**Check Information**

## Envolve Vision
112 ZEBULON COURT
ROCKY MOUNT, NC 27804

## AMARILLO EYE ASSOCIATES PC
8601 SW 45TH AVE
AMARILLO, TX 791196565
EFT #: 097622
Check Date: 12/26/2024
Check Amount: $3,820.73
Provider Adj Amt: $0.00

Provider #: 1639335516
Provider Tax ID #: 752728938
NPI / Group Provider Number: 1932112372
Created Date: 12/26/2024

**Claim Information**

Patient Name: JOSIAH ALVAREZ
Insured Name: JOSIAH ALVAREZ
Claim ID: 241212560266
Claim Status: Processed as Primary
Claim Payment Amount: $119.53
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 623640224
Insured Member Identification: 623640224
Patient Account Number: 128648872
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304DU
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | 92083 | $94.00 | $47.69 | $0.00 | $0.00 | $0.00 | $0.00 | $46.31 | CO-45 | $47.69 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | 92133 | $65.00 | $34.94 | $0.00 | $0.00 | $0.00 | $0.00 | $30.06 | CO-45 | $34.94 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | 99213 | $120.00 | $36.90 | $0.00 | $0.00 | $0.00 | $0.00 | $83.10 | CO-45 | $36.90 | N381 |
| SERVICE LINE TOTALS: | | | | | $279.00 | $119.53 | $0.00 | $0.00 | $0.00 | $0.00 | $159.47 | | $119.53 | |

**Claim Information**

Patient Name: PAEZLI CHAFFIN
Insured Name: PAEZLI CHAFFIN
Claim ID: 2412161576094
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 626417019
Insured Member Identification: 626417019
Patient Account Number: 128781494
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 20241217046T
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1639335516 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/13/2024 | 12/13/2024 | 1639335516 | 2 | V2103 | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: PAEZLI CHAFFIN
Insured Name: PAEZLI CHAFFIN
Claim ID: 2412161576096
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 626417019
Insured Member Identification: 626417019
Patient Account Number: 128781747
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 20241217047R
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1639335516 | 1 | S0620 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: FAITH CUMMINGS
Insured Name: FAITH CUMMINGS
Claim ID: 241212560254
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 0000000063865599
Insured Member Identification: 529867773
Patient Account Number: 128613633
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304DN
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | S0620 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: FAITH CUMMINGS
Insured Name: FAITH CUMMINGS
Claim ID: 241212560252
Claim Status: Processed as Primary
Claim Payment Amount: $182.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 0000000063865599
Insured Member Identification: 529867773
Patient Account Number: 128612179
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304DZ
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 2 | V2109 | $130.00 | $112.00 | $0.00 | $0.00 | $0.00 | $0.00 | $18.00 | CO-45 | $112.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $182.00 | $0.00 | $0.00 | $0.00 | $0.00 | $27.00 | | $182.00 | |

**Claim Information**

Patient Name: JAEDEN DARNES
Insured Name: JAEDEN DARNES
Claim ID: 241213575599
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 0000000075573640
Insured Member Identification: 610888751
Patient Account Number: 128701090
Rendering Provider: JAMES FITCH
Rendering NPI: 1740293919
Payer Claim Control # / ICN#: 2024121402C0
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1740293919 | 1 | S0621 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: JAEDEN DARNES
Insured Name: JAEDEN DARNES
Claim ID: 241213575600
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 0000000075573640
Insured Member Identification: 610888751
Patient Account Number: 128702106
Rendering Provider: JAMES FITCH
Rendering NPI: 1740293919
Payer Claim Control # / ICN#: 2024121402C1
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1740293919 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/12/2024 | 12/12/2024 | 1740293919 | 2 | V2103 | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: GIDAYA DOBBINS
Insured Name: GIDAYA DOBBINS
Claim ID: 241213581644
Claim Status: Processed as Primary
Claim Payment Amount: $72.13
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:
Member Identification #: U9845052501
Insured Member Identification: U9845052501
Patient Account Number: 128684430
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121402BH
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1639335516 | 1 | S0621 | $115.00 | $72.13 | $0.00 | $0.00 | $0.00 | $0.00 | $42.87 | CO-45 | $72.13 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $72.13 | $0.00 | $0.00 | $0.00 | $0.00 | $42.87 | | $72.13 | |

