



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

## Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/12/2023  
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Peter R Futrell  
925B Peachtree St NE Ste 750  
Atlanta GA 30309

PIN: Peter R Futrell  
TIN: 0007674007  
XXXXXXX7916  
NO PAY

### 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: HELENE ODIETE (self)

Claim ID: M0537926402 Recd: 06/20/23 Member ID: 101673373100 Patient Account: 0.3006790

Member: HELENE ODIETE

DIAG: M48.062, M47.816, M43.16

Group Name: Silver 3: Aetna network of doctors & hospitals + \$0 Walk-in clinic + \$0 Telehealth 24/7

Group Number: 000001-EXGA 0110

Product: Direct Access HMO (Aetna)

Contract State: GA

Funding: Insured

Aetna Health 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
05/17/23	21	95941		35,370.00	0.00		35,370.00	1				0.00
05/17/23	21	9582226		4,872.00	0.00		4,872.00	1				0.00
05/17/23	21	9593826		5,886.00	0.00		5,886.00	1				0.00
05/17/23	21	9590926		2,724.00	0.00		2,724.00	1				0.00
05/17/23	21	9588626		5,400.00	0.00		5,400.00	1				0.00
05/17/23	21	9588626		5,400.00	0.00		5,400.00	1				0.00
		XU										
05/17/23	21	95999		8,000.00	0.00		8,000.00	1				0.00
TOTALS				67,652.00			67,652.00					0.00

ISSUED AMT:

NO PAY

#### Remarks:

1 - This is a duplicate claim. We've already considered it for payment. [114]

For Questions Regarding This Claim P.O. BOX 14079 LEXINGTON KY 40512-4079  
USA

**CALL 1-888-632-3862** 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.