



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

## Claim Payment

Please Retain for Future Reference

Printed: 10/23/2023  
Page: 1 of 22

PHYSICIAN OVERSIGHT, LLC

PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

Aetna Life Insurance Company or an Affiliated Company  
as Agent for Specified Payer(s)  
P.O. BOX 14079  
LEXINGTON KY 40512-4079  
USA

ID No: XXXXXXXX2512  
Seq No: 000000004

Trace No: 000253926  
Acct: 09046

10-23-2023 51 - 44  
119 CT

**NON-NEGOTIABLE NON-NEGOTIABLE**

PAY

Six Thousand Eighty Three Dollars and 04/100

VOID AFTER ONE YEAR  
\*\*\*\*\*\$6,083.04

TO THE  
ORDER OF

Bank of America

PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

**VOID VOID**

766 (10-02)

**Payment was made via Electronic Funds Transfer**



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

## Explanation Of Benefits

Please Retain for Future Reference

**Payment Address:**

PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

**Provider Address:**

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

Printed: 10/23/2023  
Page: 2 of 22

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

### 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: CAROLYN K CLARK (self)

Claim ID: ERNR8RPJ602 Recd: 10/20/23 Member ID: W269379692 Patient Account: 0.3054744

Member: CAROLYN K CLARK

Group Name: SOUTHWEST AIRLINES CO.

Product: Aetna Choice® POS II

DIAG: G50.0

Group Number: 0169622-12-005 IL P1.%94

Network ID: 00000

Funding: Self-funded

Network Status: Out-of-Network

#### Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/QPA	COPAY AMOUNT	PENDING	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
06/27/23	21	95999		5,400.00	0.00		5,400.00	1				0.00
TOTALS				5,400.00			5,400.00					0.00

ISSUED AMT:

NO PAY

#### Remarks:

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

- A full description of the service and the itemized bill
- Clinical documentation that supports the medical necessity of the billed service (which includes the primary diagnosis)
- Copies of current history and physical exam, office or nursing notes, operative reports, lab or diagnostic testing results, if they apply
- Copies of documentation from the ordering physician which includes the expected period of time they need the drug or equipment, medical history and/or physical exam report that supports medical necessity of the drug or equipment and copies of drug administration notes, if they apply

You can find our Clinical Policy Bulletins at:

<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, 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 denial at that time.

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 the peer review. To schedule the 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. [ICMN-970]

Continued on Next Page



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PHYSICIAN OVERSIGHT LLC  
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PHOENIX AZ 85038-9650

Printed: 10/23/2023  
Page: 3 of 22

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

**Patient Name: CAROLYN K CLARK (self)**

Claim ID: **ERNR8RPJ601** Recd: **10/20/23** Member ID: **W269379692** Patient Account: **0.3054744**  
Member: **CAROLYN K CLARK**  
Group Name: **SOUTHWEST AIRLINES CO.**  
Product: **Aetna Choice® POS II**

DIAG: **G50.0**  
Group Number: **0169622-12-005 IL P1.%94**  
Network ID: **00000**  
Funding: **Self-funded**  
Network Status: **Out-of-Network**

### Aetna Life Insurance Company

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
06/27/23	21	9265326	1.0	287.00	85.86		201.14	1				85.86
<b>TOTALS</b>				<b>287.00</b>	<b>85.86</b>		<b>201.14</b>					<b>85.86</b>

**ISSUED AMT: \$85.86**

### Remarks:

- 1 - The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under the NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at [FederalNSA@Aetna.com](mailto:FederalNSA@Aetna.com). Our Provider Contact Center team can be reached at 1-888-632-3862 (1-888-MD AETNA) if you need details on initiating an Open Negotiation. If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process. [FDZ]
- Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

Claim ID: **ERNR8RPJ600** Recd: **10/20/23** Member ID: **W269379692** Patient Account: **0.3054744**  
Member: **CAROLYN K CLARK**  
Group Name: **SOUTHWEST AIRLINES CO.**  
Product: **Aetna Choice® POS II**

DIAG: **G50.0**  
Group Number: **0169622-12-005 IL P1.%94**  
Network ID: **00000**  
Funding: **Self-funded**  
Network Status: **Out-of-Network**

