ANTHEM INSURANCE COMPANIES, INC.
DBA ANTHEM BLUE CROSS AND BLUE SHIELD
3075 VANDERCAR WAY
CINCINNATI, OH 45209

1012AI030107-017534

3299777138

PROVIDER ID NO	TAX ID NO	DATE
000001048740	XXXXX2508	10/12/23

#BWNCQXF
#591999998740/DF1#
MONITORING ASSOCIATES LLC
PO BOX 29650 DEPT 880256
PHOENIX AZ 85038-9650

PAY EXACTLY
******431 DOLLARS AND 69 CENTS

DEPOSITED TO:
ABA # 124001545
ACC # XXXXX7975
EFT # 3223364184
ON 10/13/23

ACH DEPOSIT MADE - THIS IS NOT A CHECK

ANTHEM INSURANCE COMPANIES, INC.

1222 S PATTERSON BLVD
DAYTON, OH 45402

ANTHEM.COM

DATE 10/12/23

PROVIDER NAME	MONITORING ASSOCIATES LLC
ADDRESS	PO BOX 29650 DEPT 880256 PHOENIX AZ 85038-9650
PROVIDER-NPI IDS	000001048740 - 1174916522
TAX ID NO	XXXXX2508
CHECK NUMBER:	

PAYMENT SUMMARY

GROSS APPROVED CLAIM AMOUNT	431.69	IRS WITHHELD	0.00
INTEREST	0.00	STATE WITHHELD	0.00
PENALTY	0.00	AMOUNT PREVIOUSLY OVERPAID	0.00
LEVY/GARNISHMENT	0.00	AMOUNT DISBURSED	431.69
NET AMOUNT DUE	431.69	RECOUPMENT BALANCE	0.00

PAYEE ENDORSEMENT ACKNOWLEDGEMENT: "I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION , OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS." (42 CFR 455.19)

IMPORTANT NOTE:YOU ARE NOT PERMITTED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ABOUT INDIVIDUALS THAT YOU ARE NOT CURRENTLY TREATING.THIS APPLIES TO PROTECTED HEALTH INFORMATION ACCESSIBLE IN ANY ANTHEM ONLINE TOOL, OR SENT IN ANY OTHER MEDIUM INCLUDING MAIL, EMAIL, FAX, OR OTHER ELECTRONIC TRANSMISSION.

Health Insurance fraud hurts us all. You can assist us in fighting health insurance fraud by carefully examining the information presented on the other side of this form.

Health Insurance fraud often involves the collection of fees for services never rendered, the payment of claims filed on ineligible patients, and claims filed for services different than those actually received. If after reviewing this Explanation of Benefits, you believe that medical insurance fraud may have occurred, please contact our Special Investigations department at the number below using your toll free hotline. Callers will remain anonymous if they so choose. For anything other than suspected fraud, including questions regarding your coverage or questions about this Explanation of Benefits form, contact your Customer Service unit directly, using the phone number on the front of this form.

SPECIAL INVESTIGATIONS TOLL-FREE HOTLINE 1-877-283-1524

MONITORING ASSOCIATES LLC
PROVIDER ID NO: 000001048740 CHECK/EFT DT: 10/12/23
CHECK/EFT:

INDIANA MEDICARE WLP -

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: SCHULTHEIS,KATHERINE S				INSURED'S ID: VOK953M92646					PATIENT NAME: SCHULTHEIS,KATHERINE S			FOR INQUIRIES CALL:	
PATIENT ACCOUNT#: 0.3077629				CLAIM NUMBER: 253244862000					RECEIVED DATE: 08/31/2023				(800) 676-2583
SERVICE PROVIDER NAME: NATH, AUDREY R.				SERVICE PROVIDER ID: 1053679019					EXPL CD:		APPEALS CODE: MA		
NETWORK: OUT OF NETWORK				RELATIONSHIP TO INSURED:				PLAN TYPE:					
07/19/2023 07/19/2023	9582226	22	1,755.00-	0.00	0.00	0.00	0.00	0.00	1,755.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	9593826	22	3,107.00-	0.00	0.00	0.00	0.00	0.00	3,107.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	9590926	22	555.00-	0.00	0.00	0.00	0.00	0.00	555.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	9588626	22	2,972.00-	0.00	0.00	0.00	0.00	0.00	2,972.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	9588626,XU	22	2,972.00-	0.00	0.00	0.00	0.00	0.00	2,972.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	95999	22	7,200.00-	0.00	0.00	0.00	0.00	0.00	7,200.00-	M45 252	0.00		0.00
	TOTAL:		18,561.00-	0.00	0.00	0.00	0.00	0.00	18,561.00-		0.00		0.00
INTEREST													0.00
	TOTAL NET PAID												0.00

