MHN
A Health Net Company℠

MHN SERVICES
PO Box 9088
San Rafael, CA 94903
(800) 444-4281

Check No.:
Date: 4/16/21
Page: 1

Remittance Advice

Vendor
SAGE BRUSH, LLC
1310 E CHAPMAN AVE 180
FULLERTON CA 92831

Vendor No.	Federal ID No.
0001282297	320572774

PROV NAME	SVC DT	FORM #	SVC CODE	DESCRIPTION	BILLED $	ALLOWED $	DTL CNT	COINS + COPAY + DEDUCT + NOT COV $	NET $	WITHHELD $	NET $ PAID
BUTTERFIELD,GARRETT		395607258-05	OE8505583								
SAGE BRUSH, LLC	031221	23103411	0906	IOP-Intensive OP	3095.00	3095.00	001	3095.00	.00	.00	.00
898856938	031521	23103407	0906	IOP-Intensive OP	3095.00	3095.00	002	3095.00	.00	.00	.00
898856934	031621	23103408	0906	IOP-Intensive OP	3095.00	3095.00	003	3095.00	.00	.00	.00
898856935	031721	23103409	0906	IOP-Intensive OP	3095.00	3095.00	004	3095.00	.00	.00	.00
898856936	032421	23103831	0906	IOP-Intensive OP	3095.00	3095.00	005	3095.00	.00	.00	.00
899221668											
				MEMBER SUBTOTAL **	15475.00	15475.00		15475.00	.00	.00	.00
				VENDOR TOTAL ***	15475.00	15475.00		15475.00	.00	.00	.00

	ADJUSTMENT REASON	NOT COVERED REASON	COPAY REASON	COINSURANCE REASON	DEDUCTIBLE REASON	PROCEDURE MODIFIER1	PROCEDURE MODIFIER2	PROCEDURE MODIFIER3	PROCEDUR MODIFIER
	**********	**********	******	**********	**********	*********	*********	*********	********
R001		BS							
R002		BS							
R003		BS							
R004		BS							
R005		BS							

REASON CODE LEGEND:

BS = This is not a denial. This is a request for a detailed itemized bill. This is not a request for medical records. Please resubmit an itemized, original UB04 claim form that: (a) provides details of the member's program for each date of service; (b) includes specific clinical services provided , including the revenue code and corresponding most specific HCPCS/CPT for each service; (c) contains the appropriate Type of Bill for the procedure rendered and (d) a breakdown of the services for each day; not the itemization of the higher level of care by date. The MHN website is available to you at www.mhn.com/providers/claims/claims-submission if you need billing assistance.

MHN
A Health Net Company℠

MHN SERVICES
PO Box 9088
San Rafael, CA 94903
(800) 444-4281

Check No.:
Date: 4/09/21
Page: 1

Remittance Advice

Vendor

SAGE BRUSH, LLC
1310 E CHAPMAN AVE 180
FULLERTON CA 92831

Vendor No.	Federal ID No.
0001282297	320572774

PROV NAME	SVC DT	FORM #	SVC CODE	DESCRIPTION	BILLED $	ALLOWED $	DTL CNT	COINS + COPAY + DEDUCT + NOT COV $	NET $	WITHHELD $	NET $ PAID
BUTTERFIELD,GARRETT		395607258-05	0E8505583								
SAGE BRUSH, LLC	030321	26587649	0913	BEHAVIORAL HEALTH	3995.00	3995.00	001	3995.00	.00	.00	.00
896830884	030421	26587650	0913	BEHAVIORAL HEALTH	3995.00	3995.00	002	3995.00	.00	.00	.00
896830885	030521	26587651	0913	BEHAVIORAL HEALTH	3995.00	3995.00	003	3995.00	.00	.00	.00
896830886	031121	26586744	0906	IOP-Intensive OP	3095.00	3095.00	004	3095.00	.00	.00	.00
896207150											
				MEMBER SUBTOTAL **	15080.00	15080.00		15080.00	.00	.00	.00
				VENDOR TOTAL ***	15080.00	15080.00		15080.00	.00	.00	.00

	ADJUSTMENT REASON	NOT COVERED REASON	COPAY REASON	COINSURANCE REASON	DEDUCTIBLE REASON	PROCEDURE MODIFIER1	PROCEDURE MODIFIER2	PROCEDURE MODIFIER3	PROCEDUR MODIFIER
	**********	**********	******	**********	**********	*********	*********	*********	********
R001		BS							
R002		BS							
R003		BS							
R004		IG							

REASON CODE LEGEND:

BS = This is not a denial. This is a request for a detailed itemized bill. This is not a request for medical records. Please resubmit an itemized, original UB04 claim form that: (a) provides details of the member's program for each date of service; (b) includes specific clinical services provided , including the revenue code and corresponding most specific HCPCS/CPT for each service; (c) contains the appropriate Type of Bill for the procedure rendered and (d) a breakdown of the services for each day; not the itemization of the higher level of care by date. The MHN website is available to you at www.mhn.com/providers/claims/claims-submission if you need billing assistance.