### Aetna Life Insurance Company

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
06/27/23	21	9595526	1.0	1,755.00	50.96		1,704.04	1				50.96
06/27/23	21	95941	3.0	8,280.00	997.38		7,282.62	1				997.38
06/27/23	21	9593826	1.0	3,107.00	43.67		3,063.33	1				43.67
06/27/23	21	9586726		742.00	0.00		742.00	2				0.00
06/27/23	21	9586726	1.0	742.00	40.02		701.98	1				40.02
<b>TOTALS</b>				<b>14,626.00</b>	<b>1,132.03</b>		<b>13,493.97</b>					<b>1,132.03</b>

**ISSUED AMT: \$1,132.03**

### Remarks:

- 1 - The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under the NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at [FederalNSA@Aetna.com](mailto:FederalNSA@Aetna.com). Our Provider Contact Center team can be reached at 1-888-632-3862 (1-888-MD AETNA) if you need details on

Continued on Next Page



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PHYSICIAN OVERSIGHT LLC  
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PHOENIX AZ 85038-9650

Printed: 10/23/2023  
Page: 4 of 22

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

**Patient Name: CAROLYN K CLARK (self)**

**Remarks (contd):**

- initiating an Open Negotiation. If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process. [FDZ]
- 2 - The member's plan provides coverage for charges that are reasonable and appropriate as determined by us. This procedure exceeds the maximum number of services allowed under our guidelines for a single date of service. [V29]
- 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: \$1,217.89

**Patient Name: NICHOLAS D D'AGOSTINO (son)**

Claim ID: EJFC8VL3700 Recd: 10/19/23 Member ID: W157821056 Patient Account: 0.3088504

Member: MARIO M D'AGOSTINO

Group Name: CITY OF EL PASO

Product: Aetna HealthFund® Aetna Choice® POS II

DIAG: M4029/4

Group Number: 0620388-14-001 HD P15}0

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
07/28/23	21	95999		9,000.00	0.00		9,000.00	1				0.00
07/28/23	21	9595526		1,755.00	0.00		1,755.00	1				0.00
07/28/23	21	95941		8,280.00	0.00		8,280.00	1				0.00
07/28/23	21	9593926		3,814.00	0.00		3,814.00	1				0.00
07/28/23	21	9593826		3,107.00	0.00		3,107.00	1				0.00
07/28/23	21	9591326		1,224.00	0.00		1,224.00	1				0.00
<b>TOTALS</b>				<b>27,180.00</b>			<b>27,180.00</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.
- 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,

Continued on Next Page



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**Page:** 5 of 22

**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

PHYSICIAN OVERSIGHT, LLC

**Patient Name: NICHOLAS D D'AGOSTINO (son)**

**Remarks (contd):**

*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 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 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: CHERYL L HANKINSON (self)**

**Claim ID: EJPC8T1KX00** **Recd: 10/19/23** **Member ID: W264862189** **Patient Account: 0.3090082**

**Member: CHERYL L HANKINSON**

**Group Name: MEMORIAL HERMANN HEALTH SYSTEM**

**Product: Open Access Aetna Select<sup>SM</sup>**

**DIAG: M5412, M5002/0, Z98.1**

**Group Number: 0109072-10-001 A V1;@J0**

**Network ID: 00000**

**Funding: Self-funded**

**Network Status: Out-of-Network**

**Aetna Life Insurance Company**

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/QPA	COPAY AMOUNT	PENDING	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/31/23	22	95999		7,200.00	0.00		7,200.00	1				0.00
07/31/23	22	9595526		1,755.00	0.00		1,755.00	1				0.00
07/31/23	22	95941		11,040.00	0.00		11,040.00	1				0.00
07/31/23	22	9593926		3,814.00	0.00		3,814.00	1				0.00
07/31/23	22	9593826		3,107.00	0.00		3,107.00	1				0.00
07/31/23	22	9586826		1,310.00	0.00		1,310.00	1				0.00
		XU										
<b>TOTALS</b>				<b>28,226.00</b>			<b>28,226.00</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,

**Continued on Next Page**



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LEXINGTON KY 40512-4079  
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**Payment Address:**  
PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

**Printed:** 10/23/2023  
**Page:** 6 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: CHERYL L HANKINSON (self)**

**Remarks (contd):**

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 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)

Claim ID: **EJPC8T1KX01** Recd: **10/19/23** Member ID: **W264862189** Patient Account: **0.3090082**

