Check Summary **Transaction Date:** October 18, 2023

BLUECROSS BLUESHIELD OF TEXAS P O BOX 660044 DALLAS, TX 752660044	**Payee Tax ID:** **Payee ID:** **Check/EFT Trace Number:** **Payment Amount:** **Check/EFT Date:** **Production End Cycle Date:**	850542512 1770111452 C23291N36706190 0.00 10/18/2023 10/18/2023	**Payee Name:** **Payee Address:**	PHYSICIAN OVERSIGHT LLC DEPT 880359 PO BOX 29650 PHOENIX, AZ 850389650	

Patient Name: SMITH, FRANK **Claim Number:** 02023269500920G0X00 **Claim Date:** 07/03/2023-07/03/2023 **Claim Status Code:** 1

Patient ID: T2S839038155	**Group / Policy:** 0003850000001	**Facility Type:** 22		**Claim Charge:**	$11,932.00
Patient Ctrl Nmbr: 0.3060049	**Contract Hdr:** PREFERRED PROVIDER ORGANIZATION	**Claim Frequency:** 1		**Claim Payment:**	$0.00
Rendering Prvd: DE JESUS, MARIA A		**Claim Received Date:**	09/26/2023	**Patient Resp:**	$445.30
Original Ref Nmbr:	**Rendering Prv ID:**				

Line Details **Results:** 4

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
7337763847Z1	07/03/2023 - 07/03/2023				HC:95941 / / 2	N830	$281.56 (B6)	$5,520.00	PR-1 CO-45	$281.56 $5,238.44	$0.00
7337763847Z2	07/03/2023 - 07/03/2023				HC:95865 / 26 / 1	N830	$99.41 (B6)	$1,310.00	CO-45 PR-1	$1,210.59 $99.41	$0.00
7337763847Z3	07/03/2023 - 07/03/2023				HC:95865 / 26,XU / 1	N830	$64.33 (B6)	$1,502.00	CO-45 PR-1	$1,437.67 $64.33	$0.00
7337763847Z4	07/03/2023 - 07/03/2023				HC:95999 / / 1	N830		$3,600.00	CO-45	$3,600.00	$0.00

Supplemental Information - AMT/Payer Codes: $445.30 (AU)

Code Descriptions

REMARK CODE(S):

Payer: BLUECROSS BLUESHIELD OF TEXAS	**Check/EFT Trace Number:** C23291N36706190	**Check/EFT Date:** 10/18/2023	**Total Paid:** $0.00

REMARK CODE(S):

N830=Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ No Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es).

AMT CODE(S):

B6=Allowed - Actual
AU=Coverage Amount

GROUP CODE(S):

PR=Patient Responsibility
CO=Contractual Obligations

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)

CLAIM STATUS CODE(S):

1=Processed as Primary