IG = Please resubmit claim with appropriate Type of Bill and/or Procedure/Revenue code combination for the services rendered See www.mhn.com/provider/start.do for billing instructions.

MHN
A Health Net Company℠

MHN SERVICES
PO Box 9088
San Rafael, CA 94903
(800) 444-4281

Check No.:
Date: 4/02/21
Page: 1

Remittance Advice

Vendor
SAGE BRUSH, LLC
1310 E CHAPMAN AVE 180
FULLERTON CA 92831

Vendor No.	Federal ID No.
0001282297	320572774

BUTTERFIELD, GARRETT 395607258-05 0E8505583

PROV NAME	SVC DT	FORM #	SVC CODE	DESCRIPTION	BILLED $	ALLOWED $	DTL CNT	COINS + COPAY + DEDUCT + NOT COV $	NET $	WITHHELD $	NET $ PAID
SAGE BRUSH, LLC	030821	26586741	0913	BEHAVIORAL HEALTH	3995.00	3995.00	001	3995.00	.00	.00	.00
896207147	030921	26586742	0913	BEHAVIORAL HEALTH	3995.00	3995.00	002	3995.00	.00	.00	.00
896207148	031021	26586743	0913	BEHAVIORAL HEALTH	3995.00	3995.00	003	3995.00	.00	.00	.00
896207149				MEMBER SUBTOTAL **	11985.00	11985.00		11985.00	.00	.00	.00
				VENDOR TOTAL ***	11985.00	11985.00		11985.00	.00	.00	.00

	ADJUSTMENT REASON	NOT COVERED REASON	COPAY REASON	COINSURANCE REASON	DEDUCTIBLE REASON	PROCEDURE MODIFIER1	PROCEDURE MODIFIER2	PROCEDURE MODIFIER3	PROCEDUR MODIFIER
	**********	**********	******	**********	**********	*********	*********	*********	********
R001		IG							
R002		IG							
R003		IG							

REASON CODE LEGEND:

IG = Please resubmit claim with appropriate Type of Bill and/or Procedure/Revenue code combination for the services rendered See www.mhn.com/provider/start.do for billing instructions.

continued from previous page

Totals:	3095.00	0.00	3095.00	0.00	0.00	0.00	0.00		0.00

Total Amount Not Paid By Plan 3095.00

Participant: Camille N. Fredericksen **Patient Name:** Jesse J. Fredericksen **Pat Acct No:** 896207267
Plan No: 6475 **Relationship:** Child **Claim No:** 20210325-740
Plan Name: ILWU-PMA Welfare Plan **Provider:** Sagebrush, LLC DBA THE EDGE TREATM **Paid Date:** 04/07/2021

Service Dates	Service Type	Charge Amount	PPO/ Other Insurance/ Medicare Discount	Not Covered	Less Deductible	Less Co-Insurance	Basic Paid Amount	Major Medical Paid Amount	Major Medical Paid At	Benefit Amount	Remark Code
03/05/21-03/05/21	906 SA - Outpatient I	67.11	0.00	67.11	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
03/05/21-03/05/21	906 VISIT	3027.89	0.00	3027.89	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
Totals:		3095.00	0.00	3095.00	0.00	0.00	0.00	0.00		0.00	

Total Amount Not Paid By Plan 3095.00

Participant: Camille N. Fredericksen **Patient Name:** Jesse J. Fredericksen **Pat Acct No:** 896207266
Plan No: 6475 **Relationship:** Child **Claim No:** 20210325-742
Plan Name: ILWU-PMA Welfare Plan **Provider:** Sagebrush, LLC DBA THE EDGE TREATM **Paid Date:** 04/07/2021

