



Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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

10/26/23 3224547232

1026AI 030107-017127000000

1026AI 030107-017127

3299777138

PROVIDER ID NO

000001048740

TAX ID NO

XXXXX2508

DATE

10/26/23



#BWNCQXF

#591999998740/DF1#

MONITORING ASSOCIATES LLC

PO BOX 29650 DEPT 880256

PHOENIX AZ 85038-9650

PAY EXACTLY

\*\*\*\*\*59

DOLLARS AND 94 CENTS

DEPOSITED TO:

ABA # 124001545  
ACC # XXXXX7975  
EFT # 3224547232  
ON 10/27/23

ACH DEPOSIT MADE - THIS IS NOT A CHECK

ANTHEM INSURANCE COMPANIES, INC.

DATE 10/26/23

1222 S PATTERSON BLVD  
DAYTON, OH 45402

ANTHEM.COM

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	59.94	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	59.94
NET AMOUNT DUE	59.94	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

An independent licensee of the Blue Cross and Blue Shield Association

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® Registered Marks Blue Cross and Blue Shield Association



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MONITORING ASSOCIATES, LLC  
PROVIDER ID NO: 000001048740

CHECK/EFT DT: 10/26/23  
CHECK/EFT:

INDIANA MEDI CARE WLP -

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPLAN(S) CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPLAN(S) CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: MILLER, ELAINE M PATIENT ACCOUNT #: 0. 2453094 SERVICE PROVIDER NAME: NATH, AUDREY R. NETWORK: OUT OF NETWORK INSURED'S ID: XPK359M11535 CLAIM NUMBER: 238978693500 SERVICE PROVIDER ID: 1053679019 RELATIONSHIP TO INSURED: PATIENT NAME: MILLER, ELAINE M RECEIVED DATE: 01/30/2023 EXPL CD: MA FOR INQUIRIES CALL: (800) 676-2583 APPEALS CODE: MA GENERAL INFO CD: CM02													
02/06/2022	02/06/2022	21	13,800.00-	0.00	0.00	0.00	0.00	0.00	0.00	PXN 45	13,800.00-	GYB 256	0.00
02/06/2022	02/06/2022	21	3,814.00-	114.36-	0.00	0.00	22.87-	0.00	3,699.64-	PXN 45	0.00		91.49-
02/06/2022	02/06/2022	21	1,755.00-	55.00-	0.00	0.00	11.00-	0.00	1,700.00-	PXN 45	0.00		44.00-
02/06/2022	02/06/2022	21	3,107.00-	43.80-	0.00	0.00	8.76-	0.00	3,063.20-	PXN 45	0.00		35.04-
02/06/2022	02/06/2022	21	583.00-	0.00	0.00	0.00	0.00	0.00	583.00-	Fq3 222	0.00		0.00
02/06/2022	02/06/2022	21	2,332.00-	0.00	0.00	0.00	0.00	0.00	2,332.00-	GDO 18	0.00		0.00
02/06/2022	02/06/2022	21	7,200.00-	0.00	0.00	0.00	0.00	0.00	0.00		7,200.00-	GYB 256	0.00
02/06/2022	02/06/2022	21	583.00-	0.00	0.00	0.00	0.00	0.00	583.00-	Fq3 222	0.00		0.00
02/06/2022	02/06/2022	21	583.00-	0.00	0.00	0.00	0.00	0.00	583.00-	Fq3 222	0.00		0.00
02/06/2022	02/06/2022	21	583.00-	0.00	0.00	0.00	0.00	0.00	583.00-	Fq3 222	0.00		0.00
02/06/2022	02/06/2022	21	34,340.00-	213.16-	0.00	0.00	42.63-	0.00	13,126.84-		21,000.00-		170.53-
TOTAL NET PAID													170.53-