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: SCHULTHEIS,KATHERINE S				INSURED'S ID: VOK953M92646					PATIENT NAME: SCHULTHEIS,KATHERINE S			FOR INQUIRIES CALL:	
PATIENT ACCOUNT#: 0.3077629				CLAIM NUMBER: 253244862001					RECEIVED DATE: 08/31/2023				(800) 676-2583
SERVICE PROVIDER NAME: NATH, AUDREY R.				SERVICE PROVIDER ID: 1053679019					EXPL CD:		APPEALS CODE: MA		
NETWORK: OUT OF NETWORK				RELATIONSHIP TO INSURED:				PLAN TYPE:					
07/19/2023 07/19/2023	9582226	22	1,755.00	53.91	0.00	0.00	0.00	0.00	1,702.17	PXN 45 LS5 253	0.00		52.83
07/19/2023 07/19/2023	9593826	22	3,107.00	42.75	0.00	0.00	0.00	0.00	3,065.11	PXN 45 LS5 253	0.00		41.89
07/19/2023 07/19/2023	9590926	22	555.00	74.95	0.00	0.00	0.00	0.00	481.55	PXN 45 LS5 253	0.00		73.45
07/19/2023 07/19/2023	9588626	22	2,972.00	86.12	0.00	0.00	0.00	0.00	2,887.60	PXN 45 LS5 253	0.00		84.40
07/19/2023 07/19/2023	9588626,XU	22	2,972.00	86.12	0.00	0.00	0.00	0.00	2,887.60	PXN 45 LS5 253	0.00		84.40
07/19/2023 07/19/2023	95999	22	7,200.00	0.00	0.00	0.00	0.00	0.00	0.00		7,200.00	GYB 256	0.00
	TOTAL:		18,561.00	343.85	0.00	0.00	0.00	0.00	11,024.03		7,200.00		336.97
INTEREST													0.00
	TOTAL NET PAID												336.97

TOTAL APPROVED AMOUNT 336.97
TOTAL INTEREST 0.00
TOTAL NET AMOUNT DUE: INDIANA MEDICARE WLP 336.97

OHIO GROUP MEDICARE -

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: KELDERMAN,DONALD B				INSURED'S ID: ZVR207W14680					PATIENT NAME: KELDERMAN,DONALD B			FOR INQUIRIES CALL:	
PATIENT ACCOUNT#: 0.3077160				CLAIM NUMBER: 253254756500					RECEIVED DATE: 08/31/2023				(833) 812-1797
SERVICE PROVIDER NAME: DE JESUS, MARIA A.				SERVICE PROVIDER ID: 1336176387					EXPL CD:		APPEALS CODE: MA		
NETWORK: OUT OF NETWORK				RELATIONSHIP TO INSURED:				PLAN TYPE:					
07/19/2023 07/19/2023	9582226	21	1,755.00-	0.00	0.00	0.00	0.00	0.00	1,755.00-	M45 252	0.00		0.00

MONITORING ASSOCIATES LLC
PROVIDER ID NO: 000001048740 CHECK/EFT DT: 10/12/23
CHECK/EFT:

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: KELDERMAN,DONALD B				INSURED'S ID: ZVR207W14680					PATIENT NAME: KELDERMAN,DONALD B			FOR INQUIRIES CALL:	
PATIENT ACCOUNT#: 0.3077160				CLAIM NUMBER: 253254756500					RECEIVED DATE: 08/31/2023			(833) 812-1797	
SERVICE PROVIDER NAME: DE JESUS, MARIA A.				SERVICE PROVIDER ID: 1336176387					EXPL CD:		APPEALS CODE: MA		
NETWORK: OUT OF NETWORK				RELATIONSHIP TO INSURED:				PLAN TYPE:					
07/19/2023 07/19/2023	9593826	21	3,107.00-	0.00	0.00	0.00	0.00	0.00	3,107.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	9586126	21	1,614.00-	0.00	0.00	0.00	0.00	0.00	1,614.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	9586126,XU	21	1,614.00-	0.00	0.00	0.00	0.00	0.00	1,614.00-	M45 252	0.00		0.00
07/19/2023 07/19/2023	95999	21	5,400.00-	0.00	0.00	0.00	0.00	0.00	5,400.00-	M45 252	0.00		0.00
	TOTAL:		13,490.00-	0.00	0.00	0.00	0.00	0.00	13,490.00-		0.00		0.00
INTEREST													0.00
	TOTAL NET PAID												0.00

