aetna®

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Summary of Claim Payment

Please Retain for Future Reference

Printed: 10/10/2023
Page: 1 of 26

Monitoring Associates LLC
TIN: XXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Notes: Enclosed is a group payment to the XXXXXXX2508. Below is a itemization of the check. Please refer to the attached statements of details.

Breakdown of Payment(s) Issued:

NAME	PIN	ISSUED AMT
Indranil Sen-Gupta	0004945742	$587.07
Omar J Moore	0006247487	$3,606.25
Audrey R Nath	0006483171	$1,077.23
Maria A De Jesus	0007051585	$215.01

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P.O. BOX 981106
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USA

ID No: XXXXXXX2508
Seq No: 000000004

Trace No: 201002421
Acct: 09146

51 - 44
119 CT

10-10-2023

NON-NEGOTIABLE NON-NEGOTIABLE

VOID AFTER ONE YEAR

PAY ***Six Thousand Two Hundred Thirty One Dollars and 23/100*** ******$6,231.23**

TO THE ORDER OF

MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Bank of America

VOID VOID

766 (10-02)

Payment was made via Electronic Funds Transfer

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Summary of Claim Payment

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Printed: 10/10/2023

Monitoring Associates LLC
TIN: XXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

NAME	PIN	ISSUED AMT
Matthew B McAuliffe	0007066969	$745.67
TOTAL ISSUED AMOUNT		$6,231.23

TOTAL TRACE AMOUNT:	**$6,231.23**

Explanation Of Benefits

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USA

Printed: 10/10/2023
Page: 3 of 26

Indranil Sen-Gupta
PIN: 0004945742
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Indranil Sen-Gupta
PO Box 29650
Phoenix AZ 85038

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: Lynda Lee I Hovey-Crain (self)

Claim ID: **ETAC62L8B03** Recd: **10/06/23** Member ID: **101624980200** Patient Account: **0.3044492**
Member: **Lynda Lee I Hovey-Crain** DIAG: **M54.16, M48.061, M51.36**
Group Name: **Aetna Medicare Prime Plus Plan (HMO-POS)** Group Number: **000003-NV00 0021**
Product: **Direct Access POS - Medicare (Aetna)**
Contract State: **NV** 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
06/19/23	22	9593826	1.0	3,107.00			0.91	1				44.79
							3,061.30	2				
								3				
06/19/23	22	9586126	1.0	1,614.00			1.64	1				88.46
							1,531.94	4				
								2				
								3				
06/19/23	22	9586126 XU	1.0	1,614.00			1.64	1				88.46
							1,531.94	4				
								2				
								3				
06/19/23	22	95999		5,400.00			5,400.00	5				0.00
TOTALS				**11,735.00**			**11,529.37**					**221.71**

ISSUED AMT: $221.71

Remarks:

1 - *This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]*
2 - *We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]*
3 - *Payment made according to Medicare allowable rate. [P49]*
4 - *The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]*
5 - *We need more details to complete our review. Please send us:*

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name,

Continued on Next Page

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Explanation Of Benefits

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Indranil Sen-Gupta
PIN: 0004945742
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: Lynda Lee I Hovey-Crain (self)

Remarks (contd):

patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
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CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $221.71

Patient Name: CARRIE D PIERCE (self)

Claim ID: **ETAC62L5K03** Recd: **10/06/23** Member ID: **101210092900** Patient Account: **0.3044565**
Member: **CARRIE D PIERCE** DIAG: **M51.26**
Group Name: **Aetna Medicare Select Plan (HMO-POS)** Group Number: **000003-NV00 0007**
Product: **Direct Access POS - Medicare (Aetna)**
Contract State: **NV** 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
06/19/23	21	9593826	1.0	3,107.00			0.91	1				44.79
							3,061.30	2				
								3				
06/19/23	21	9595526	1.0	1,755.00			1.07	1				57.84
							1,701.35	4				
								2				
								3				
06/19/23	21	9592926	1.0	2,459.00			1.59	1				85.81
							2,379.40	4				
								2				
								3				
06/19/23	21	9586126	1.0	1,614.00			1.64	1				88.46
							1,531.94	4				
								2				
								3				
06/19/23	21	9586126 XU	1.0	1,614.00			1.64	1				88.46
							1,531.94	4				
								2				
								3				
06/19/23	21	95999		3,600.00			3,600.00	5				0.00
TOTALS				**14,149.00**			**13,812.78**					**365.36**

