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

Summary of Claim Payment

Please Retain for Future Reference

Printed: 10/17/2023
Page: 1 of 11

Monitoring Associates LLC
TIN: XXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

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
Omar J Moore	0006247487	$252.42
Audrey R Nath	0006483171	$367.05
Jonathan D Burns	0009730214	$0.00

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

ID No: XXXXXXX2508
Seq No: 000000004

Trace No: 901007114
Acct: 09146
51 - 44
119 CT

10-17-2023

NON-NEGOTIABLE NON-NEGOTIABLE

VOID AFTER ONE YEAR

PAY ***Seven Hundred Ninety Dollars and 60/100*** **********$790.60**

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

Please Retain for Future Reference

Printed: 10/17/2023

Monitoring Associates LLC
TIN: XXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

NAME	PIN	ISSUED AMT
Marcos J Cruz	0009963206	$171.13
TOTAL ISSUED AMOUNT		$790.60

TOTAL TRACE AMOUNT:	**$790.60**

Explanation Of Benefits

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

Please Retain for Future Reference

Printed: 10/17/2023
Page: 3 of 11

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

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: Jacqueline Hilliard *(self)*

Claim ID: **EPAC8K8FX03** Recd: **10/06/23** Member ID: **101376536100** Patient Account: **0.2832188**
Member: **Jacqueline Hilliard** DIAG: **M19.011**
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
							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 XU	1.0	1,614.00			1.71	1				84.03
							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,

Continued on Next Page

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

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/17/2023
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Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

Omar J Moore
PIN: 0006247487
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Patient Name: Jacqueline Hilliard (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
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

[redacted] Total Payment to: Omar J Moore ***$252.42***

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
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USA

Printed: 10/17/2023
Page: 5 of 11

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

Provider Address:
Audrey R Nath
PO BOX 29650
PHOENIX AZ 85038

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Patient Name: Stephen P Atkinson (self)

Claim ID: **EYY16Z9W603** Recd: **10/11/23** Member ID: **101049100400** Patient Account: **0.2857754**
Member: **Stephen P Atkinson** DIAG: **M50.122, M47.22**
Group Name: **Aetna Medicare Premier Plus (PPO)** Group Number: **000003-AR00 0001**
Product: **PPO - Medicare (Aetna)**
Contract State: **AR** Funding: **Insured**
Coventry Health and 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
01/12/23	22	9593826	1.0	3,107.00			0.42	1		20.97	20.97	20.56
							3,065.05	2				
01/12/23	22	9595526	1.0	1,755.00			0.49	1		24.67	24.67	24.19
							1,705.65	2				
01/12/23	22	9586826		1,310.00			1,310.00	3				0.00
01/12/23	22	9586826	1.0	1,310.00			0.58	1		28.85	28.85	28.28
		XU					1,252.29	2				
01/12/23	22	9587026	2.0	2,332.00			0.36	1		18.07	18.07	17.71
		XU					2,295.86	2				
01/12/23	22	9587026	2.0	2,332.00			0.36	1		18.07	18.07	17.71
		XU					2,295.86	2				
01/12/23	22	95999		5,400.00			5,400.00	4				0.00
TOTALS				**17,546.00**			**17,326.92**			**110.63**	**110.63**	**108.45**

ISSUED AMT: $108.45

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

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Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/17/2023
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Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Patient Name: Stephen P Atkinson (self)

Remarks (contd):
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: $110.63
Claim Payment: $108.45

Patient Name: DARRYL E DISCHER (self)

Claim ID: **EYPC6Z9W903** Recd: **10/11/23** Member ID: **101499225400** Patient Account: **0.2856409**
Member: **DARRYL E DISCHER** DIAG: **M41.86**
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
01/12/23	22	9593826	1.0	2,943.00			0.92	1				44.90
							2,897.18	2				
01/12/23	22	9595526	1.0	2,436.00			1.07	1				52.54
							2,382.39	2				
01/12/23	22	9586126	1.0	1,200.00			1.64	1				80.58
							1,117.78	2				
01/12/23	22	9586126 XU	1.0	1,200.00			1.64	1				80.58
							1,117.78	2				
01/12/23	22	95999		4,000.00			4,000.00	3				0.00
TOTALS				**11,779.00**			**11,520.40**					**258.60**