Member: **CHERYL L HANKINSON**

Group Name: **MEMORIAL HERMANN HEALTH SYSTEM**

Product: **Open Access Aetna Select<sup>SM</sup>**

Aetna Life Insurance Company

DIAG: **M5412, M5002/0, Z98.1**

Group Number: **0109072-10-001 A V1;@J0**

Network ID: **04549 DIS-NAPP-**

Network Status: **Out-of-Network**

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/31/23	22	9586826		1,310.00			1,310.00	1				0.00
07/31/23	22	9586126		1,614.00			1,614.00	1				0.00
		XU										
07/31/23	22	9586126		1,614.00			1,614.00	1				0.00
<b>TOTALS</b>				<b>4,538.00</b>			<b>4,538.00</b>					<b>0.00</b>

**ISSUED AMT:**

**NO PAY**

**Remarks:**

1 - Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]

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

**Continued on Next Page**



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**Page:** 7 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: CHERYL L HANKINSON** (self)

For Questions Regarding This Claim PO BOX 981106 EL PASO, TX 79998-1106

**CALL (888) 337-0265** 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: ANGELA R HAWKS-JOHNSON** (spouse)

Claim ID: EXAC637X300 Recd: 10/18/23 Member ID: W278869745 Patient Account: 0.3088037

Member: MARC F JOHNSON

Group Name: AT&T SERVICES, INC.

Product: Open Access Aetna Select<sup>SM</sup>

DIAG: M5416, M7138, M5459  
Group Number: 0187648-18-032 I V1B=?0  
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
07/28/23	22	95999		3,600.00	0.00		3,600.00	1				0.00
07/28/23	22	9595526		1,755.00	0.00		1,755.00	1				0.00
07/28/23	22	95941		2,760.00	0.00		2,760.00	1				0.00
07/28/23	22	9593826		3,107.00	0.00		3,107.00	1				0.00
07/28/23	22	9586126		1,614.00	0.00		1,614.00	1				0.00
07/28/23	22	9586126		1,614.00	0.00		1,614.00	1				0.00
		XU										
<b>TOTALS</b>				<b>14,450.00</b>			<b>14,450.00</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.

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

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

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

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**Printed:** 10/23/2023  
**Page:** 8 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: ANGELA R HAWKS-JOHNSON** (spouse)

**Remarks (contd):**

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]

**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

**Patient Name: DEBORAH L LIGHT** (self)

Claim ID: E3TX60GHX01 Recd: 10/11/23 Member ID: W269378752 Patient Account: 0.3077618

Member: DEBORAH L LIGHT

Group Name: SOUTHWEST AIRLINES CO.

Product: Open Choice®

DIAG: M5116, G96.11

Group Number: 0169622-13-005 DA D(3)Q0

Network ID: 00000

Funding: Self-funded

Network Status: Out-of-Network

**Aetna Life Insurance Company**

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/QPA	COPAY AMOUNT	PENDING	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/19/23	21	95999		5,400.00	0.00		5,400.00	1				0.00
<b>TOTALS</b>				<b>5,400.00</b>			<b>5,400.00</b>					<b>0.00</b>

**ISSUED AMT:**

**NO PAY**

**Remarks:**

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

- A full description of the service and the itemized bill
- Clinical documentation that supports the medical necessity of the billed service (which includes the primary diagnosis)
- Copies of current history and physical exam, office or nursing notes, operative reports, lab or diagnostic testing results, if they apply
- Copies of documentation from the ordering physician which includes the expected period of time they need the drug or equipment, medical history and/or physical exam report that supports medical necessity of the drug or equipment and copies of drug administration notes, if they apply

You can find our Clinical Policy Bulletins at:

<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, 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 denial at that time.

The following does not apply to Federal plans:

**Continued on Next Page**





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

## Explanation Of Benefits

Please Retain for Future Reference

**Payment Address:**  
PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

**Printed:** 10/23/2023  
**Page:** 9 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: DEBORAH L LIGHT (self)**

**Remarks (contd):**

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 the peer review. To schedule the 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. [ICMN-970]

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

Claim ID: **E3TX60GHX00** Recd: **10/11/23** Member ID: **W269378752** Patient Account: **0.3077618**

Member: **DEBORAH L LIGHT**

Group Name: **SOUTHWEST AIRLINES CO.**

Product: **Open Choice®**

DIAG: **M5116, G96.11**

Group Number: **0169622-13-005 DA D()3Q0**

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	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/19/23	21	9595526		1,755.00	0.00		1,755.00	1				0.00
07/19/23	21	95941		11,040.00	0.00		11,040.00	1				0.00
07/19/23	21	9593826	1.0	3,107.00	50.39		3,056.61	2				50.39
07/19/23	21	9586126		1,614.00	0.00		1,614.00	1				0.00
07/19/23	21	9586126		1,614.00	0.00		1,614.00	1				0.00
		XU										
<b>TOTALS</b>				<b>19,130.00</b>	<b>50.39</b>		<b>19,079.61</b>					<b>50.39</b>