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: KELDERMAN,DONALD B				INSURED'S ID: ZVR207W14680					PATIENT NAME: KELDERMAN,DONALD B			FOR INQUIRIES CALL:	
PATIENT ACCOUNT#: 0.3077160				CLAIM NUMBER: 253254756501					RECEIVED DATE: 08/31/2023			(833) 812-1797	
SERVICE PROVIDER NAME: DE JESUS, MARIA A.				SERVICE PROVIDER ID: 1336176387					EXPL CD:		APPEALS CODE: MA		
NETWORK: OUT OF NETWORK				RELATIONSHIP TO INSURED:				PLAN TYPE:					
07/19/2023 07/19/2023	9582226	21	1,755.00	53.91	0.00	0.00	0.00	0.00	1,701.09	GB1 45 PXN 45	0.00		52.83
07/19/2023 07/19/2023	9593826	21	3,107.00	42.75	0.00	0.00	0.00	0.00	3,064.25	GB1 45 PXN 45	0.00		41.89
07/19/2023 07/19/2023	9586126	21	1,614.00	0.00	0.00	0.00	0.00	0.00	1,614.00	fq3 222	0.00		0.00
07/19/2023 07/19/2023	9586126,XU	21	1,614.00	0.00	0.00	0.00	0.00	0.00	1,614.00	h28 222	0.00		0.00
07/19/2023 07/19/2023	95999	21	5,400.00	0.00	0.00	0.00	0.00	0.00	0.00		5,400.00	GYB 256	0.00
	TOTAL:		13,490.00	96.66	0.00	0.00	0.00	0.00	7,993.34		5,400.00		94.72
INTEREST													0.00
	TOTAL NET PAID												94.72

TOTAL APPROVED AMOUNT	94.72
TOTAL INTEREST	0.00
TOTAL NET AMOUNT DUE: OHIO GROUP MEDICARE	94.72
GROSS APPROVED CLAIM AMOUNT	431.69
TOTAL INTEREST	0.00
NET AMOUNT DUE	431.69

EXPL CODES	EXPLANATION
M45	Submit medical records for review
PXN	This was paid in accordance with your contracted or out of network rates. For additional information related to this amount, consult your contract.
LS5	This is a reduction in payment due to Federal Sequestration. For additional information related to this amount, consult Medicare.
GYB	This was not paid because it is not reimbursable.
GB1	Claim paid, the plan out of pocket maximum has been reached. For the quickest and easiest way to check a member's benefits, from Availity.com use the Patient Registration tab to access Eligibility and Benefits Inquiry.
fq3	Quantity billed was over the Medically Unlikely Edit limit
h28	Quantity billed was over the Medically Unlikely Edit limit with other lines on the current claim.
252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS)

	THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION.
253	SEQUESTRATION - REDUCTION IN FEDERAL PAYMENT.
256	SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT.
222	EXCEEDS THE CONTRACTED MAXIMUM NUMBER OF HOURS/DAYS/UNITS BY THIS PROVIDER FOR THIS PERIOD. THIS IS NOT PATIENT SPECIFIC. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT, IF PRESENT.