**Claim Information**

Patient Name: GIDAYA DOBBINS
Insured Name: GIDAYA DOBBINS
Claim ID: 241213581645
Claim Status: Processed as Primary
Claim Payment Amount: $109.90
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:
Member Identification #: U9845052501
Insured Member Identification: U9845052501
Patient Account Number: 128687851
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121402C4
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1639335516 | 1 | V2020 | $229.00 | $137.40 | $0.00 | $0.00 | $0.00 | $0.00 | $151.00 | CO-45 | $78.00 | N381 |
| 12/12/2024 | 12/12/2024 | 1639335516 | 2 | V2107 | $130.00 | $16.90 | $0.00 | $0.00 | $0.00 | $0.00 | $113.10 | CO-45 | $16.90 | N381 |
| 12/12/2024 | 12/12/2024 | 1639335516 | 1 | V2750 | $30.00 | $15.00 | $0.00 | $0.00 | $0.00 | $0.00 | $15.00 | CO-45 | $15.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $389.00 | $169.30 | $0.00 | $0.00 | $0.00 | $0.00 | $279.10 | | $109.90 | |

**Claim Information**

Patient Name: ELASIA DURAN
Insured Name: ELASIA DURAN
Claim ID: 2412161576095
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:
Member Identification #: 740630217
Insured Member Identification: 740630217
Patient Account Number: 128781533
Rendering Provider: JAMES FITCH
Rendering NPI: 1740293919
Payer Claim Control # / ICN#: 2024121704BU
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1740293919 | 1 | S0621 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: SESLIE ESCOBAR RINCON
Insured Name: SESLIE ESCOBAR RINCON
Claim ID: 2412161576103
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 726202413
Insured Member Identification: 726202413
Patient Account Number: 128790698
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121704CD
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1639335516 | 1 | V2020 | $99.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $29.00 | CO-45 | $70.00 | N381 |
| 12/13/2024 | 12/13/2024 | 1639335516 | 2 | V2100 | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $229.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $89.00 | | $140.00 | |

**Claim Information**

Patient Name: SESLIE ESCOBAR RINCON
Insured Name: SESLIE ESCOBAR RINCON
Claim ID: 2412161576102
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 726202413
Insured Member Identification: 726202413
Patient Account Number: 128790409
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121704CG
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1639335516 | 1 | S0620 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: EVANDER ESPARZA
Insured Name: EVANDER ESPARZA
Claim ID: 241212590104
Claim Status: Denied
Claim Payment Amount: $0.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 607451892
Insured Member Identification: 607451892
Patient Account Number: 128671731
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304E5
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/3/2024 | 12/3/2024 | 1639335516 | 0 | V2020,RB | $79.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $79.00 | CO-B13 | $0.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $79.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $79.00 | | $0.00 | |

**Claim Information**

Patient Name: JERZIE EWING
Insured Name: JERZIE EWING
Claim ID: 2412161576093
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 610097227
Insured Member Identification: 610097227
Patient Account Number: 128780591
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 20241217044Z
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1639335516 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/13/2024 | 12/13/2024 | 1639335516 | 2 | V2103 | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: JERZIE EWING
Insured Name: JERZIE EWING
Claim ID: 2412161576097
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 610097227
Insured Member Identification: 610097227
Patient Account Number: 128781771
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 20241217048C
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1639335516 | 1 | S0620 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: NOLAN FLOWERS
Insured Name: NOLAN FLOWERS
Claim ID: 2412161576099
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 749354860
Insured Member Identification: 749354860
Patient Account Number: 128789054
Rendering Provider: STERLING SCHAEFFER
Rendering NPI: 1891366597
Payer Claim Control # / ICN#: 20241217043D
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1891366597 | 1 | V2020,RB | $129.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $59.00 | CO-45 | $70.00 | N381 |
| 12/13/2024 | 12/13/2024 | 1891366597 | 2 | V2103,RB | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $259.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $119.00 | | $140.00 | |