**ISSUED AMT: \$50.39**

**Remarks:**

- Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]
- The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under the NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at [FederalNSA@Aetna.com](mailto:FederalNSA@Aetna.com). Our Provider Contact Center team can be reached at 1-888-632-3862 (1-888-MD AETNA) if you need details on initiating an Open Negotiation. If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process. [FDZ]  
Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

Continued on Next Page



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

## Explanation Of Benefits

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PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

Printed: 10/23/2023  
Page: 10 of 22

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

**Patient Name: DEBORAH L LIGHT** (self)

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: \$50.39

**Patient Name: SAMEER K MYLAVARAPU** (self)

Claim ID: E6FC67Z6G01 Recd: 10/21/23 Member ID: W272584645 Patient Account: 0.3080629

Member: SAMEER K MYLAVARAPU

Group Name: AMAZON AND SUBSIDIARIES

Product: Aetna Choice® POS II

Aetna Life Insurance Company

DIAG: M4802

Group Number: 0868402-18-001 C P1/CT0

Network ID: 04546 DIS-NAP

Network Status: Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/21/23	22	9586126 XU		1,614.00			1,614.00	1				0.00
<b>TOTALS</b>				<b>1,614.00</b>			<b>1,614.00</b>					<b>0.00</b>

**ISSUED AMT: NO PAY**

### Remarks:

1 - Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]

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

**Patient Name: LEWIS C REARICK** (self)

Claim ID: E6FC67Z2D02 Recd: 10/21/23 Member ID: W173213912 Patient Account: 0.3073826

Member: LEWIS C REARICK

Group Name: BP CORPORATION NORTH AMERICA INC.

Product: Aetna HealthFund® Aetna Choice® POS II

DIAG: M4807, M961

Group Number: 0839202-11-002 AB P1\$M10

Network ID: 00000

Funding: Self-funded

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
07/17/23	22	95999		7,200.00	0.00		7,200.00	1				0.00
<b>TOTALS</b>				<b>7,200.00</b>			<b>7,200.00</b>					<b>0.00</b>

Continued on Next Page



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USA

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**Payment Address:**  
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PO BOX 29650  
PHOENIX AZ 85038-9650

Printed: 10/23/2023  
Page: 11 of 22

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

**Patient Name: LEWIS C REARICK** (self)

ISSUED AMT:

NO PAY

### Remarks:

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

- A full description of the service and the itemized bill
- Clinical documentation that supports the medical necessity of the billed service (which includes the primary diagnosis)
- Copies of current history and physical exam, office or nursing notes, operative reports, lab or diagnostic testing results, if they apply
- Copies of documentation from the ordering physician which includes the expected period of time they need the drug or equipment, medical history and/or physical exam report that supports medical necessity of the drug or equipment and copies of drug administration notes, if they apply

You can find our Clinical Policy Bulletins at:

<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, 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 denial at that time.

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 the peer review. To schedule the 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. [ICMN-970]

Claim ID: **E6FC67Z2D01** Recd: **10/21/23** Member ID: **W173213912** Patient Account: **0.3073826**

Member: **LEWIS C REARICK**

Group Name: **BP CORPORATION NORTH AMERICA INC.**

Product: **Aetna HealthFund® Aetna Choice® POS II**

**Aetna Life Insurance Company**

DIAG: **M4807, M961**

Group Number: **0839202-11-002 AB P1\$M10**

Network ID: **04546 DIS-NAP**

Network Status: **Out-of-Network**

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/17/23	22	9588626 XU		2,972.00			2,972.00	1				0.00
<b>TOTALS</b>				<b>2,972.00</b>			<b>2,972.00</b>					<b>0.00</b>

ISSUED AMT:

NO PAY

### Remarks:

1 - Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage

Continued on Next Page



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

## Explanation Of Benefits

Please Retain for Future Reference

**Payment Address:**  
PHYSICIAN OVERSIGHT LLC  
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PHOENIX AZ 85038-9650

**Printed:** 10/23/2023  
**Page:** 12 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: LEWIS C REARICK** (self)

**Remarks (contd):**

under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]  
Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

