Electronic Remittance Advice (X12/835)

Transaction Information

Check ID:	**216633002499793**	Date:	06/04/2020
Total Actual Provider Payment Amount:	**$2,494.41**	Payer Identifier:	1630103830
Payment Method Code:	Automated Clearing House (ACH)		
Sender DFI Identifier:	216633002		
Sender Bank Account Number:	7163013830		
Receiver or Provider Bank ID Number:	062001186		
Receiver or Provider Account Number:	79200271		
Production Date:	06/04/2020		

Payer

Name:	**AL BCBS**
Identifier:	00510
Address:	450 RIVERCHASE PKWY EAST, BIRMINGHAM, AL 35244
Contact:	EDI SERVICES, Phone: (800) 492-8872, Phone: (205) 220-6899

Payee

Name:	**RIVER REGION PSYCHIATRY ASSOCIATES**
Identifier:	1386891497
Address:	233 WINTON M BLOUNT LOOP, MONTGOMERY, AL 36117-3507
Additional Identifier:	TJ / 262976526

Claim Reference ID:	13293Z70810
Status:	1 (Processed as Primary)
Total Claim Charge:	**$105.00**
Claim Payment Amount:	**$48.31**
Patient Responsibility:	**$25.00**
Claim Filing Indicator Code:	15 (Indemnity Insurance)
Payer Claim Control Number:	3091477255
Facility Type Code:	2
Patient Name:	ALEXANDER, BETHANI NICOLE
Patient ID:	R06994466 (Member Identification Number)
Corrected Patient/Insured ID:	R06994466
Insured Name:	ALEXANDER, DOUGLAS
Insured ID:	R06994466 (Member Identification Number)
Service Date:	05/21/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37034	05/21/2020	99214:95:CR / 1	$105.00 / $73.31	$31.69 / CO-45		/ $25.00	$48.31

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 13447Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$161.00**
Claim Payment Amount: **$111.00**
Patient Responsibility: **$25.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3041481419
Facility Type Code: 2
Patient Name: ANDERSON, DIROSLYN W
Patient ID: R58358554 (Member Identification Number)
Corrected Patient/Insured ID: R58358554
Service Date: 05/26/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37858	05/26/2020	90837:95:CR / 1	$161.00 / $136.00	$25.00 / CO-45		/ $25.00	$111.00

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 13289Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$161.00**
Claim Payment Amount: **$106.00**
Patient Responsibility: **$30.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3021480641
Facility Type Code: 2
Patient Name: PETTWAY, CATRINA HOLLINS
Patient ID: R60771596 (Member Identification Number)
Corrected Patient/Insured Name: HOLLINS PETTWY
Corrected Patient/Insured ID: R60771596
Service Date: 05/21/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37242	05/21/2020	90837:95:CR / 1	$161.00 / $136.00	$25.00 / CO-45		/ $30.00	$106.00

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 13405Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$161.00**
Claim Payment Amount: **$106.00**
Patient Responsibility: **$30.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)

Payer Claim Control Number: 3021473425
Facility Type Code: 2
Patient Name: BRADLEY, HAYLEY
Patient ID: R58992715 (Member Identification Number)
Corrected Patient/Insured ID: R58992715
Insured Name: BRADLEY, KEVIN
Insured ID: R58992715 (Member Identification Number)
Service Date: 05/21/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37280	05/21/2020	90837:95 / 1	$161.00 / $136.00	$25.00 / CO-45		/ $30.00	$106.00

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 12933Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$83.00**
Claim Payment Amount: **$21.00**
Patient Responsibility: **$25.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3011414582
Facility Type Code: 2
Patient Name: STANGE, AMANDA
Patient ID: R58524213 (Member Identification Number)
Corrected Patient/Insured ID: R58524213
Insured Name: STANGE, GEORGE
Insured ID: R58524213 (Member Identification Number)
Service Date: 05/18/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
36282	05/18/2020	98968:CR / 1	$83.00 / $46.00	$37.00 / CO-45		/ $25.00	$21.00

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 10435Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$161.00**
Claim Payment Amount: **$136.00**
Patient Responsibility: **$25.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3081488362
Facility Type Code: 2
Patient Name: BROWN, DAKOTA
Patient ID: R59451307 (Member Identification Number)

Corrected Patient/Insured ID: R59451307
Insured Name: BROWN, ROBERT
Insured ID: R59451307 (Member Identification Number)
Service Date: 04/30/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37545	04/30/2020	90837:95:CR / 1	$161.00 / $161.00			/ $25.00	$136.00

