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 2

UNIVERSITY NEURO LLC
PIN: 0006066983
TIN: XXXXXXXX5495
NO PAY

UNIVERSITY NEURO LLC
550 N CENTRAL EXPY UNIT 1955
MCKINNEY TX 75070-0091

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: CHARLES T DALTON (son)

Claim ID: **ER588N6YY00** Recd: **10/11/23** Member ID: **W151128004** Patient Account: **0.3082583**
Member: **PAMELA C DALTON** DIAG: **Q07.00**
Group Name: **HCA HEALTHCARE** Group Number: **0169582-50-204 A D(<~+0**
Product: **Open Choice®** Network ID: **00000**
Funding: **Self-funded**
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
07/24/23	21	95999		7,200.00	0.00		7,200.00	1				0.00
07/24/23	21	95941		2,760.00	0.00		2,760.00	1				0.00
07/24/23	21	9593926		3,814.00	0.00		3,814.00	1				0.00
07/24/23	21	9593826		3,107.00	0.00		3,107.00	1				0.00
07/24/23	21	9586826		1,310.00	0.00		1,310.00	1				0.00
07/24/23	21	9586826 XU		1,310.00	0.00		1,310.00	1				0.00
TOTALS				**19,501.00**			**19,501.00**					**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

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 2

Mailing Address:
UNIVERSITY NEURO LLC
550 N CENTRAL EXPY UNIT 1955
MCKINNEY TX 75070-0091

UNIVERSITY NEURO LLC
PIN: 0006066983
TIN: XXXXXXXX5495
NO PAY

Patient Name: CHARLES T DALTON (son)

Remarks (contd):

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]

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 14079 LEXINGTON, KY 40512-4079
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

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.