

UnitedHealthcare Insurance Company of New York
 GREENSBORO SERVICE CENTER
 P.O. BOX 740800
 ATLANTA GA 30374-0800
 PHONE: 1-877-842-3210



DPSS\$\$PKG
 NEW YORK ACUPUNCTURE AND CHIRO
 JOHN BROWN DC
 353 LEXINGTON AVE RM 1005
 NEW YORK NY 10016



PAYMENT DATE: 08/21/23
 TIN: 465561424
 NPI: 1003076662
 PAYEE NAME: NEW YORK ACUPUNCTURE
 AND CHIRO
 PAYMENT NUMBER: TZ 57552462
 PAYMENT AMOUNT: \$0.00
 GROUP NUMBER: 752502
 GROUP NAME: VAN ECK ASSOCIATES
 CORPORATION

PROVIDER REMITTANCE ADVICE

PROVIDER REMITTANCE AT A GLANCE

AMOUNT OF TOTAL BENEFITS AVAILABLE	\$532.40
LESS AMOUNT PREVIOUSLY OWED	\$532.40
TOTAL PAID	\$0.00

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STD - PRA



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PATIENT: ANTHONY M VITALONE (EE)

SUBSCRIBER ID: A 931052625 **SUBSCRIBER NAME:** ANTHONY M VITALONE **CLAIM NUMBER:** EA39459219 0072826424
CLAIM DATE: 08/10/23-08/10/23 **DATE RECEIVED:** 08/11/23 **PRODUCT:** CHOYC+
REND PROV ID: 1003076662 **REND PROV:** J. BROWN DC

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
069-VIT9839025					\$650.00				\$532.40	

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	SUB UNITS	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
984617189 002	08/10/23 - 08/10/23		97110	GP		1	1	\$225.00	\$198.00	\$27.00	PI	131	\$198.00	IT, Y1
984617189 002	08/10/23 - 08/10/23		97110	GP		1	1	\$225.00	\$158.40	\$66.60	PI	131	\$158.40	IT, Y1
984617189 001	08/10/23 - 08/10/23		98940	GP		1	1	\$200.00	\$176.00	\$24.00	PI	131	\$176.00	IT
CLAIM# EA39459219 0072826424								SUBTOTAL	\$650.00	\$532.40	\$117.60		\$532.40	Y2

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

TOTAL PAYABLE TO PROVIDER												\$532.40	
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NOTES

- PI131 PAYER INITIATED REDUCTIONS - CLAIM SPECIFIC NEGOTIATED DISCOUNT.
- IT THIS OUT-OF-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE BASED ON AN AGREEMENT WITH MULTIPLAN. IF YOU HAVE PAID THE PROVIDER MORE THAN THE AMOUNT YOU OWE, PLEASE CALL THEM FOR A REFUND.
- Y1 THE SERVICE WAS BILLED WITH MULTIPLE UNITS. FOR PROCESSING PURPOSES, THE UNITS HAVE BEEN SEPARATED TO MULTIPLE SERVICE LINES.
- Y2 THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER. FOR PROCESSING PURPOSES, THIS SERVICE LINE HAS BEEN RECODED WITHOUT A MODIFIER.

If you disagree with a claim reimbursement decision

The member, health care professional or an authorized representative may contest the claim payment decision by submitting comments, documents or other information that shows why they believe the decision should be changed.

Network health care professionals: There is a 2-step reconsideration and appeal process. This process allows for a total of 12 months for timely submission for Step 1: Reconsideration and Step 2: Appeal. Claim reconsideration does not apply in some states based on applicable state law. The timetable may be different if required by law or by your participation agreement (contract). For more information and submission instructions, refer to



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Chapter 10 (Our claim process) of the Network Administrative Guide available at UHCprovider.com/guides. To appeal a clinical or prior authorization determination, follow the instructions in Chapter 7 (Medical management) of the guide.