Claim Reference ID: 9384Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$161.00**
Claim Payment Amount: **$131.00**
Patient Responsibility: **$30.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3081488366
Facility Type Code: 2
Patient Name: HUDAK, JOHN A
Patient ID: R60153138 (Member Identification Number)
Corrected Patient/Insured ID: R60153138
Insured Name: HUDAK, JOHN
Insured ID: R60153138 (Member Identification Number)
Service Date: 04/27/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37456	04/27/2020	90837:95:CR / 1	$161.00 / $161.00			/ $30.00	$131.00

Claim Reference ID: 10202Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$161.00**
Claim Payment Amount: **$136.00**
Patient Responsibility: **$25.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3081488369
Facility Type Code: 2
Patient Name: PARKER, MARY HELEN
Patient ID: R59293201 (Member Identification Number)
Corrected Patient/Insured ID: R59293201
Insured Name: PARKER, JESSICA
Insured ID: R59293201 (Member Identification Number)
Service Date: 04/30/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37543	04/30/2020	90837:95:CR / 1	$161.00 / $161.00			/ $25.00	$136.00

Claim Reference ID: 13922Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$181.00**
Claim Payment Amount: **$97.10**
Patient Responsibility: **$30.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3031499923
Facility Type Code: 11
Patient Name: CHRYSOSTOM, STACEY
Patient ID: R60673396 (Member Identification Number)
Corrected Patient/Insured ID: R60673396
Insured Name: CHRYSOSTOM, JUSTIN
Insured ID: R60673396 (Member Identification Number)
Service Date: 05/27/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
38449	05/27/2020	99213 / 1	$75.00 / $45.95	$29.05 / CO-45		/ $30.00	$15.95
38450	05/27/2020	90836 / 1	$106.00 / $81.15	$24.85 / CO-45			$81.15

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 13244Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$189.00**
Claim Payment Amount: **$112.27**
Patient Responsibility: **$30.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3021473435
Facility Type Code: 2
Patient Name: SMART, JAMEILA
Patient ID: R60265418 (Member Identification Number)
Corrected Patient/Insured ID: R60265418
Service Date: 05/21/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37253	05/21/2020	99214:95:CR / 1	$105.00 / $73.31	$31.69 / CO-45		/ $30.00	$43.31
37254	05/21/2020	90833:95:CR / 1	$84.00 / $68.96	$15.04 / CO-45			$68.96

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 13581Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$189.00**

Claim Payment Amount: **$117.27**
Patient Responsibility: **$25.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3041481412
Facility Type Code: 2
Patient Name: DUBOIS, KATHERINE
Patient ID: R58047715 (Member Identification Number)
Corrected Patient/Insured ID: R58047715
Insured Name: DUBOIS, JAMES
Insured ID: R58047715 (Member Identification Number)
Service Date: 05/26/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37877	05/26/2020	99214:95:CR / 1	$105.00 / $73.31	$31.69 / CO-45		/ $25.00	$48.31
37878	05/26/2020	90833:95:CR / 1	$84.00 / $68.96	$15.04 / CO-45			$68.96

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 13297Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$1,104.00**
Claim Payment Amount: **$876.33**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3051434490
Facility Type Code: 21
Patient Name: ECKERT, MARTHA A
Patient ID: R59190529 (Member Identification Number)
Corrected Patient/Insured ID: R59190529
Service Date: 05/08/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
36987	05/08/2020	99223 / 1	$250.00 / $196.82	$53.18 / CO-45			$196.82
36988	05/09/2020	99233:Q6 / 1	$129.00 / $101.48	$27.52 / CO-45			$101.48
36989	05/10/2020	99233 / 1	$129.00 / $101.48	$27.52 / CO-45			$101.48
36990	05/11/2020	99233 / 1	$129.00 / $101.48	$27.52 / CO-45			$101.48
36991	05/12/2020	99233 / 1	$129.00 / $101.48	$27.52 / CO-45			$101.48
36992	05/13/2020	99233 / 1	$129.00 / $101.48	$27.52 / CO-45			$101.48
36993	05/15/2020	99233 / 1	$129.00 / $101.48	$27.52 / CO-45			$101.48
36994	05/18/2020	99238 / 1	$80.00 / $70.63	$9.37 / CO-45			$70.63