**Claim Information**

Patient Name: OLIVER FLOWERS
Insured Name: OLIVER FLOWERS
Claim ID: 2412161576100
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 737788401
Insured Member Identification: 737788401
Patient Account Number: 128789170
Rendering Provider: STERLING SCHAEFFER
Rendering NPI: 1891366597
Payer Claim Control # / ICN#: 2024121704AC
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1891366597 | 1 | V2020,RB | $179.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $109.00 | CO-45 | $70.00 | N381 |
| 12/13/2024 | 12/13/2024 | 1891366597 | 1 | V2100,RB,RT | $65.00 | $35.00 | $0.00 | $0.00 | $0.00 | $0.00 | $30.00 | CO-45 | $35.00 | N381 |
| 12/13/2024 | 12/13/2024 | 1891366597 | 1 | V2103,RB,LT | $65.00 | $35.00 | $0.00 | $0.00 | $0.00 | $0.00 | $30.00 | CO-45 | $35.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $309.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $169.00 | | $140.00 | |

**Claim Information**

Patient Name: AALIYAH GARZA
Insured Name: AALIYAH GARZA
Claim ID: 241212560264
Claim Status: Denied
Claim Payment Amount: $0.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 749333221
Insured Member Identification: 749333221
Patient Account Number: 128647683
Rendering Provider: STERLING SCHAEFFER
Rendering NPI: 1891366597
Payer Claim Control # / ICN#: 2024121304D2
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1891366597 | 0 | V2020 | $99.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $99.00 | CO-119 | $0.00 | N381 |
| 12/11/2024 | 12/11/2024 | 1891366597 | 0 | V2104 | $130.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $130.00 | CO-119 | $0.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $229.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $229.00 | | $0.00 | |

**Claim Information**

Patient Name: JOSEPHINE HOLT
Insured Name: JOSEPHINE HOLT
Claim ID: 2412161576098
Claim Status: Processed as Primary
Claim Payment Amount: $32.47
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 523798335
Insured Member Identification: 523798335
Patient Account Number: 128782823
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121704B8
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1639335516 | 1 | 99213 | $120.00 | $32.47 | $0.00 | $0.00 | $0.00 | $0.00 | $87.53 | CO-45 | $32.47 | N381 |
| SERVICE LINE TOTALS: | | | | | $120.00 | $32.47 | $0.00 | $0.00 | $0.00 | $0.00 | $87.53 | | $32.47 | |

**Claim Information**

Patient Name: JESUS LECHUGA
Insured Name: JESUS LECHUGA
Claim ID: 241213581648
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 736562052
Insured Member Identification: 736562052
Patient Account Number: 128713218
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121402AD
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1639335516 | 2 | V2104,RB | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| 12/12/2024 | 12/12/2024 | 1639335516 | 1 | V2020,RB | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: JESUS LECHUGA
Insured Name: JESUS LECHUGA
Claim ID: 241213581649
Claim Status: Processed as Primary
Claim Payment Amount: $130.73
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 736562052
Insured Member Identification: 736562052
Patient Account Number: 128713786
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121402E6
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1639335516 | 1 | 92060 | $82.00 | $32.73 | $0.00 | $0.00 | $0.00 | $0.00 | $49.27 | CO-45 | $32.73 | N381 |
| 12/12/2024 | 12/12/2024 | 1639335516 | 1 | S0621 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $197.00 | $130.73 | $0.00 | $0.00 | $0.00 | $0.00 | $66.27 | | $130.73 | |

**Claim Information**

Patient Name: ESTEFANIA NAVARRO
Insured Name: ESTEFANIA NAVARRO
Claim ID: 241213575597
Claim Status: Processed as Primary
Claim Payment Amount: $51.83
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:
Member Identification #: 716292381
Insured Member Identification: 716292381
Patient Account Number: 128694654
Rendering Provider: JAMES FITCH
Rendering NPI: 1740293919
Payer Claim Control # / ICN#: 2024121402DB
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1740293919 | 1 | 99214 | $174.00 | $51.83 | $0.00 | $0.00 | $0.00 | $0.00 | $122.17 | CO-45 | $51.83 | N381 |
| SERVICE LINE TOTALS: | | | | | $174.00 | $51.83 | $0.00 | $0.00 | $0.00 | $0.00 | $122.17 | | $51.83 | |