ISSUED AMT: $365.36

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P.O. BOX 981106
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USA

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/10/2023
Page: 5 of 26

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Indranil Sen-Gupta
PIN: 0004945742
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: CARRIE D PIERCE (self)

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]

3 - Payment made according to Medicare allowable rate. [P49]

4 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]

5 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$365.36

Total Payment to: Indranil Sen-Gupta ***$587.07***

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EL PASO TX 79998-1106
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Indranil Sen-Gupta
PIN: 0004945742
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

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EL PASO TX 79998-1106
USA

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/10/2023
Page: 7 of 26

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Omar J Moore
PO Box 29650
Phoenix AZ 85038

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: William P Fisher (self)

Claim ID: **E5TX6CQQX05** Recd: **09/06/23** Member ID: **101240580400** Patient Account: **0.2804771**
Member: **William P Fisher** DIAG: **M48.061**
Group Name: **Medicare (C02) ESA PPO** Group Number: **100113-01EG 0001**
Product: **ESA - Medicare (Aetna)**
Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
11/29/22	21	9582226	1.0	1,755.00			1.11	1				54.29
							1,699.60	2				
								3				
11/29/22	21	9593826	1.0	3,107.00			0.88	1				43.24
							3,062.88	2				
								3				
11/29/22	21	9590826	1.0	437.00			1.29	1				63.18
							372.53	2				
								3				
11/29/22	21	9588626	2.0	2,972.00			1.76	1				86.48
							2,883.76	2				
								3				
11/29/22	21	9588626 XU	2.0	2,972.00			1.76	1				86.48
							2,883.76	2				
								3				
11/29/22	21	95999	4.0	7,200.00			5,040.00	4				2,160.00
TOTALS				**18,443.00**			**15,949.33**					**2,493.67**

Late Claim Interest/Penalty was applied to this claim. [H11] $2.67

ISSUED AMT: $2,496.34

Remarks:

1 - *This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]*
2 - *We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]*
3 - *Payment made according to Medicare allowable rate. [P49]*
4 - *This charge is paid at a percentage of billed, according to the default value on the Aetna Fee Schedule. Pharmacy J drug codes will still be at 60%. [PH5]*
The payment reflects applicable interest incurred. P91

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Printed: 10/10/2023
Page: 8 of 26

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: William P Fisher (self)

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $2,496.34

Patient Name: Barbara G Fox (self)

Claim ID: **EPAC8KDVH03** Recd: **10/05/23** Member ID: **101216745200** Patient Account: **0.2852676**
Member: **Barbara G Fox** DIAG: **M43.16**
Group Name: **Aetna Medicare Value (PPO)** Group Number: **000003-IL00 0008**
Product: **PPO - Medicare (Aetna)**
Contract State: **IL** Funding: **Insured**
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
01/09/23	21	9593826	1.0	3,107.00			0.94	1				46.24
							3,059.82	2				
								3				
01/09/23	21	9595526	1.0	1,755.00			1.11	1				54.18
							1,699.71	2				
								3				
01/09/23	21	9590926	1.0	555.00			1.65	1				80.75
							472.60	2				
								3				
01/09/23	21	9588626	2.0	5,944.00			1.90	1				93.17
							5,848.93	2				
								3				
01/09/23	21	9588626 XU	2.0	5,944.00			1.90	1				93.17
							5,848.93	2				
								3				
01/09/23	21	95999		7,200.00			7,200.00	4				0.00
TOTALS				**24,505.00**			**24,137.49**					**367.51**

ISSUED AMT: $367.51

Remarks:
1 - *This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]*
2 - *We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]*
3 - *Payment made according to Medicare allowable rate. [P49]*
4 - *We need more details to complete our review. Please send us:*

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.