APPEALS CODE	APPEALS
MA	Non-Contracted Medicare Provider Appeal - Medicare Advantage/Medicare Medicaid Plans If a claim is partially or fully denied for payment, the non-contracted provider must request an appeal of the denial within 60 calendar days from the remittance notification. When submitting the appeal, a signed Waiver of Liability form must be included. To obtain this form, please go to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip. The purpose of the Waiver of Liability form is to hold the enrollee harmless regardless of the outcome of the appeal. With the appeal, the non-contracted provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. The appeal must be in writing and mailed. Please mail the appeal to this address: Grievances and Appeals Mailstop: OH0205-A537 4361 Irwin Simpson Rd. Mason, OH 45040-9398 Non-Contracted Medicare Provider Payment Disputes - Medicare Advantage/Medicare Medicaid Plans A payment dispute is when you believe the amount we paid is different than what Original Medicare would have paid. If you disagree with the payment amount, you may file a non-contracted Medicare provider payment dispute in writing within 120 calendar days. Your payment dispute should be sent to: Provider Payment Disputes P.O.Box 61599 Virginia Beach, VA 23466-1599

RECOUPMENT NOTIFICATION

PROVIDER: **MONITORING ASSOCIATES LLC**
PAYEE ID: **000001048740**
NEG BAL REF #:
DATE: **10/12/23**
CHECK AMT: **431.69**

THIS IS A DETAILED NOTIFICATION OF THE RECOUPMENT PROCESSED BY ANTHEM FOR OVERPAYMENTS MADE TO YOUR ACCOUNT AS INDICATED ON THE ENCLOSED REMITTANCE ADVICE.
THE "ORIGINAL NEGATIVE CLAIM NUMBER" COLUMN CONTAINS THE ORIGINAL CLAIM ID THAT CREATED THE NEGATIVE BALANCE. THE CORRESPONDING PRIOR AND CURRENT RECOUPMENT SECTIONS BELOW SHOW THE RECOUPMENT DETAILS FOR EACH ORIGINAL NEGATIVE CLAIM LISTED IN THE NEGATIVE BALANCE HISTORY.
THE 'NEGATIVE BALANCE DEFERRED' SECTION SHOWS DEFERRED (FUTURE) RECOUPMENTS WHERE REFUNDS ARE DUE. THESE ARE NOT REFLECTED ON THIS REMITTANCE ADVICE.
A SEPERATE LETTER HAS BEEN SENT WITH FURTHER DETAILS AND OVERPAYMENT RECOVERY WILL COMMEMCE FOLLOWING EXISTING PROCESSES IF A REFUND IS NOT RECEIVED.
IF YOU HAVE QUESTIONS REGARDING A RECOUPMENT, PLEASE CONTACT PROVIDER SERVICE AT NUMBER NOTED ON REMITTANCE ADVICE.

REMIT. DATE	PATIENT NAME	PATIENT ACCT	SUBSCRIBER ID	CLAIM NUMBER/ REFUND ID	DATE OF SERVICE	ORIGINAL NEGATIVE CLAIM NUMBER	CLAIM AMOUNT	CREDITS RECOVERED	ADJ CD	CHARGE AMT	RECOVERY LETTER ID

NEGATIVE BALANCE HISTORY:

PRIOR RECOUPMENT:

CURRENT RECOUPMENT:

REMIT. DATE	PATIENT NAME	PATIENT ACCT	SUBSCRIBER ID	CLAIM NUMBER/ REFUND ID	DATE OF SERVICE	ORIGINAL NEGATIVE CLAIM NUMBER	CLAIM AMOUNT	EXPECTED RECOUP DATE	ADJ CD	CHARGE AMT	RECOVERY LETTER ID

NEGATIVE BALANCE DEFERRED:

10/11/23	KEEFER	SHEILAH	0.2171874	363M99926	2022034DT243898	06/04/21	2022034DT243898	98.77-	12/31/99	14,699.00	15126680
10/11/23	REILLY	PAULETTE	1945879	359M54867	2021223QA186896	05/19/21	2021223QA186896	45.82-	12/31/99	13,304.00	12936090
10/11/23	STEWART	GEORGANNA	0.2090377	007M72156	2021152EP429896	03/31/21	2021152EP429896	242.49-	12/31/99	14,328.00	12482503
					TOTAL NEGATIVE BALANCE DEFERRED			387.08-			

THIS IS NOT A BILL PLEASE RETAIN FOR YOUR RECORDS. THIS IS THE ONLY COPY YOU WILL RECEIVE.

RECOUPMENT NOTIFICATION

TOTAL PRIOR RECOUPMENT	0.00
TOTAL CURRENT RECOUPMENT	0.00
TOTAL OUTSTANDING NEGATIVE BAL	0.00
TOTAL DEFERRED	387.08-
OUTSTANDING NEGBAL WITH DIFER	387.08-