**Claim ID: E6FC67Z2D00**    **Recd: 10/21/23**    **Member ID: W173213912**    **Patient Account: 0.3073826**  
**Member: LEWIS C REARICK**  
**Group Name: BP CORPORATION NORTH AMERICA INC.**  
**Product: Aetna HealthFund® Aetna Choice® POS II**

**DIAG: M4807, M961**  
**Group Number: 0839202-11-002 AB P1\$M10**  
**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	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/17/23	22	9595526		1,755.00	0.00		1,755.00	1				0.00
07/17/23	22	95941		5,520.00	0.00		5,520.00	1				0.00
07/17/23	22	9593826	1.0	3,107.00	3,107.00							3,107.00
07/17/23	22	9590926	1.0	555.00	555.00							555.00
07/17/23	22	9588626		2,972.00	0.00		2,972.00	1				0.00
<b>TOTALS</b>				<b>13,909.00</b>	<b>3,662.00</b>		<b>10,247.00</b>					<b>3,662.00</b>

**ISSUED AMT: \$3,662.00**

**Remarks:**

1 - Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]  
Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)  
We denied or reduced one or more services on this claim. The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under the NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at [FederalNSA@Aetna.com](mailto:FederalNSA@Aetna.com). Our Provider Contact Center team can be reached at 1-888-632-3862 (1-888-MD AETNA) if you need details on initiating an Open Negotiation. If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process. [FDX]

**For Questions Regarding This Claim** PO 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:** \$3,662.00

Continued on Next Page



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

## Explanation Of Benefits

Please Retain for Future Reference

**Payment Address:**  
PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

Printed: 10/23/2023  
Page: 13 of 22

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

### Patient Name: YALU D BOSCAN (spouse)

Claim ID: EFFC8TM8401 Recd: 10/19/23 Member ID: W233942693 Patient Account: 0.3087675  
Member: LEONARDO J RENDON  
Group Name: GENERAL ELECTRIC COMPANY  
Product: Aetna Choice® POS II

DIAG: M4806/2, M5127  
Group Number: 0836403-25-001 BH P1EC{0  
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
07/28/23	21	95999		3,600.00	0.00		3,600.00	1				0.00
<b>TOTALS</b>				<b>3,600.00</b>			<b>3,600.00</b>					<b>0.00</b>

ISSUED AMT:

NO PAY

#### Remarks:

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

- A full description of the service and the itemized bill
- Clinical documentation that supports the medical necessity of the billed service (which includes the primary diagnosis)
- Copies of current history and physical exam, office or nursing notes, operative reports, lab or diagnostic testing results, if they apply
- Copies of documentation from the ordering physician which includes the expected period of time they need the drug or equipment, medical history and/or physical exam report that supports medical necessity of the drug or equipment and copies of drug administration notes, if they apply

You can find our Clinical Policy Bulletins at:

<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, 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 denial at that time.

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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 the peer review. To schedule the 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. [ICMN-970]

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

Claim ID: EFFC8TM8400 Recd: 10/19/23 Member ID: W233942693 Patient Account: 0.3087675  
Member: LEONARDO J RENDON  
Group Name: GENERAL ELECTRIC COMPANY  
Product: Aetna Choice® POS II

DIAG: M4806/2, M5127  
Group Number: 0836403-25-001 BH P1EC{0  
Network ID: 00000  
Funding: Self-funded  
Network Status: Out-of-Network

Aetna Life Insurance Company

Continued on Next Page



P.O. BOX 14079  
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USA

## Explanation Of Benefits

Please Retain for Future Reference

**Payment Address:**  
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PO BOX 29650  
PHOENIX AZ 85038-9650

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**Page:** 14 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: YALU D BOSCAN** (spouse)

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
07/28/23	21	9595526		1,755.00	0.00		1,755.00	1				0.00
07/28/23	21	95941		2,760.00	0.00		2,760.00	1				0.00
07/28/23	21	9593826	1.0	3,107.00	43.67		3,063.33	2		8.73	8.73	34.94
07/28/23	21	9586126		1,614.00	0.00		1,614.00	1				0.00
07/28/23	21	9586126		1,614.00	0.00		1,614.00	1				0.00
		XU										
<b>TOTALS</b>				<b>10,850.00</b>	<b>43.67</b>		<b>10,806.33</b>			<b>8.73</b>	<b>8.73</b>	<b>34.94</b>

