

Check Summary

Transaction Date: October 24, 2023

BLUECROSS BLUESHIELD OF TEXAS P O BOX 660044 DALLAS, TX 752660044	Payee Tax ID: 850542512 Payee ID: 1770111452 Check/EFT Trace Number: C23293E11079050 Payment Amount: 254.00 Check/EFT Date: 10/24/2023 Production End Cycle Date: 10/20/2023	Payee Name: PHYSICIAN OVERSIGHT LLC Payee Address: DEPT 880359 PO BOX 29650 PHOENIX, AZ 850389650
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Patient Name: PRINCE, WINDERLYN

Claim Number: 0202320250P02030X00

Claim Date: 07/12/2023-07/12/2023 Claim Status Code: 22

Patient ID: JEA012642960

Group / Policy: 0002380000100

Facility Type: 21

Claim Charge: \$-32,941.00

Patient Ctrl Nmbr: 0.3069745

Contract Hdr: HEALTH MAINTENANCE
ORGANIZATION

Claim Frequency: 1

Claim Payment: \$-439.56

Rendering Prvd: DE JESUS, MARIA A

Rendering Prv ID:

Claim Received Date: 07/21/2023

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
7105762724Z1	07/12/2023 - 07/12/2023				HC:95941 // 2	N830		\$-13,800.00	PR-1 PR-2 CO-45	\$-18.50 \$-105.22 \$-13,518.44	\$-157.84
7105762724Z2	07/12/2023 - 07/12/2023				HC:95822 / 26 / 1	N830		\$-1,755.00	PR-2 CO-45	\$-24.20 \$-1,694.49	\$-36.31
7105762724Z3	07/12/2023 - 07/12/2023				HC:95938 / 26 / 1	N830		\$-3,107.00	PR-2 CO-45	\$-19.22 \$-3,058.94	\$-28.84
7105762724Z4	07/12/2023 - 07/12/2023				HC:95912 / 26 / 1	N830		\$-1,135.00	PR-2 CO-45	\$-66.91 \$-967.72	\$-100.37
7105762724Z5	07/12/2023 - 07/12/2023				HC:95886 / 26 / 2	N830		\$-2,972.00	PR-2 CO-45	\$-38.72 \$-2,875.18	\$-58.10
7105762724Z6	07/12/2023 - 07/12/2023				HC:95886 / 26,XU / 2	N830		\$-2,972.00	PR-2 CO-45	\$-38.72 \$-2,875.18	\$-58.10
7105762724Z7	07/12/2023 - 07/12/2023				HC:95999 // 1	N830		\$-7,200.00	CO-45	\$-7,200.00	\$0.00

Payer: BLUECROSS BLUESHIELD OF TEXAS	Check/EFT Trace Number: C23293E11079050	Check/EFT Date: 10/24/2023	Total Paid: \$254.00
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Patient Name: PRINCE, WINDERLYN M	Claim Number: 0202320250P02030X01	Claim Date: 07/12/2023-07/12/2023	Claim Status Code: 1
Patient ID: JEA012642960	Group / Policy: 0002380000100	Facility Type: 21	Claim Charge: \$32,941.00
Patient Ctrl Nmbr: 0.3069745	Contract Hdr: HEALTH MAINTENANCE ORGANIZATION	Claim Frequency:	Claim Payment: \$693.56
Rendering Prvd: DE JESUS, MARIA A	Rendering Prv ID:	Claim Received Date: 09/26/2023	Patient Resp: \$480.83
Original Ref Nmbr: 0202320250P02030X00			

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
	07/12/2023 - 07/12/2023				HC:95941 // 5	N830	\$703.90 (B6)	\$13,800.00	PR-1 \$18.50 PR-2 \$274.16 CO-45 \$13,096.10		\$411.24
	07/12/2023 - 07/12/2023				HC:95822 / 26 / 1	N830	\$60.51 (B6)	\$1,755.00	PR-2 \$24.20 CO-45 \$1,694.49		\$36.31
	07/12/2023 - 07/12/2023				HC:95938 / 26 / 1	N830	\$48.06 (B6)	\$3,107.00	PR-2 \$19.22 CO-45 \$3,058.94		\$28.84
	07/12/2023 - 07/12/2023				HC:95912 / 26 / 1	N830	\$167.28 (B6)	\$1,135.00	PR-2 \$66.91 CO-45 \$967.72		\$100.37
	07/12/2023 - 07/12/2023				HC:95886 / 26 / 2	N830	\$96.82 (B6)	\$2,972.00	PR-2 \$38.72 CO-45 \$2,875.18		\$58.10
	07/12/2023 - 07/12/2023				HC:95886 / 26,XU / 2	N830	\$96.82 (B6)	\$2,972.00	PR-2 \$38.72 CO-45 \$2,875.18		\$58.10
	07/12/2023 - 07/12/2023				HC:95999 // 1	N830	\$1.00 (B6)	\$7,200.00	PR-2 \$0.40 CO-45 \$7,199.00		\$0.60

Supplemental Information - AMT/Payer Codes: \$1,174.39 (AU)

Code Descriptions

REMARK CODE(S):

N830=Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ No Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es).

Payer: BLUECROSS BLUESHIELD OF TEXAS	Check/EFT Trace Number: C23293E11079050	Check/EFT Date: 10/24/2023	Total Paid: \$254.00
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AMT CODE(S):

B6=Allowed - Actual
AU=Coverage Amount

GROUP CODE(S):

PR=Patient Responsibility
CO=Contractual Obligations

CLAIM ADJUSTMENT REASON CODE(S):

1=Deductible Amount
2=Coinsurance Amount
45=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. (Use only with Group Codes PR or CO depending upon liability)

CLAIM STATUS CODE(S):

22=Reversal of Previous Payment
1=Processed as Primary