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Explanation Of Benefits

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Printed: 10/10/2023
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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: Barbara G Fox (self)

Remarks (contd):

2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $367.51

Patient Name: Richard Kimball (self)

Claim ID: **EPFC8LR8Y03** Recd: **10/06/23** Member ID: **101251143200** Patient Account: **0.2833779**
Member: **Richard Kimball** DIAG: **M48.062, M54.16**
Group Name: **Medicare (C04) ESA PPO** Group Number: **200-EGS0000 0131**
Product: **ESA - Medicare (Aetna)**
Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/20/22	21	9593826		3,107.00			3,107.00	1				0.00
								2				
12/20/22	21	9595526		1,755.00			1,755.00	1				0.00
								2				
12/20/22	21	9590726	1.0	138.00			1.12	3				54.93
							81.95	1				
								4				
12/20/22	21	9588626	2.0	2,972.00			1.93	3				94.43
							2,875.64	1				
								4				
12/20/22	21	9588626	2.0	2,972.00			1.93	3				94.43
		XU					2,875.64	1				
								4				
12/20/22	21	95999		3,600.00			3,600.00	5				0.00
TOTALS				**14,544.00**			**14,300.21**					**243.79**

ISSUED AMT: $243.79

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: Richard Kimball (self)

Remarks:

1 - We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]

2 - Charges for or in connection with services or supplies that are, as determined by us, considered to be experimental or investigational are excluded from coverage under the member's plan. The member is not responsible for this charge, unless they agreed to be responsible for this charge in writing before the service or supply was given. 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, the Code Edit Lookup tools. [777]

3 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

4 - Payment made according to Medicare allowable rate. [P49]

5 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
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USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$243.79

Patient Name: Karen J Krueger (self)

Claim ID: **EPFC8LR3F03** Recd: **10/06/23** Member ID: **101349332200** Patient Account: **0.2832179**
Member: **Karen J Krueger** DIAG: **M19.012**
Group Name: **Aetna Medicare Premier Plus (PPO)** Group Number: **000003-FL00 0033**
Product: **PPO - Medicare (Aetna)**
Contract State: **FL** Funding: **Insured**
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
12/19/22	22	9592526	1.0	353.00			0.61	1				29.88
							322.51	2				
								3				
12/19/22	22	9595526	1.0	1,755.00			1.11	1				54.48

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Printed: 10/10/2023

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Patient Name: Karen J Krueger (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
							1,699.41	2				
								3				
12/19/22	22	9586126	1.0	1,614.00			1.71	1				84.03
							1,528.26	2				
								3				
12/19/22	22	9586126	1.0	1,614.00			1.71	1				84.03
		XU					1,528.26	2				
								3				
12/19/22	22	95999		3,600.00			3,600.00	4				0.00
TOTALS				**8,936.00**			**8,683.58**					**252.42**

ISSUED AMT: $252.42

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]

3 - Payment made according to Medicare allowable rate. [P49]

4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $252.42

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EL PASO TX 79998-1106
USA

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/10/2023
Page: 12 of 26

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: WANDA R REGENOLD (self)

Claim ID: **ETJM62P2N03** Recd: **10/06/23** Member ID: **101507468900** Patient Account: **0.3044211**
Member: **WANDA R REGENOLD** DIAG: **M19.011, M25.511**
Group Name: **Aetna Medicare Premier Plus (PPO)** Group Number: **000003-FL00 0033**
Product: **PPO - Medicare (Aetna)**
Contract State: **FL** Funding: **Insured**
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
06/19/23	22	9595526	1.0	1,755.00			1.09	1				53.37
							1,700.54	2				
								3				
06/19/23	22	9592526	1.0	353.00			0.59	1				29.10
							323.31	2				
								3				
06/19/23	22	9586126	1.0	1,614.00			1.67	1				81.86
							1,530.47	2				
								3				
06/19/23	22	9586126 XU	1.0	1,614.00			1.67	1				81.86
							1,530.47	2				
								3				
06/19/23	22	95999		1,800.00			1,800.00	4				0.00
TOTALS				**7,136.00**			**6,889.81**					**246.19**

ISSUED AMT: $246.19

Remarks:

1 - *This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]*
2 - *We adjusted the payment due to the Merit-based Incentive Payment System. The adjustment applies to the Medicare allowed amount. We also deducted the member cost share. [PWX]*
3 - *Payment made according to Medicare allowable rate. [P49]*
4 - *We need more details to complete our review. Please send us:*

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

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P.O. BOX 981106
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Explanation Of Benefits

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: WANDA R REGENOLD (self)

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$246.19

Total Payment to: Omar J Moore ***$3,606.25***

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

Explanation Of Benefits

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P.O. BOX 981106
EL PASO TX 79998-1106
USA

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Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Audrey R Nath
PO Box 29650
Phoenix AZ 85038

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: Stephanie A Calaway (self)

Claim ID: **ET366XRLB03** Recd: **10/06/23** Member ID: **101354369500** Patient Account: **0.2831759**
Member: **Stephanie A Calaway** DIAG: **G90.513, G90.523**
Group Name: **Aetna Medicare Select Plan (PPO)** Group Number: **000003-NV00 0014**
Product: **PPO - Medicare (Aetna)**
Contract State: **NV** Funding: **Insured**
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
12/19/22	22	9593826	1.0	3,107.00			0.56	1		18.66	18.66	27.44
							3,060.34	2				
12/19/22	22	9595526	1.0	1,755.00			0.66	1		21.86	21.86	35.34
							1,700.35	3				
								2				
12/19/22	22	9586126	1.0	1,614.00			1.01	1		33.58	33.58	54.30
							1,530.05	3				
								2				
12/19/22	22	9586126	1.0	1,614.00			1.01	1		33.58	33.58	54.30
		XU					1,530.05	3				
								2				
12/19/22	22	9586826		1,310.00			1,310.00	4				0.00
12/19/22	22	9586826	1.0	1,310.00			0.77	1		25.66	25.66	41.48
		XU					1,245.86	3				
								2				
12/19/22	22	95999		5,400.00			5,400.00	5				0.00
TOTALS				**16,110.00**			**15,780.66**			**133.34**	**133.34**	**212.86**

ISSUED AMT: $212.86

Remarks:

1 - *This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]*
2 - *Payment made according to Medicare allowable rate. [P49]*
3 - *The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]*
4 - *Procedures designated as bilateral should not be billed with multiple units. Payment has been based on one unit. [DXT]*
5 - *We need more details to complete our review. Please send us:*

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: Stephanie A Calaway (self)

Remarks (contd):

5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$133.34
Claim Payment:	$212.86

Patient Name: Edward F Carter JR (self)

Claim ID: **E4FC6VL3G03** Recd: **10/03/23** Member ID: **101393318300** Patient Account: **0.2820335**
Member: **Edward F Carter JR** DIAG: **M48.02, M50.11**
Group Name: **Aetna Medicare Eagle (PPO)** Group Number: **000003-FL00 0058**
Product: **PPO - Medicare - MA (Aetna)**
Contract State: **FL** Funding: **Insured**
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
12/09/22	22	9593926	1.0	3,814.00			2.46	1				120.64
							3,690.90	2				
12/09/22	22	9593826	1.0	3,814.00			0.94	1				46.29
							3,766.77	2				
12/09/22	22	9595526	1.0	1,755.00			1.10	1				54.09
							1,699.81	2				
12/09/22	22	9586126	1.0	1,614.00			1.70	1				83.42
		XU					1,528.88	2				
12/09/22	22	9586126	1.0	1,614.00			1.70	1				83.42
							1,528.88	2				
12/09/22	22	9586526		1,502.00			1,502.00	3				0.00
12/09/22	22	9586526	1.0	1,502.00			1.72	1				84.14
		XU					1,416.14	2				
12/09/22	22	9586826		1,502.00			1,502.00	3				0.00
		XU										
12/09/22	22	9586826	1.0	1,310.00			1.30	1				63.54
		XU					1,245.16	2				
12/09/22	22	95999		7,200.00			7,200.00	4				0.00
TOTALS				**25,627.00**			**25,091.46**					**535.54**

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: Edward F Carter JR (self)