**ISSUED AMT: \$34.94**

### Remarks:

- Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]
- The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under the NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at FederalNSA@Aetna.com. Our Provider Contact Center team can be reached at 1-888-632-3862 (1-888-MD AETNA) if you need details on initiating an Open Negotiation. If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process. [FDZ]  
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: \$8.73**  
**Claim Payment: \$34.94**

**Patient Name: JANICE C SALINAS** (self)

**Claim ID: ERWZ7T2JB00**    **Recd: 08/31/23**    **Member ID: W056709206**    **Patient Account: 0.3064344**  
**Member: JANICE C SALINAS**  
**Group Name: EXXONMOBIL**  
**Product: Open Access Aetna Select<sup>SM</sup>**

**DIAG: M4807, M5117**  
**Group Number: 0721000-31-002 KR V1C&Y0**  
**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	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/07/23	21	95999		5,400.00	0.00		5,400.00	1			5,400.00	0.00
07/07/23	21	95941		2,760.00	0.00		2,760.00	2				0.00
07/07/23	21	9593826		3,107.00	0.00		3,107.00	1			3,107.00	0.00
07/07/23	21	9586126		1,614.00	0.00		1,614.00	2				0.00
07/07/23	21	9586126		1,614.00	0.00		1,614.00	2				0.00

Continued on Next Page



P.O. BOX 14079  
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## Explanation Of Benefits

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**Payment Address:**  
PHYSICIAN OVERSIGHT LLC  
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PHOENIX AZ 85038-9650

**Printed:** 10/23/2023  
**Page:** 15 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: JANICE C SALINAS (self)**

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
07/07/23	21	XU 9582226		1,755.00	0.00		1,755.00	1			1,755.00	0.00
<b>TOTALS</b>				<b>16,250.00</b>			<b>16,250.00</b>				<b>10,262.00</b>	<b>0.00</b>

**ISSUED AMT:**

**NO PAY**

**Remarks:**

- 1 - We denied this service. We did not receive the details we asked for. You can refer to the prior EOB for these charges by logging into your secure provider portal. [PPND - 717]
- 2 - Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]

**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:** \$10,262.00  
**Claim Payment:** \$0.00

**Patient Name: RAFAEL SANTOS (self)**

**Claim ID: EJPC8T1GB01**    **Recd: 10/19/23**    **Member ID: W268043293**    **Patient Account: 0.3128815**  
**Member: RAFAEL SANTOS**  
**Group Name: INTERNATIONAL CELLULOSE CORPORATION**  
**Product: Aetna Choice® POS II**

**DIAG: M4803, S14.129A**  
**Group Number: 0775668-10-720 U P1.H?F**  
**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	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
09/04/23	21	9587026 XU	1.0	4,820.00	18.87		4,801.13	1				18.87
09/04/23	21	9586826 XU		4,214.00	0.00		4,214.00	2				0.00
09/04/23	21	9586826	1.0	4,214.00	59.56		4,154.44	1				59.56
<b>TOTALS</b>				<b>13,248.00</b>	<b>78.43</b>		<b>13,169.57</b>					<b>78.43</b>

**ISSUED AMT:**

**\$78.43**

**Remarks:**

- 1 - The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under the NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at FederalNSA@Aetna.com. Our Provider Contact Center team can be reached at 1-888-632-3862 (1-888-MD AETNA) if you need details on initiating an Open Negotiation. If the 30-day negotiation period does not result in the issue of a determination you have 4 business days

**Continued on Next Page**



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**Page:** 16 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: RAFAEL SANTOS (self)**

**Remarks (contd):**

- beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process. [FDZ]
- 2 - Procedures designated as bilateral should not be billed with multiple units. Payment has been based on one unit. W18  
Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)

Claim ID: **EJPC8T1GB00** Recd: **10/19/23** Member ID: **W268043293** Patient Account: **0.3128815**  
Member: **RAFAEL SANTOS**  
Group Name: **INTERNATIONAL CELLULOSE CORPORATION**  
Product: **Aetna Choice® POS II**

DIAG: **M4803, S14.129A**  
Group Number: **0775668-10-720 U P1.H?F**  
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
09/03/23	21	9587026		4,820.00	0.00		4,820.00	1				0.00
		XU										
09/04/23	21	95999		7,200.00	0.00		7,200.00	1				0.00
09/04/23	21	9595526		6,979.00	0.00		6,979.00	1				0.00
09/04/23	21	95941		16,560.00	0.00		16,560.00	1				0.00
09/04/23	21	9593926		10,303.00	0.00		10,303.00	1				0.00
09/04/23	21	9593826		7,270.00	0.00		7,270.00	1				0.00
<b>TOTALS</b>				<b>53,132.00</b>			<b>53,132.00</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.
- 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

