Amerigroup Insurance Company
PO BOX 7368 / GA081W-0014
COLUMBUS, GA 31908-7368

1011AI161355-019861

3359874354

Coverage is provided by Amerigroup Insurance Company.

PROVIDER ID NO	TAX ID NO	DATE
11193283	XXXXX2508	10/11/23

#BWNCQXF
#61/888067////DF4#
MONITORING ASSOCIATES LLC
PO BOX 29650 DEPT 880256
PHOENIX AZ 85038-9650

PAY EXACTLY
XXXXXXX79 DOLLARS AND 27 CENTS

DEPOSITED TO:

ABA # 124001545
ACC # XXXXX7975
EFT # 3223289210
ON 10/12/23

ACH DEPOSIT MADE - THIS IS NOT A CHECK

Amerigroup Insurance Company

DATE 10/11/23

PROVIDER NAME	MONITORING ASSOCIATES LLC
ADDRESS	PO BOX 29650 DEPT 880256 PHOENIX AZ 85038-9650
PROVIDER-NPI IDS	11193283 - 1174916522
TAX ID NO	XXXXX2508
CHECK NUMBER:	

PAYMENT SUMMARY

GROSS APPROVED CLAIM AMOUNT	79.27	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	79.27
NET AMOUNT DUE	79.27	RECOUPMENT BALANCE	0.00

Amerigroup

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MONITORING ASSOCIATES LLC
PROVIDER ID NO: 11193283 CHECK/EFT DT: 10/11/23
CHECK/EFT:

HOUSTON MEDICARE -

SERVICE DATE(S)	SERVICE/ REVENUE CODE(S)	COUNT/ DAYS	POS	CHARGE	ALLOWED	DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CONTRACTUAL DIFFERENCE	TPP	PROV RESP AMOUNT	EXPL/ANSI CODE(S)	INSURED'S RESP AMOUNT	EXPL/ANSI CODE(S)	NET PAID
PATIENT NAME: MENDOZA,JUAN					MEMBER ID: 813W12525		STATE/ALT ID: XXXXXG3TE70		DRG#:					FOR INQUIRIES CALL:
PATIENT ACCOUNT#: 0.2836207					CLAIM NUMBER: 255610965700		TOB:		RECEIVED DATE: 10/06/2023					(844) 469-6822
SERVICE PROVIDER NAME: DE JESUS, MARIA A.					SERVICE PROVIDER ID: 1336176387		AUTH#:		EXPL CD:		APPEALS CODE: MA		GENERAL INFO CD: CM01	
12/21/22 12/21/22	9593826	1	22	3,107.00	46.47	0.00	9.29	0.00	0.00	3,061.27	PXN 45 LS5 253	0.00		36.44
12/21/22 12/21/22	9595526	1	22	1,755.00	54.62	0.00	10.92	0.00	0.00	1,701.25	PXN 45 LS5 253	0.00		42.83
TOTAL:				4,862.00	101.09	0.00	20.21	0.00	0.00	4,762.52		0.00		79.27
INTEREST														0.00
TOTAL NET PAID														79.27

TOTAL APPROVED AMOUNT	79.27
TOTAL INTEREST	0.00
TOTAL NET AMOUNT DUE: HOUSTON MEDICARE	79.27
GROSS APPROVED CLAIM AMOUNT	79.27
TOTAL INTEREST	0.00
NET AMOUNT DUE	79.27

GENERAL INFORMATION

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)

CM01 - The plan is responsible for coordinating the processing of Medicare primary and secondary claims for its dual eligible members. Please note that any cost share applied will be processed by the plan according to the State's Medicaid COB guidelines. Due to processing time you may receive the secondary claim on this EOP or a subsequent EOP. Per CMS Medicare providers and suppliers may not bill beneficiaries enrolled in the Medicaid/QMB for Medicare cost-sharing.

EXPL CODES	EXPLANATION	GROUP CODE	CARC	RARC
PXN	This was paid in accordance with your contracted or out of network rates. For additional information related to this amount, consult your contract.	CO	45	N381
LS5	This is a reduction in payment due to Federal Sequestration. For additional information related to this amount, consult Medicare.	CO	253	
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.			

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