ISSUED AMT: $535.54

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]
2 - Payment made according to Medicare allowable rate. [P49]
3 - Procedures designated as bilateral should not be billed with multiple units. Payment has been based on one unit. [DXT]
4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $535.54

Patient Name: REGINALD HOWARD (self)

Claim ID: **EPAC8K8MH03** Recd: **10/06/23** Member ID: **101497355000** Patient Account: **0.2832170**
Member: **REGINALD HOWARD** DIAG: **M51.27, G60.3**
Group Name: **Aetna Medicare Prime Plan (HMO-POS)** Group Number: **000003-NV00 0010**
Product: **Direct Access POS - Medicare (Aetna)**
Contract State: **NV** Funding: **Insured**
Coventry Health Care of Nebraska, 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
12/19/22	22	9593826	1.0	3,107.00			0.93	1				45.73
							3,060.34	2				
12/19/22	22	9595526	1.0	1,755.00			1.09	1				58.92
							1,700.35	3				
								2				
12/19/22	22	9586126	1.0	1,614.00			1.68	1				90.50
							1,530.05	3				

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Explanation Of Benefits

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Page: 17 of 26

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: REGINALD HOWARD (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
								2				
12/19/22	22	9586126	1.0	1,614.00			1.68	1				90.50
		XU					1,530.05	3				
								2				
12/19/22	22	9587026	1.0	583.00			0.40	1				21.59
		XU					562.97	3				
								2				
12/19/22	22	9587026	1.0	1,166.00			0.40	1				21.59
		XU					1,145.97	3				
								2				
12/19/22	22	95999		7,200.00			7,200.00	4				0.00
TOTALS				**17,039.00**			**16,735.91**					**328.83**

ISSUED AMT: $328.83

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]

4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $328.83

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Explanation Of Benefits

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Page: 18 of 26

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

[redacted] ***Total Payment to: Audrey R Nath*** ***$1,077.23***

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

Explanation Of Benefits

Please Retain for Future Reference

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Printed: 10/10/2023
Page: 19 of 26

Maria A De Jesus
PIN: 0007051585
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Maria A De Jesus
PO Box 29650
Phoenix AZ 85038

Medical providers: sign up before it's your turn

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Patient Name: Scott T Fults (self)

Claim ID: **ETJM62P5F03** Recd: **10/06/23** Member ID: **101280088500** Patient Account: **0.3044439**
Member: **Scott T Fults** DIAG: **S22.052A**
Group Name: **Medicare (P01) PPO** Group Number: **200-EGS0000 0301**
Product: **PPO - Medicare (Aetna)**
Contract State: **TX** Funding: **Insured**
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
06/19/23	21	9593926	1.0	3,814.00			2.40	1				117.38
							3,694.22	2				
06/19/23	21	9593826	1.0	3,107.00			0.92	1				44.92
							3,061.16	2				
06/19/23	21	9595526	1.0	1,755.00			1.08	1				52.71
							1,701.21	2				
06/19/23	21	95999		3,600.00			3,600.00	3				0.00
TOTALS				**12,276.00**			**12,060.99**					**215.01**

ISSUED AMT: $215.01

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

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P.O. BOX 981106
EL PASO TX 79998-1106
USA

Explanation Of Benefits

Please Retain for Future Reference

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Maria A De Jesus
PIN: 0007051585
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: Scott T Fults (self)

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$215.01

Total Payment to: Maria A De Jesus ***$215.01***

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

Explanation Of Benefits

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P.O. BOX 981106
EL PASO TX 79998-1106
USA

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Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Provider Address:
Matthew B McAuliffe
PO Box 29650
Phoenix AZ 85038

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: TODD K CLAIR (self)