ISSUED AMT: $258.60

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

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Explanation Of Benefits

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Page: 7 of 11

Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

Audrey R Nath
PIN: 0006483171
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Patient Name: DARRYL E DISCHER (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:	$258.60

Total Payment to: Audrey R Nath ***$367.05***

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- 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:
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P.O. Box 14067
Lexington KY 40512
Fax: 724-741-4953

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Fax: 860-900-7995

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EL PASO TX 79998-1106
USA

Printed: 10/17/2023
Page: 8 of 11

Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

Provider Address:
Jonathan D Burns
PO BOX 29650
PHOENIX AZ 85038

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Patient Name: JAMES B WETZEL *(self)*

Claim ID: **EPAC8N38Z03** Recd: **10/12/23** Member ID: **101209279300** Patient Account: **0.2861705**
Member: **JAMES B WETZEL** DIAG: **M50.01**
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
01/17/23	22	9593826	1.0	3,107.00			3,062.14	1	44.86		44.86	0.00
01/17/23	22	9595526	1.0	1,755.00			1,702.34	1	52.66		52.66	0.00
01/17/23	22	95999		3,600.00			3,600.00	2				0.00
TOTALS				**8,462.00**			**8,364.48**		**97.52**		**97.52**	**0.00**

ISSUED AMT: **NO PAY**

Remarks:
1 - Payment made according to Medicare allowable rate. [P49]
2 - 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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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: $97.52
Claim Payment: $0.00

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

Explanation Of Benefits

Please Retain for Future Reference

Printed: 10/17/2023

Jonathan D Burns
PIN: 0009730214
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

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- 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
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USA

Printed: 10/17/2023
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Marcos J Cruz
PIN: 0009963206
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

Provider Address:
Marcos J Cruz
PO BOX 29650
PHOENIX AZ 85038

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Patient Name: S J SCHOPER-SATTERFIELD (self)

Claim ID: **EC368LYFL03** Recd: **10/13/23** Member ID: **101208713400** Patient Account: **0.3094559**
Member: **S J SCHOPER-SATTERFIELD** DIAG: **G90.522**
Group Name: **Aetna Medicare Freedom Plan (PPO)** Group Number: **000003-GA00 0010**
Product: **PPO - Medicare (Aetna)**
Contract State: **GA** Funding: **Insured**
Aetna Health and 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
08/04/23	22	9593826	1.0	3,107.00			0.56	1		15.07	15.07	27.43
							3,063.94	2				
08/04/23	22	9595526	1.0	1,755.00			0.66	1		17.69	17.69	35.40
							1,704.47	3				
								2				
08/04/23	22	9586126	1.0	1,614.00			1.00	1		27.05	27.05	54.15
							1,536.72	3				
								2				
08/04/23	22	9586126 XU	1.0	1,614.00			1.00	1		27.05	27.05	54.15
							1,536.72	3				
								2				
08/04/23	22	95999		5,400.00			5,400.00	4				0.00
TOTALS				**13,490.00**			**13,245.07**			**86.86**	**86.86**	**171.13**

ISSUED AMT: $171.13

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,

Continued on Next Page

P.O. BOX 981106
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USA

Explanation Of Benefits

Please Retain for Future Reference

Payment Address:
MONITORING ASSOCIATES LLC
PO BOX 29650
PHOENIX AZ 85038

Marcos J Cruz
PIN: 0009963206
TIN: XXXXXXXX2508
Trace Number: 882328901007114
Trace Amount: $790.60

Patient Name: S J SCHOPER-SATTERFIELD (self)

Remarks (contd):
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:	$86.86
Claim Payment:	$171.13

Total Payment to: Marcos J Cruz ***$171.13***

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

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.