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPLAN(S) CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPLAN(S) CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: MILLER, ELAINE M PATIENT ACCOUNT #: 0. 2453094 SERVICE PROVIDER NAME: NATH, AUDREY R. NETWORK: OUT OF NETWORK INSURED'S ID: XPK359M11535 CLAIM NUMBER: 238978693501 SERVICE PROVIDER ID: 1053679019 RELATIONSHIP TO INSURED: PATIENT NAME: MILLER, ELAINE M RECEIVED DATE: 01/30/2023 EXPL CD: MA FOR INQUIRIES CALL: (800) 676-2583 APPEALS CODE: MA GENERAL INFO CD: CM02													
02/06/2022	02/06/2022	21	13,800.00	0.00	0.00	0.00	0.00	0.00	0.00	PXN 45	13,800.00	GYB 256	0.00
02/06/2022	02/06/2022	21	3,814.00	114.36	0.00	0.00	22.87	0.00	3,699.64	PXN 45	0.00		91.49
02/06/2022	02/06/2022	21	1,755.00	55.00	0.00	0.00	11.00	0.00	1,700.00	PXN 45	0.00		44.00
02/06/2022	02/06/2022	21	3,107.00	43.80	0.00	0.00	8.76	0.00	3,063.20	PXN 45	0.00		35.04
02/06/2022	02/06/2022	21	2,332.00	0.00	0.00	0.00	0.00	0.00	2,332.00	GDO 18	0.00		0.00
02/06/2022	02/06/2022	21	7,200.00	0.00	0.00	0.00	0.00	0.00	0.00		7,200.00	GYB 256	0.00
02/06/2022	02/06/2022	21	2,332.00	74.92	0.00	0.00	14.98	0.00	2,257.08	PXN 45	0.00		59.94
02/06/2022	02/06/2022	21	34,340.00	288.08	0.00	0.00	57.61	0.00	13,051.92		21,000.00		230.47
TOTAL NET PAID													230.47

TOTAL APPROVED AMOUNT	59.94
TOTAL INTEREST	0.00
TOTAL NET AMOUNT DUE: INDIANA MEDI CARE WLP	59.94
GROSS APPROVED CLAIM AMOUNT	59.94
TOTAL INTEREST	0.00
NET AMOUNT DUE	59.94

INDIANA MEDICARE WLP -

CM02 - The member is eligible for both Medicare and Medicaid. Verify the member's secondary Medicaid coverage and send all claims for Medicare cost sharing to the State or the appropriate Medicaid MCO. Per CMS guidelines, Medicare providers and suppliers may not bill beneficiaries enrolled in the Medicaid/OMB program for Medicare cost-sharing.

EXPL CODES	EXPLANATION
GYB	This was not paid because it is not reimbursable.
PXN	This was paid in accordance with your contracted or out of network rates. For additional information related to this amount, consult your contract.
Fq3	Quantity billed was over the Medicaidly Unlikely Edit limit
GDO	This service is a duplicate of a previously submitted service for this member.
256	SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT.
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.
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.
18	EXACT DUPLICATE CLAIM/SERVICE

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/MACs/Downloads/Model-Waiver-of-Liability\\_Feb2019v508.zip](https://www.cms.gov/Medicare/Appeals-and-Grievances/MACs/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:



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MONITORING ASSOCIATES, LLC  
PROVIDER ID NO: 000001048740

CHECK/EFT DT: 10/26/23  
CHECK/EFT:

Provider Payment Disputes  
P.O. Box 61599  
Virginia Beach, VA 23466-1599

RECOUPMENT NOTIFICATION

PROVIDER:  
PAYEE ID:  
NEG BAL REF #:  
DATE:  
CHECK AMT:

MONITORING ASSOCIATES LLC  
000001048740  
10/26/23  
59.94

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 SEPARATE LETTER HAS BEEN SENT WITH FURTHER DETAILS AND OVERPAYMENT RECOVERY WILL COMMENCE 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
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NEGATIVE BALANCE HISTORY:

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PRIOR RECOUPMENT:

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CURRENT RECOUPMENT:

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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
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NEGATIVE BALANCE DEFERRED:

10/25/23	KEEFER										
10/25/23	REILLY										
10/25/23	STEWART										
TOTAL NEGATIVE BALANCE DEFERRED							387.08-				

RECOUPMENT NOTIFICATION

PAGE 2

TOTAL PRIOR RECOUPMENT	0.00
TOTAL CURRENT RECOUPMENT	0.00
TOTAL OUTSTANDING NEGATIVE BAL.	0.00
TOTAL DEFERRED	387.08-
OUTSTANDING NEGATIVE BAL. WITH DEFER	387.08-