



Your Client ID:  
Report Name:  
Payer Report:

\*\*\*\*\* Remittance Notice(s) from Insurance Company \*\*\*\*\*  
The following information was sent from the insurance company. If you have a  
question or concern please contact the insurance company directly.  
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PAYER: SENSIBLE  
DATE: 06/13/2023  
PAYMENT METHOD:  
CHECK/EFT #: 0123456789

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: H SMITH, JOHN	05/18/2023					ACNT: M12345678		ICN: GG01234		ASG: Y	
INTEGRATIVE	05/18-05/18/23	1		99205		500.00	383.18	0.00	0.00	CO-45	368.18
										PR-3	15.00
	PT RESP	15.00		CLAIM TOTALS		500.00	383.18	0.00	0.00		368.18
ADJ. TO TOTALS: PREV PD				INTEREST		0.00	LATE FILING CHARGE		0.00	NET	368.18

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: DOE, JANEN	05/31/2023					ACNT: M23456789		ICN: GG12345		ASG: Y	
INTEGRATIVE	05/31-05/31/23	1		99214		300.00	204.88	0.00	0.00	CO-45	189.88
										PR-3	15.00
INTEGRATIVE	05/31-05/31/23	1		90833		300.00	131.75	0.00	0.00	CO-45	131.75
	PT RESP	15.00		CLAIM TOTALS		600.00	336.63	0.00	0.00		321.63
ADJ. TO TOTALS: PREV PD				INTEREST		0.00	LATE FILING CHARGE		0.00	NET	321.63

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: MOUSE, MICK	04/24/2023					ACNT: M34567890		ICN: GG56789		ASG: Y	
INTEGRATIVE	04/24-04/24/23	1		99214		300.00	204.88	0.00	0.00	CO-45	189.88
										PR-3	15.00
INTEGRATIVE	04/24-04/24/23	1		90833		300.00	131.75	0.00	0.00	CO-45	131.75
	PT RESP	15.00		CLAIM TOTALS		600.00	336.63	0.00	0.00		321.63
ADJ. TO TOTALS: PREV PD				INTEREST		0.00	LATE FILING CHARGE		0.00	NET	321.63

Summary

Payer	:	SENSIBLE
Check/EFT Date	:	06/13/2023
Check/EFT #	:	0123456789
Total Claims	:	3
Billed Amount	:	1700.00
Total Reason Code Adjustment Amount	:	643.56
Total Allowed Amount	:	1056.44
Total Coinsurance Amount	:	0.00
Total Deductible Amount	:	0.00
Total Paid to Provider	:	1011.44
Total Interest Amount	:	0.00
Total Check/EFT Amount	:	1011.44

**GLOSSARY:**

3 Co-payment Amount

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This 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) This change effective 3/1/2016: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount

CO Contractual Obligation

PR Patient Responsibility