371296916Z9	08/19/2022 - 08/19/2022				HC:95999 / / 4	M15		$7,200.00	CO-234	$7,200.00	$0.00

Code Descriptions

REMARK CODE(S):

" "=

M15=Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Payer: MOLINA HEALTHCARE TEXAS	Check/EFT Trace Number: CHKHST41163518	Check/EFT Date: 10/06/2023	Total Paid: $0.00

REMARK CODE(S):

M47=Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).
MA66=Missing/incomplete/invalid principal procedure code.

GROUP CODE(S):

CO=Contractual Obligations

CLAIM ADJUSTMENT REASON CODE(S):

16=Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
29=The time limit for filing has expired.
234=This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

CLAIM STATUS CODE(S):

1=Processed as Primary