Claim ID: **EKTX8JGF703** Recd: **10/03/23** Member ID: **101193519500** Patient Account: **0.2820559**
Member: **TODD K CLAIR** DIAG: **M51.36, M48.061**
Group Name: **Aetna Medicare Premier Plan (HMO-POS)** Group Number: **000003-NV00 0011**
Product: **Direct Access POS - Medicare (Aetna)**
Contract State: **NV** Funding: **Insured**
Coventry Health Care of Nebraska, 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
12/09/22	22	9593926	1.0	3,814.00			2.43	1				119.26
							3,692.31	2				
12/09/22	22	9593826	1.0	3,107.00			0.93	1				45.73
							3,060.34	2				
12/09/22	22	9595526	1.0	3,814.00			1.09	1				58.92
							3,759.35	3				
								2				
12/09/22	22	9586126	1.0	1,614.00			1.68	1				90.50
							1,530.05	3				
								2				
12/09/22	22	9586126 XU	1.0	1,614.00			1.68	1				90.50
							1,530.05	3				
								2				
12/09/22	22	95999		7,200.00			7,200.00	4				0.00
TOTALS				**21,163.00**			**20,779.91**					**404.91**

ISSUED AMT: $404.91

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]

2 - Payment made according to Medicare allowable rate. [P49]

3 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]

4 - We need more details to complete our review. Please send us:

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

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USA

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: TODD K CLAIR (self)

Remarks (contd):

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $404.91

Patient Name: Jennifer C Jayme (self)

Claim ID: **EPPC8F6DF03** Recd: **10/05/23** Member ID: **101321426100** Patient Account: **0.2830193**
Member: **Jennifer C Jayme** DIAG: **M51.26**
Group Name: **Aetna Medicare Choice Plan (PPO)** Group Number: **000003-NV00 0015**
Product: **PPO - Medicare (Aetna)**
Contract State: **NV** Funding: **Insured**
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
12/16/22	21	9593826	1.0	3,107.00			0.93	1				45.73
							3,060.34	2				
12/16/22	21	9595526	1.0	1,755.00			1.09	1				58.92
							1,700.35	3				
								2				
12/16/22	21	9590726	1.0	138.00			1.09	1				53.21
							83.70	2				
12/16/22	21	9588626	2.0	2,972.00			1.87	1				91.45
							2,878.68	2				
12/16/22	21	9588626	2.0	2,972.00			1.87	1				91.45
		XU					2,878.68	2				
12/16/22	21	95999		7,200.00			7,200.00	4				0.00
TOTALS				**18,144.00**			**17,808.60**					**340.76**

ISSUED AMT: $340.76

Remarks:

1 - This adjustment in provider payment reflects recent changes made in CMS/Medicare reimbursement levels due to sequestration. The members cost share is not affected by this adjustment. We have deducted the members cost share from the original allowed amount and withheld the sequestration adjustment of the remaining balance payable to the provider. [M52]
2 - Payment made according to Medicare allowable rate. [P49]
3 - The amount paid reflects a physician incentive for performing services in a zip code area that is qualified for the Health Professional Shortage Areas (HPSA) bonus program. [MI7]
4 - We need more details to complete our review. Please send us:

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: Jennifer C Jayme *(self)*

Remarks (contd):

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.
2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

To ensure proper identification and tracking of this claim, we'll need the subscriber's name, patient's name and the subscriber's ID number. Just attach the information to this document and return it to us at P.O. Box 14089, Attn: ICMC, Lexington, KY 40512. Or, to expedite this process, you can fax the information to 859-455-8650. You have 45 days from the date of this statement to send us this information. If we don't receive it, we'll deny the claim. You will have a right to appeal the denial at that time. [D41]

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $0.00
Claim Payment: $340.76

Patient Name: WILLIAM J MITCHELL *(self)*

Claim ID: **E4FC6YGZJ00** Recd: **10/07/23** Member ID: **101204167500** Patient Account: **0.2838987**
Member: **WILLIAM J MITCHELL** DIAG: **G06.1**
Group Name: **Aetna Medicare Value Plan (PPO)** Group Number: **000003-CS00 0030**
Product: **PPO - Medicare (Aetna)**
Contract State: **UT** Funding: **Insured**
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
12/24/22	21	9593826		2,943.00			2,943.00	1				0.00
12/24/22	21	9595526		1,800.00			1,800.00	1				0.00
12/24/22	21	9586126		1,200.00			1,200.00	1				0.00
12/24/22	21	9586126		1,200.00			1,200.00	1				0.00
		XU										
12/24/22	21	95999		2,000.00			2,000.00	1				0.00
TOTALS				**9,143.00**			**9,143.00**					**0.00**

