Check Summary **Transaction Date:** October 17, 2023

BLUECROSS BLUESHIELD OF ILLINOIS 300 E RANDOLPH CHICAGO, IL 606015099	**Payee Tax ID:** **Payee ID:** **Check/EFT Trace Number:** **Payment Amount:** **Check/EFT Date:** **Production End Cycle Date:**	271622508 1174916522 C23286E28560330 3,075.70 10/17/2023 10/13/2023	**Payee Name:** **Payee Address:**	MONITORING ASSOCIATES LLC PO BOX 29650 PHOENIX, AZ 850389650	

Patient Name: GRZYWACZ, BRIAN **Claim Number:** 02023279503679S0X00 **Claim Date:** 09/12/2023-09/12/2023 **Claim Status Code:** 1

Patient ID: BWL803339883	**Group / Policy:** 000P150160000	**Facility Type:** 21		**Claim Charge:**	$23,963.00
Patient Ctrl Nmbr: 0.3139042	**Contract Hdr:** PREFERRED PROVIDER ORGANIZATION	**Claim Frequency:** 1		**Claim Payment:**	$3,075.70
Rendering Prvd: ,		**Claim Received Date:**	10/06/2023	**Patient Resp:**	$20,887.30
Original Ref Nmbr:	**Rendering Prv ID:**				

Line Details **Results:** 7

Line Ctrl Nmbr	Dates of Service	Rend Prov ID	Rev	Sub Proc / Modifier / Units	Adjud Proc / Modifier / Units	Remark / Payer Code	Supp Info (AMT)	Charge	Adjustments (Qty)	Adj Amount	Payment
7376035031Z1	09/12/2023 - 09/12/2023	1881910255			HC:95941 / / 2		$5,520.00 (B6)	$5,520.00	PR-1 PR-45	$365.14 $5,154.86	$0.00
7376035031Z2	09/12/2023 - 09/12/2023	1881910255			HC:95938 / 26 / 1		$3,107.00 (B6)	$3,107.00	PR-1 PR-2 PR-45	$34.86 $8.81 $3,036.89	$26.44
7376035031Z3	09/12/2023 - 09/12/2023	1881910255			HC:95955 / 26 / 1		$1,755.00 (B6)	$1,755.00	PR-2 PR-45	$20.50 $1,673.00	$61.50
7376035031Z4	09/12/2023 - 09/12/2023	1881910255			HC:95908 / 26 / 1		$437.00 (B6)	$437.00	PR-2 PR-45	$25.29 $335.85	$75.86
7376035031Z5	09/12/2023 - 09/12/2023	1881910255			HC:95886 / 26 / 2		$2,972.00 (B6)	$2,972.00	PR-2 PR-45	$35.32 $2,830.73	$105.95
7376035031Z6	09/12/2023 - 09/12/2023	1881910255			HC:95886 / 26,XU / 2		$2,972.00 (B6)	$2,972.00	PR-2 PR-45	$35.32 $2,830.73	$105.95
7376035031Z7	09/12/2023 - 09/12/2023	1881910255			HC:95999 / / 1	N640	$7,200.00 (B6)	$7,200.00	PR-2 PR-222	$900.00 $3,600.00	$2,700.00

Supplemental Information - AMT/Payer Codes: $4,500.94 (AU)

Payer: BLUECROSS BLUESHIELD OF ILLINOIS	Check/EFT Trace Number: C23286E28560330	Check/EFT Date: 10/17/2023	Total Paid: $3,075.70

Code Descriptions

REMARK CODE(S):

N640=Exceeds number/frequency approved/allowed within time period.

AMT CODE(S):

B6=Allowed - Actual
AU=Coverage Amount

GROUP CODE(S):

PR=Patient Responsibility

CLAIM ADJUSTMENT REASON CODE(S):

1=Deductible Amount
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. (Use only with Group Codes PR or CO depending upon liability)
2=Coinsurance Amount
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 (loop 2110 Service Payment Information REF), if present.

CLAIM STATUS CODE(S):

1=Processed as Primary