Out-of-network health care professionals: As an out-of-network health care professional or facility, you can submit a request for an administrative review/reconsideration if permitted by state law. If you don't agree with the outcome of the review, you may submit an appeal on the member's behalf. You are required to provide written authorization from the member in order to appeal. Requests for reviews and appeals must be submitted through the UnitedHealthcare Provider Portal within the time frame discussed in the member's benefit plan.

All health care professionals: To initiate additional review of the claim, as outlined above, please follow these steps:

- Go to UHCprovider.com
- Sign in to the portal using your One Healthcare ID and password. If you don't have a One Healthcare ID, visit UHCprovider.com/access to get started.
- Go to Claims & Payments > Look up a Claim and enter the claim information, then click Act on a Claim
 - **Out-of-network health care professionals:** For appeal requests, you must include the member's signed authorization.
- For assistance, go to UHCprovider.com/contact-us

New York Out of Network (OON) Provider Rights of Review for Emergency Room (ER) Services and Surprise Bills for Services Provided to Fully Insured Commercial Members in New York

What if a provider disagrees with the amount allowed on a claim?

If you are an out-of-network provider and provided emergency services to a covered member, or provided non-emergency services to a covered member at a facility that is in network, then your claim may be subject to the New York Surprise Bill Law. If you disagree with what was paid for that emergency service, you have the right to request negotiation. Please submit your request online at www.uhcprovider.com or by mail at the address on the members ID card.

In any event, please do not bill the member for any amount above their in-network cost share (copay, coinsurance and deductible).

How does the independent dispute resolution process work?

A health care provider or the health plan may dispute a payment or charge for emergency services, including inpatient physician and hospital services after an emergency room visit, or for a surprise bill. Applicants must: (1) visit the Department of Financial Services (DFS) website at dfs.ny.gov to get a file number; (2) complete the application; and (3) send the application and the requested information to the assigned independent dispute resolution entity (IDRE). For help call 800-342-3736 or e-mail IDRquestions@dfs.ny.gov.

The New York Department of Financial Services will select an independent dispute resolution entity (IDRE) to review the disputed claims. The IDRE will request information about the services received and determine the reasonable fee for the services. The IDRE will either request the parties to negotiate or issue a decision accepting either the health plan's payment amount or the provider's billed charge.

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PAYMENT AMOUNT: \$0.00

OVERPAYMENT REDUCTION DETAIL

MEMBER LAST NAME	PATIENT FIRST NAME	MEMBER ID#	PATIENT ACCT#	POLICY NUMBER	CLAIM/ CONTROL NUMBER	DATE(S) OF SERVICE	ORIGINAL OVERPAYMENT AMOUNT	PREVIOUSLY DEDUCTED	OVERPAYMENT DEDUCTED	OVERPAYMENT AMOUNT REMAINING
HARMAN ARCO	ELIZABETH	XXXXX4692	036-HAR9863520	925089	DM59081141 0015767816	08/30/22 - 08/30/22	\$448.80	\$0.00	\$448.80	\$0.00
HARMAN ARCO	ELIZABETH	XXXXX4692	039-HAR9863520	925089	DM92237565 0016189580	09/09/22 - 09/09/22	\$448.00	\$0.00	\$83.60	\$364.40
TOTAL PAYMENT ADJUSTMENT									\$532.40	
TOTAL PAID TO THE PROVIDER									\$0.00	

REMARKS:

THE AMOUNT PAYABLE FOR THIS STATEMENT HAS BEEN USED TO REDUCE AN OVERPAYMENT MADE ON THE CLAIM(S) NOTED ABOVE. PLEASE ADJUST YOUR PATIENT ACCOUNT BALANCE BASED ON THIS INFORMATION.

IF YOU WOULD LIKE TO PURSUE AN APPEAL ON BEHALF OF THE PLAN MEMBER, PLEASE GO TO <https://www.uhcprovider.com/content/dam/provider/docs/public/claims/Commercial-Courtesy-Review-Auth-Form.pdf> FOR AN APPROVED FORM SUITABLE FOR YOUR USE AS THEIR DESIGNATED AUTHORIZED REPRESENTATIVE.