ISSUED AMT: NO PAY

Remarks:
1 - The member is not responsible for this charge, because the claim was not filed within the required time limit. U19

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Patient Name: WILLIAM J MITCHELL (self)

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 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: SHELLEY E STEPANEK (self)

Claim ID: **EMTX8GL9J03** Recd: **09/29/23** Member ID: **101129302500** Patient Account: **0.2801442**
Member: **SHELLEY E STEPANEK** DIAG: **G06.1**
Group Name: **Aetna Medicare Premier Plan (HMO-POS)** Group Number: **000003-NV00 0009**
Product: **Direct Access POS - Medicare (Aetna)**
Contract State: **NV** Funding: **Insured**
Coventry Health Care of Nebraska, 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
11/26/22	21	9593926		3,814.00			3,814.00	1				0.00
11/26/22	21	9593826		3,107.00			3,107.00	1				0.00
11/26/22	21	9595526		1,755.00			1,755.00	1				0.00
11/26/22	21	9586126		1,614.00			1,614.00	2				0.00
11/26/22	21	9586126		1,614.00			1,614.00	2				0.00
		XU										
11/26/22	21	9586526		1,502.00			1,502.00	2				0.00
11/26/22	21	9586526		1,502.00			1,502.00	2				0.00
		XU										
11/26/22	21	9586826		1,310.00			1,310.00	2				0.00
		XU										
11/26/22	21	9586826		1,310.00			1,310.00	2				0.00
		XU										
11/26/22	21	95999		7,200.00			7,200.00	3				0.00
TOTALS				**24,728.00**			**24,728.00**					**0.00**

ISSUED AMT: NO PAY

Remarks:

1 - *Charges for or in connection with services or supplies that are, as determined by us, considered to be experimental or investigational are excluded from coverage under the member's plan. The member is not responsible for this charge, unless they agreed to be responsible for this charge in writing before the service or supply was given. 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, the Code Edit Lookup tools. [777]*

2 - *This service does not meet the coverage requirements in the applicable Local Coverage Determination (LCD) or National Coverage Determination (NCD). Related services performed in connection with the denied procedure are also not covered. The member is not responsible for this charge. [D0F]*

3 - *We need more details to complete our review. Please send us:*

1. The clinical details to support the medical necessity for this service. This includes details around the drugs, DME and implants.

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P.O. BOX 981106
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Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Patient Name: SHELLEY E STEPANEK (self)

Remarks (contd):

2. Copies of current history and the physical exam, office or nursing notes, operative report, lab or diagnostic testing results, administration notes and air ambulance transportation records, if it applies
3. The diagnosis and the expected period-of-time the member will need the drug or equipment
4. If billing an unlisted code, a complete description of the service and the itemized bill
5. If photos are a part of the clinical records, please send copies since originals will not be returned

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For Questions Regarding This Claim
P.O. BOX 981106 EL PASO TX 79998-1106
USA
CALL 1-800-624-0756 FOR ASSISTANCE
Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility:	$0.00
Claim Payment:	$0.00

Total Payment to: Matthew B McAuliffe ***$745.67***

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Payment Address:
MONITORING ASSOCIATES LLC
PO Box 29650
Phoenix AZ 85038

Matthew B McAuliffe
PIN: 0007066969
TIN: XXXXXXXX2508
Trace Number: 882328201002421
Trace Amount: $6,231.23

If you are a non-contracted provider and disagree with our decision, you can appeal using the information provided below:

Pursuant to federal regulations governing the Medicare Advantage program, non-contract providers may request reconsideration of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 days of the remittance notification date and include:

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- A signed waiver of liability form
  http://www.aetnamedicare.com/documents/individual/website/provider_waiver_of_liability.pdf
- A copy of the original claim
- A copy of remit notice showing the denial
- Any additional information, clinical record or documentation

Mail the appeal request to:
Medicare Part C Appeals
P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

If you are a contracted provider and disagree with our decision, you can dispute using the information provided below:

Mail the appeal request to:
Medicare Provider Appeals
P.O. Box 14835
Lexington KY 40512
Fax: 860-900-7995

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.