# Example Insurance Company Explanation of Benefits (EOB)

175

THIS IS NOT A BILL

|  |  |
| --- | --- |
| Date Processed: **08/31/2022**  179 | Group Name: **COMPANY INSUR**  135 |
| Patient Name: **Henry Levin**  130 | Group Number: **7654321**  134 |
| Member ID: **1234567**  1 | Plan Name: **COMPANY PLAN A**  155 |
| Subscriber ID: **192837465**  132 | Plan ID: **564738291**  154 |
|  |  |

## Claim #: **987654321**

178

177

35

## For the Period: **07/01/2022 – 07/31/2022**

Provider: **Hospital ABC** (In-Network) National Provider Identifier: **7346777777**

101

167

94

Payee: **Hospital ABC**

121

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Claim Detail** | | | **What Your Provider Can Charge You** | | | **Your Responsibility** | | **Total Claim Cost** | | |
| **Line No.** | **Date of Service** | **Service** | **Provider Charges** | **Allowed Amount** | **Discount** | **Co-Pay or Co-Insurance** | **Deductible** | **Paid by Insurer** | **You**  **May Owe** | **Remark Code** |
| 1  36 | 07/19/2022  90 | XRAY – CHEST (0324)  86 | $800.00 | $730.00 | $70.00 | $100.00  20d | $600.00 | $30.00  20g | $700.00  20f | 1  \*  20aA  20b  20c  20e |
| 2 | 07/19/2022 | RADIOLOGY (0329) | $400.00 | $350.00 | $50.00 | $50.00 | $0.00 | $300.00 | $0.00 | 1 |
| **Totals:** | | | $1,200.00  148a | $1080.00 | $120.00 | $150.00 | $700.00  148g  148d  148c  148b  148e  148f | $330.00 | $700.00 |  |

## Remark Explanations

1 – Billed amount is more than the maximum amount insurance allows.

181

## Claim #: **1234567890**

Provider: **Dr. PCP** (In-Network) National Provider Identifier: **7777771234**

Payee: **DR. PCP**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Claim Detail** | | | **What Your Provider Can Charge You** | | | **Your Responsibility** | | **Total Claim Cost** | | |
| **Line No.** | **Date of Service** | **Service** | **Provider Charges** | **Allowed Amount** | **Discount** | **Co-Pay or Co-Insurance** | **Deductible** | **Paid by Insurer** | **You**  **May Owe** | **Remark Code** |
| 1 | 07/21/2022  118 | OFFICE VISIT (99213)  40 | $240.00 | $200.00 | $40.00 | $20.00 | $0.00 | $180.00 | $0.00 | 1 |
| 2 | 07/19/2022 | LABORATORY SERVICES (85576) | $60.00 | $50.00 | $10.00 | $20.00 | $0.00 | $30.00 | $0.00 | 1 |
| **Totals:** | | | $300.00 | $250.00 | $50.00 | $40.00 | $0.00 | $210.00 | $0.00 |  |