**Claim Information**

Patient Name: ANGELICA OLIVAREZ
Insured Name: ANGELICA OLIVAREZ
Claim ID: 241212560256
Claim Status: Processed as Primary
Claim Payment Amount: $154.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:
Member Identification #: 504896418
Insured Member Identification: 504896418
Patient Account Number: 128617293
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304DV
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 2 | V2204 | $170.00 | $84.00 | $0.00 | $0.00 | $0.00 | $0.00 | $86.00 | CO-45 | $84.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $249.00 | $154.00 | $0.00 | $0.00 | $0.00 | $0.00 | $95.00 | | $154.00 | |

**Claim Information**

Patient Name: ANGELICA OLIVAREZ
Insured Name: ANGELICA OLIVAREZ
Claim ID: 241212560257
Claim Status: Denied
Claim Payment Amount: $0.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:
Member Identification #: 504896418
Insured Member Identification: 504896418
Patient Account Number: 128617512
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304E4
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 0 | S0621 | $115.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $115.00 | CO-119 | $0.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $115.00 | | $0.00 | |

**Claim Information**

Patient Name: PRESLEY PEOPLES
Insured Name: PRESLEY PEOPLES
Claim ID: 2412161576101
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 626339776
Insured Member Identification: 626339776
Patient Account Number: 128789984
Rendering Provider: STERLING SCHAEFFER
Rendering NPI: 1891366597
Payer Claim Control # / ICN#: 202412170446
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/13/2024 | 12/13/2024 | 1891366597 | 1 | V2020,RB | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/13/2024 | 12/13/2024 | 1891366597 | 2 | V2108,RB | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: CALEIGH STEWART
Insured Name: CALEIGH STEWART
Claim ID: 241213575596
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 705253008
Insured Member Identification: 705253008
Patient Account Number: 128693539
Rendering Provider: JAMES FITCH
Rendering NPI: 1740293919
Payer Claim Control # / ICN#: 2024121402BP
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1740293919 | 1 | V2020,RB | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/12/2024 | 12/12/2024 | 1740293919 | 2 | V2104,RB | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: CALEIGH STEWART
Insured Name: CALEIGH STEWART
Claim ID: 241213575598
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 705253008
Insured Member Identification: 705253008
Patient Account Number: 128694694
Rendering Provider: JAMES FITCH
Rendering NPI: 1740293919
Payer Claim Control # / ICN#: 2024121402C5
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1740293919 | 1 | S0621 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: ADALYNN SUTTON
Insured Name: ADALYNN SUTTON
Claim ID: 241212560253
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 0000000095020802
Insured Member Identification: 714744738
Patient Account Number: 128613277
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304CT
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 2 | V2104 | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: ADALYNN SUTTON
Insured Name: ADALYNN SUTTON
Claim ID: 241212560255
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 0000000095020802
Insured Member Identification: 714744738
Patient Account Number: 128613737
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304DS
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | S0620 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: DOMINGA VENTURA ORDONE
Insured Name: DOMINGA VENTURA ORDONE
Claim ID: 241212560265
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 735937670
Insured Member Identification: 735937670
Patient Account Number: 128648009
Rendering Provider: STERLING SCHAEFFER
Rendering NPI: 1891366597
Payer Claim Control # / ICN#: 2024121304DT
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10/25/2024 | 10/25/2024 | 1891366597 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 10/25/2024 | 10/25/2024 | 1891366597 | 2 | V2104 | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: MAKALEE VIGUERIA
Insured Name: MAKALEE VIGUERIA
Claim ID: 241213581647
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 528612944
Insured Member Identification: 528612944
Patient Account Number: 128689085
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121402CU
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/12/2024 | 12/12/2024 | 1639335516 | 1 | S0620 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: KIMBERLEY ZAMORA
Insured Name: KIMBERLEY ZAMORA
Claim ID: 241212560271
Claim Status: Processed as Primary
Claim Payment Amount: $126.14
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 625797417
Insured Member Identification: 625797417
Patient Account Number: 128650998
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304CV
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | 92250 | $73.00 | $28.14 | $0.00 | $0.00 | $0.00 | $0.00 | $44.86 | CO-45 | $28.14 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | S0621 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $188.00 | $126.14 | $0.00 | $0.00 | $0.00 | $0.00 | $61.86 | | $126.14 | |