**Continued on Next Page**





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Page: 17 of 22

PHYSICIAN OVERSIGHT, LLC  
PIN: 0006484765  
TIN: XXXXXXXX2512  
Trace Number: 823296000253926  
Trace Amount: \$6,083.04

**Patient Name: RAFAEL SANTOS** (self)

**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]  
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: \$78.43

**Patient Name: NICHOLAS A GARCIA** (son)

Claim ID: E536627MT01 Recd: 10/10/23 Member ID: W161705415 Patient Account: 0.3083315

Member: SARAH SCOTT

Group Name: CVS PHARMACY, INC.

Product: Aetna HealthFund® Aetna Choice® POS II

Aetna Life Insurance Company

DIAG: M5417

Group Number: 0141974-10-002 B P1WQ'0

Network ID: 04546 DIS-NAP

Network Status: Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/24/23	21	9586126 XU		1,614.00			1,614.00	1				0.00
<b>TOTALS</b>				1,614.00			1,614.00					0.00

ISSUED AMT: NO PAY

**Remarks:**

1 - Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]  
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** PO 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: JOE SOLIS JR** (self)

Claim ID: EQAC8Q0Z300 Recd: 10/13/23 Member ID: W248656339 Patient Account: 0.3085329

Member: JOE SOLIS JR

Group Name: CHEMOURS COMPANY

Product: Aetna Choice® POS II

DIAG: M5116, M4806/2

Group Number: 0865425-10-002 AB P1E9=0

Network ID: 00000

Funding: Self-funded

Network Status: Out-of-Network

Aetna Life Insurance Company

Continued on Next Page



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**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: JOE SOLIS JR (self)**

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		3,600.00	0.00		3,600.00	1				0.00
07/26/23	21	9595526		1,755.00	0.00		1,755.00	1				0.00
07/26/23	21	95941		2,760.00	0.00		2,760.00	1				0.00
07/26/23	21	9593826		3,107.00	0.00		3,107.00	1				0.00
07/26/23	21	9586126		1,614.00	0.00		1,614.00	1				0.00
07/26/23	21	9586126		1,614.00	0.00		1,614.00	1				0.00
		XU										
<b>TOTALS</b>				<b>14,450.00</b>			<b>14,450.00</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.

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 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]

**For Questions Regarding This Claim** PO 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

**Continued on Next Page**



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## Explanation Of Benefits

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**Page:** 19 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

### Patient Name: FRANCISCO PIEPER (spouse)

Claim ID: EDY18M6V700 Recd: 10/16/23 Member ID: W146705984 Patient Account: 0.3081966  
Member: ANDREA M VANHOUTAN PIEPER  
Group Name: COX ENTERPRISES, INC.  
Product: Aetna Choice® POS II

DIAG: G89.4  
Group Number: 0779409-40-501 CC P1+VY0  
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	22	95999		1,800.00	0.00		1,800.00	1				0.00
07/24/23	22	9595526		1,755.00	0.00		1,755.00	1				0.00
07/24/23	22	95941		2,760.00	0.00		2,760.00	1				0.00
07/24/23	22	9593926		3,814.00	0.00		3,814.00	1				0.00
07/24/23	22	9593826		3,107.00	0.00		3,107.00	1				0.00
<b>TOTALS</b>				<b>13,236.00</b>			<b>13,236.00</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.

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 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]

Continued on Next Page



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**Page:** 20 of 22

**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

PHYSICIAN OVERSIGHT, LLC

**Patient Name: FRANCISCO PIEPER** (spouse)

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

**Patient Name: WHITNEY WEST** (self)

Claim ID: EZTX64XQJ00 Recd: 10/19/23 Member ID: W265946919 Patient Account: 0.3089173

Member: WHITNEY WEST

Group Name: FRONTLINE TECHNOLOGIES GROUP, LLC DBA FRONTLINE

Product: Aetna HealthFund® Aetna Choice® POS II

DIAG: M4806/1

Group Number: 0870063-11-001 AB P1/C-0

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
07/31/23	22	95999		5,400.00	0.00		5,400.00	1				0.00
07/31/23	22	9595526		1,755.00	0.00		1,755.00	1				0.00
07/31/23	22	95941		5,520.00	0.00		5,520.00	1				0.00
07/31/23	22	9593826		3,107.00	0.00		3,107.00	1				0.00
07/31/23	22	9590826		437.00	0.00		437.00	1				0.00
07/31/23	22	9588626		2,972.00	0.00		2,972.00	1				0.00
<b>TOTALS</b>				<b>19,191.00</b>			<b>19,191.00</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.