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 11931Z70810
Status: 2 (Processed as Secondary)
Total Claim Charge: **$1,055.00**
Claim Payment Amount: **$169.08**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 7171504389
Facility Type Code: 21
Patient Name: HOOPER, ANNIE R
Patient ID: R001535248 (Member Identification Number)
Corrected Patient/Insured ID: R01535248
Service Date: 05/01/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
33831	05/01/2020	99223 / 1	$250.00 / $196.93	$53.07 / CO-45 $157.57 / OA-23			$39.36
33832	05/02/2020	99233 / 1	$129.00 / $101.54	$27.46 / CO-45 $81.24 / OA-23			$20.30
33833	05/03/2020	99233 / 1	$129.00 / $101.54	$27.46 / CO-45 $81.24 / OA-23			$20.30
33834	05/04/2020	99233 / 1	$129.00 / $101.54	$27.46 / CO-45 $81.24 / OA-23			$20.30
33835	05/06/2020	99233 / 1	$129.00 / $101.54	$27.46 / CO-45 $81.24 / OA-23			$20.30
33836	05/07/2020	99232 / 1	$80.00 / $70.47	$9.53 / CO-45 $56.38 / OA-23			$14.09
33837	05/08/2020	99233 / 1	$129.00 / $101.54	$27.46 / CO-45 $81.24 / OA-23			$20.30
33838	05/09/2020	99238:Q6 / 1	$80.00 / $70.67	$9.33 / CO-45 $56.54 / OA-23			$14.13

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- 23 : Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments

Claim Reference ID: 13298Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$129.00**
Claim Payment Amount: **$101.48**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3051434484
Facility Type Code: 21
Patient Name: ECKERT, MARTHA A
Patient ID: R59190529 (Member Identification Number)
Corrected Patient/Insured ID: R59190529
Service Date: 05/14/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment

36995	05/14/2020	99233 / 1	$129.00 / $101.48	$27.52 / CO-45			$101.48

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 11933Z70810
Status: 2 (Processed as Secondary)
Total Claim Charge: **$129.00**
Claim Payment Amount: **$20.30**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 7171504388
Facility Type Code: 21
Patient Name: HOOPER, ANNIE R
Patient ID: R001535248 (Member Identification Number)
Corrected Patient/Insured ID: R01535248
Service Date: 05/05/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
33839	05/05/2020	99233 / 1	$129.00 / $101.54	$27.46 / CO-45 $81.24 / OA-23			$20.30

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- 23 : Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments

Claim Reference ID: 10757Z70810
Status: 2 (Processed as Secondary)
Total Claim Charge: **$75.00**
Claim Payment Amount: **$9.98**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 7171474193
Facility Type Code: 2
Patient Name: WRIGHT, EVELYN
Patient ID: R008888208 (Member Identification Number)
Corrected Patient/Insured ID: R08888208
Service Date: 05/06/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
32258	05/06/2020	99213:95:CR / 1	$75.00 / $49.91	$25.09 / CO-45 $39.93 / OA-23			$9.98

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- 23 : Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments

Claim Reference ID: 12844Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$165.00**
Claim Payment Amount: **$123.24**
Patient Responsibility: **$30.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3071485491
Facility Type Code: 11
Patient Name: MARUS, ALEX
Patient ID: R60118809 (Member Identification Number)
Corrected Patient/Insured ID: R60118809
Insured Name: MARUS, MARK
Insured ID: R60118809 (Member Identification Number)
Service Date: 05/19/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
37818	05/19/2020	99204 / 1	$165.00 / $153.24	$11.76 / CO-45		/ $30.00	$123.24

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Claim Reference ID: 13565Z70810
Status: 1 (Processed as Primary)
Total Claim Charge: **$115.00**
Claim Payment Amount: **$72.05**
Patient Responsibility: **$30.00**
Claim Filing Indicator Code: 15 (Indemnity Insurance)
Payer Claim Control Number: 3021480644
Facility Type Code: 2
Patient Name: SULLIVAN, ROBERT D
Patient ID: R50973516 (Member Identification Number)
Corrected Patient/Insured ID: R50973516
Service Date: 05/26/2020

ClaimID	Svc Date	Proc / Units	Billed / Allowed	Adjustment / GRP/RC	Deduct.	Coins / Copay	Payment
38047	05/26/2020	99203:95:CR / 1	$115.00 / $102.05	$12.95 / CO-45		/ $30.00	$72.05

- 45 : Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).