**Claim Information**

Patient Name: KIMBERLEY ZAMORA
Insured Name: KIMBERLEY ZAMORA
Claim ID: 241212560268
Claim Status: Processed as Primary
Claim Payment Amount: $140.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 625797417
Insured Member Identification: 625797417
Patient Account Number: 128650277
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304EO
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 2 | V2103 | $130.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $60.00 | CO-45 | $70.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $140.00 | $0.00 | $0.00 | $0.00 | $0.00 | $69.00 | | $140.00 | |

**Claim Information**

Patient Name: MARISOL ZAMORA
Insured Name: MARISOL ZAMORA
Claim ID: 241212560269
Claim Status: Processed as Primary
Claim Payment Amount: $98.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 605430801
Insured Member Identification: 605430801
Patient Account Number: 128650522
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304D0
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | Coins Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | S0621 | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | CO-45 | $98.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $98.00 | $0.00 | $0.00 | $0.00 | $0.00 | $17.00 | | $98.00 | |

**Claim Information**

Patient Name: RAUL ZAMORA
Insured Name: RAUL ZAMORA
Claim ID: 241212560267
Claim Status: Processed as Primary
Claim Payment Amount: $182.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 706776070
Insured Member Identification: 706776070
Patient Account Number: 128649662
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304CU
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | CoIns Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 1 | V2020 | $79.00 | $70.00 | $0.00 | $0.00 | $0.00 | $0.00 | $9.00 | CO-45 | $70.00 | N381 |
| 12/11/2024 | 12/11/2024 | 1639335516 | 2 | V2105 | $130.00 | $112.00 | $0.00 | $0.00 | $0.00 | $0.00 | $18.00 | CO-45 | $112.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $209.00 | $182.00 | $0.00 | $0.00 | $0.00 | $0.00 | $27.00 | | $182.00 | |

**Claim Information**

Patient Name: RAUL ZAMORA
Insured Name: RAUL ZAMORA
Claim ID: 241212560270
Claim Status: Denied
Claim Payment Amount: $0.00
Claim Adj Amt:
Claim Adj Codes:
Claim Remark Codes:

Member Identification #: 706776070
Insured Member Identification: 706776070
Patient Account Number: 128650950
Rendering Provider: RYAN HOLLINGSWORTH
Rendering NPI: 1639335516
Payer Claim Control # / ICN#: 2024121304DL
Patient Responsibility:
Patient Responsibility Reason Code:
Patient Group#:

**Service Line Information**

| Begin Service Date | End Service Date | Rendering NPI | Paid Units | Proc/Rev Code, Mods | Billed Amount | Allowed Amount | Deduct Amount | CoIns Amount | CoPay Amount | Late Filing Red. | Other Adjusts | Adjust Codes | Provider Paid | Remark Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/11/2024 | 12/11/2024 | 1639335516 | 0 | S0621 | $115.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $115.00 | CO-11 | $0.00 | N381 |
| SERVICE LINE TOTALS: | | | | | $115.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $115.00 | | $0.00 | |

**Check Totals**

| | Claim Adjustments | Billed Amount | Allowed Amount | Deduct Amount | CoIns Amount | CoPay Amount | Late Filing Red. | Other Adjustments | Total Paid |
|---|---|---|---|---|---|---|---|---|---|
| TOTALS: | $0.00 | $6,495.00 | $3,880.13 | $0.00 | $0.00 | $0.00 | $0.00 | $2,674.27 | $3,820.73 |

**Adjustment Codes Glossary**

**Billed Service Not Covered by Health Plan**

CO-11 : The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009

CO-119 : Benefit maximum for this time period or occurrence has been reached. Start: 01/01/1995 | Last Modified: 02/29/2004

CO-B13 : Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 01/01/1995

N381 : Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges. Start: 04/01/2007 | Last Modified: 07/01/2015 Notes: (Modified 7/1/15)

CO : Contractual Obligations: Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.

CO-45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and 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) Start: 01/01/1995 | Last Modified: 11/01/2015