UnitedHealthcare Choice Plus

EXPLANATION OF BENEFITS

P.O. Box 740800 · Atlanta, GA 30374 · Member Services: 1-866-892-8382 · myuhc.com

EOB #: UHC-EOB-2024-8812047

THIS IS NOT A BILL. This Explanation of Benefits summarizes how your claim was processed. You may owe the amount shown under "Patient Responsibility" to your provider.

MEMBER NAME	Michael T. Donovan	DATE OF SERVICE	September 5, 2024
MEMBER ID	MTD4471820	PROVIDER	Riverside Medical Center
GROUP NUMBER	GRP-22019-EMP	CLAIM NUMBER	CLM-2024-8812047
PLAN	UHC Choice Plus PPO	DATE PROCESSED	September 18, 2024

CLAIM STATUS
PROCESSED
Payment Issued

CLAIM DETAILS

DATE	CODE	DESCRIPTION	BILLED	ALLOWED	INS. PAID	ADJUSTMENT	PATIENT RESP.
09/05/24	—	ED Facility Fee — Level 4	$1,800.00	**$900.00**	$720.00	($180.00)	**$180.00**
09/05/24	71045	Chest X-Ray, Single View	$800.00	$650.00	$520.00	($150.00)	**$130.00**
09/05/24	93000	Electrocardiogram w/ Interpretation	$450.00	$380.00	$304.00	($76.00)	**$76.00**
09/05/24	80053	Comprehensive Metabolic Panel (1 of 2 — Allowed)	$650.00	$520.00	$416.00	($130.00)	**$104.00**
09/05/24	80053	Comprehensive Metabolic Panel (2 of 2 — NOT COVERED)	$650.00	$0.00	$0.00	$0.00	**$210.00**
09/05/24	J3490	Nitroglycerin 0.4mg Sublingual	$300.00	$240.00	$192.00	($60.00)	**$48.00**
TOTALS			**$4,650.00**	**$2,900.00**	**$2,200.00**	**($596.00)**	**$700.00**

INSURANCE PAID
$2,200.00

ADJUDICATION NOTES

CODE	APPLIES TO	NOTE	ACTION REQUIRED
N1	Lab Panel (80053 × 2)	Only one Comprehensive Metabolic Panel per visit is covered under your plan. The second panel was not medically authorized for this visit type.	You may owe $210.00 to provider as a non-covered balance.

CODE	APPLIES TO	NOTE	ACTION REQUIRED
N2	ED Facility Fee	Facility fee is subject to medical necessity review. Partial payment of $720.00 issued pending final audit. Additional payment or retraction may follow.	Do not pay facility fee in full until review is complete (est. 30 days).
N3	All Line Items	Patient may be balance billed for non-covered amounts per plan terms. Providers in the UHC network agree not to charge more than the allowed amount for covered services.	Review your Summary of Benefits for details on non-covered services.

YOUR RIGHTS & NEXT STEPS

Appeal a Denied Service	You have the right to appeal any claim denial within 180 days of this notice. Submit appeals in writing to: UHC Appeals, P.O. Box 740816, Atlanta, GA 30374, or call 1-866-892-8382.
Request an Itemized Bill	You may request an itemized bill from your provider at any time. Compare it against this EOB to verify you are not overcharged.
External Review	If your internal appeal is denied, you may request an independent external review at no cost to you under the Affordable Care Act.
Financial Assistance	If you cannot afford your patient responsibility, contact Riverside Medical Center's financial counseling team at (312) 555-0155.