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,

Continued on Next Page



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**Page:** 21 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: WHITNEY WEST** (self)

**Remarks (contd):**

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

**Claim ID:** EZTX64XQJ01 **Recd:** 10/19/23 **Member ID:** W265946919 **Patient Account:** 0.3089173

**Member:** WHITNEY WEST

**Group Name:** FRONTLINE TECHNOLOGIES GROUP, LLC DBA FRONTLINE

**Product:** Aetna HealthFund® Aetna Choice® POS II

**Aetna Life Insurance Company**

**DIAG:** M4806/1  
**Group Number:** 0870063-11-001 AB P1/C-0  
**Network ID:** 04546 DIS-NAP  
**Network Status:** Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
07/31/23	22	9588626 XU		2,972.00			2,972.00	1				0.00
<b>TOTALS</b>				<b>2,972.00</b>			<b>2,972.00</b>					<b>0.00</b>

**ISSUED AMT:**

**NO PAY**

**Remarks:**

1 - Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]  
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: JEFFREY S ZANNI** (spouse)

**Claim ID:** EFPC22MXK05 **Recd:** 10/12/23 **Member ID:** W228533629 **Patient Account:** 0.2656483

**Member:** SARAH M ZANNI

**Group Name:** ASTELLAS US LLC

**Product:** Aetna Choice® POS II

**DIAG:** M4806/2  
**Group Number:** 0466048-11-002 B P1+=O0  
**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	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
08/01/22	21	95999		7,200.00	0.00		7,200.00	1				0.00
08/01/22	21	95941		2,760.00	0.00		2,760.00	2				0.00
08/01/22	21	9593926	1.0	3,814.00	3,814.00							1,200.00
08/01/22	21	9593826	1.0	3,107.00	3,107.00							1,387.50

Continued on Next Page



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

## Explanation Of Benefits

Please Retain for Future Reference

**Payment Address:**  
PHYSICIAN OVERSIGHT LLC  
PO BOX 29650  
PHOENIX AZ 85038-9650

**Printed:** 10/23/2023  
**Page:** 22 of 22

**PHYSICIAN OVERSIGHT, LLC**  
**PIN:** 0006484765  
**TIN:** XXXXXXXX2512  
**Trace Number:** 823296000253926  
**Trace Amount:** \$6,083.04

**Patient Name: JEFFREY S ZANNI** (spouse)

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
08/01/22	21	9586126		1,614.00	0.00		1,614.00	2				0.00
08/01/22	21	9586126		1,614.00	0.00		1,614.00	2				0.00
		XU										
<b>TOTALS</b>				<b>20,109.00</b>	<b>6,921.00</b>		<b>13,188.00</b>					<b>2,587.50</b>

Less Amount Already Paid \$1,548.11

**ISSUED AMT: \$1,039.39**

### Remarks:

- The member's plan of benefits provides coverage for services or supplies that we determine are necessary. To meet this requirement the service or supply must be accepted under recognized professional standards as appropriate and effective for the diagnosis, care, or treatment of the disease or injury involved. Based on the information provided, this expense does not meet this requirement of the member's plan of benefits and is excluded from coverage. [783]
- Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field. You may also use our provider portal on Availity. From the Availity Home page, select Payer Spaces, Aetna, then Code Edit Lookup tools. [775]  
Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported. (E73)  
We denied or reduced one or more services on this claim. The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. The QPA is the difference between the "submitted charges" and "not payable" amount shown on each covered service line. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under the NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at [FederalNSA@Aetna.com](mailto:FederalNSA@Aetna.com). Our Provider Contact Center team can be reached at 1-888-632-3862 (1-888-MD AETNA) if you need details on initiating an Open Negotiation. If the 30-day negotiation period does not result in the issue of a determination you have 4 business days beginning on the 31st business day following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process. [FDX]

### 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: \$1,039.39

**Total Payment to: PHYSICIAN OVERSIGHT, LLC**

**\$6,083.04**

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.