Mapping Details

|  |  |  |
| --- | --- | --- |
| CPCDS Element ID | CPCDS Element Description | Resource/Profile Paths |
| 175 | Claim Payer Name | ExplanationOfBenefit.insurer.reference-> Organization.name |
| 179 | Adjudication Date | ExplanationOfBenefit.created |
| 130 | Patient Name | ExplanationOfBenefit.patient.reference->  Patient.name |
| 1 | Member Id | ExplanationOfBenefit.patient.reference->  Patient.identifier:memberid |
| 132 | Subscriber Id | ExplanationOfBenefit.insurance.coverage.reference->  Coverage.subscriberId |
| 135 | Group Name | ExplanationOfBenefit.insurance.coverage.reference->  Coverage.class:group.name |
| 134 | Group Id | ExplanationOfBenefit.insurance.coverage.reference->  Coverage.class:group.value |
| 155 | Plan Name | ExplanationOfBenefit.insurance.coverage.reference->  Coverage.class:plan.name |
| 154 | Plan Id | ExplanationOfBenefit.insurance.coverage.reference->  Coverage.class:plan.value |
| 177 | Statement From Date | ExplanationOfBenefit.billablePeriod.start |
| 178 | Statement Through Date | ExplanationOfBenefit.billablePeriod.end |
| 35 | Payer Claim Unique Identifier | ExplanationOfBenefit.identifier[type.coding.code = ‘uc’].value |
| 167 | Claim Billing Provider Name | ExplanationOfBenefit.provider.reference->  Organization.name  *or*  Practitioner.name |
| 101 | Claim Billing Provider Networking Status (If claim is not adjudicated in alignment with network status, an process note is typically provided) | ExplanationOfBenefit.adjudication  :adjudicationamounttype[category.coding.code=billingnetworkcontractingstatus]  .reason |
| 94 | Claim Billing Provider NPI | ExplanationOfBenefit.provider.reference->  Organization.identifier[NPI]  *or*  Practitioner.identifier[NPI] |
| 121 | Claim Payee | ExplanationOfBenefit.payee.party.reference->  Organization.name  *or*  Practitioner.name  *or*  Patient.name |
| 36 | Line Number | ExplanationOfBenefit.item.sequence |
| 90 | Service (From Date) (Outpatient & Pharmacy) | ExplanationOfBenefit.item.ServicedDate  *or*  ExplanationOfBenefit.item.ServicedPeriod.start |
| 118 | Service From Date (Professional & Oral EOB) | ExplanationOfBenefit.item.ServicedDate  *or*  ExplanationOfBenefit.item.ServicedPeriod.start |
| 86 | Revenue Center Code (IG requires codes only, a display/text may not be provided) | ExplanationOfBenefit.item.revenue |
| 20a | Line Submitted Amount | ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’submitted’].amount |
| 20b | Line Eligible Amount | ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’eligible’].amount |
| 20c | Line Discount Amount | ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’discount’].amount |
| 20d | Line Copay Amount or Line Co-insurance Amount | ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’copay’].amount  *or*  ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’coinsurance’].amount |
| 20e | Line Patient Deductible | ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’deductible’].amount |
| 20f | Sum of   * Line Amount Paid to Provider * Line Member Reimbursement | ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’paidtoprovider’].amount  +  ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’paidtopatient’].amount |
| 20g | Line Member Liability | ExplanationOfBenefit.item.adjudication:adjudicationamounttype  [category.coding.code=’memberliability’].amount |
| 148a | Claim Submitted Amount | ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’submitted’].amount |
| 148b | Claim Eligible Amount | ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’eligible’].amount |
| 148c | Claim Discount Amount | ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’discount’].amount |
| 148d | Copay Amount or Co-insurance Liability Amount | ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’copay’].amount  *or*  ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’coinsurance’].amount |
| 148e | Member Paid Deductible | ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’deductible’].amount |
| 148f | Sum of   * Claim Amount Paid to Provider * Member Reimbursement | ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’paidtoprovider’].amount  +  ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’paidtopatient’].amount |
| 148g | Member Liability | ExplanationOfBenefit.adjudication:adjudicationamounttype  [category.coding.code=’memberliability’].amount |
| 92 | Line Payment Denial Code (In EOB Documents, this is a payer defined code. These codes are not included in the IG. Instead, this IG uses [CARC and RARC codes]( ValueSet-X12ClaimAdjustmentReasonCodesCMSRemittanceAdviceRemarkCodes.html). Payers may include their own codes and descriptions in process note – 181) | ExplanationOfBenefit.item.adjudication:denialreason.reason |
| 40 | Procedure Code (IG requires codes only, display/text may not be provided) | ExplanationOfBenefit.item.productOrService |
| 181 | Payment Member Explanation | ExplanationOfBenefit.processNote.text[number = ExplanationOfBenefit.item.noteNumber] |
| \* | Remark codes are payer specific and not defined by this IG. These remarks are generally included in the process note, which can be linked by the noteNumber | ExplanationOfBenefit.item.noteNumber |

Notes on adjudication amounts:

Eligible amount = submitted amount - the noncovered amount - discount.

The subscriber pays the member liability = deductible + coinsurance + copay + noncovered. (part of the member liability may have already been paid to the provider as paidbypatient)

The eligible amount - the member liability is the payment amount to the provider (paidtoprovider) or the subscriber (paidtopatient).