Service Dates	Service Type	Charge Amount	PPO/ Other Insurance/ Medicare Discount	Not Covered	Less Deductible	Less Co-Insurance	Basic Paid Amount	Major Medical Paid Amount	Major Medical Paid At	Benefit Amount	Remark Code
03/04/21-03/04/21	906 SA - Outpatient I	67.11	0.00	67.11	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
03/04/21-03/04/21	906 VISIT	3027.89	0.00	3027.89	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
Totals:		3095.00	0.00	3095.00	0.00	0.00	0.00	0.00		0.00	

Total Amount Not Paid By Plan 3095.00

Participant: Camille N. Fredericksen **Patient Name:** Jesse J. Fredericksen **Pat Acct No:** 896207265
Plan No: 6475 **Relationship:** Child **Claim No:** 20210325-744
Plan Name: ILWU-PMA Welfare Plan **Provider:** Sagebrush, LLC DBA THE EDGE TREATM **Paid Date:** 04/07/2021

Service Dates	Service Type	Charge Amount	PPO/ Other Insurance/ Medicare Discount	Not Covered	Less Deductible	Less Co-Insurance	Basic Paid Amount	Major Medical Paid Amount	Major Medical Paid At	Benefit Amount	Remark Code
03/03/21-03/03/21	906 SA - Outpatient I	67.11	0.00	67.11	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
03/03/21-03/03/21	906 VISIT	3027.89	0.00	3027.89	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
Totals:		3095.00	0.00	3095.00	0.00	0.00	0.00	0.00		0.00	

Total Amount Not Paid By Plan 3095.00

Remark Code(s)

TC3REV **This claim is currently under review. Upon receipt of the additional information requested from provider, the claim will be processed. No further action is required by the patient at this time. This is not a denial or an adverse determination. In order to complete the processing of claim(s), TC3 has requested Medical Records from the provider. Records must be faxed to 949-234-7603 or mailed to: TC3/ Change Healthcare, 5755 Wayzata Blvd, St. Louis Park, MN 55416.**

P475302800U

ILWU-PMA COASTWISE CLAIMS OFFICE
PO Box 429101
San Francisco, CA 94142

202104080162

Electronic Service Requested

MIXED AADC 928
2803 0.3584 MB 0.436

Sagebrush, LLC DBA THE EDGE TRE 125
1310 E CHAPMAN AVE # 180
FULLERTON, CA 92831-3954

For Customer Service:
(800)955-7376
8:30 a.m.-5:00 p.m. PST

CHECK NO:

CHECK AMOUNT: $

1 OF 1 F

ENV 2803

Explanation of Payment

Participant: Camille N. Fredericksen **Patient Name:** Jesse J. Fredericksen **Pat Acct No:** 896207270
Plan No: 6475 **Relationship:** Child **Claim No:** 20210325-736
Plan Name: ILWU-PMA Welfare Plan **Provider:** Sagebrush, LLC DBA THE EDGE TREATM **Paid Date:** 04/07/2021

Service Dates	Service Type	Charge Amount	PPO/ Other Insurance/ Medicare Discount	Not Covered	Less Deductible	Less Co-Insurance	Basic Paid Amount	Major Medical Paid Amount	Major Medical Paid At	Benefit Amount	Remark Code
03/12/21-03/12/21	906 SA - Outpatient I	67.11	0.00	67.11	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
03/12/21-03/12/21	906 VISIT	3027.89	0.00	3027.89	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
	Totals:	3095.00	0.00	3095.00	0.00	0.00	0.00	0.00		0.00	

Total Amount Not Paid By Plan 3095.00

Participant: Camille N. Fredericksen **Patient Name:** Jesse J. Fredericksen **Pat Acct No:** 896207269
Plan No: 6475 **Relationship:** Child **Claim No:** 20210325-737
Plan Name: ILWU-PMA Welfare Plan **Provider:** Sagebrush, LLC DBA THE EDGE TREATM **Paid Date:** 04/07/2021

Service Dates	Service Type	Charge Amount	PPO/ Other Insurance/ Medicare Discount	Not Covered	Less Deductible	Less Co-Insurance	Basic Paid Amount	Major Medical Paid Amount	Major Medical Paid At	Benefit Amount	Remark Code
03/10/21-03/10/21	906 SA - Outpatient I	67.11	0.00	67.11	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
03/10/21-03/10/21	906 VISIT	3027.89	0.00	3027.89	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
	Totals:	3095.00	0.00	3095.00	0.00	0.00	0.00	0.00		0.00	

Total Amount Not Paid By Plan 3095.00

Participant: Camille N. Fredericksen **Patient Name:** Jesse J. Fredericksen **Pat Acct No:** 896207268
Plan No: 6475 **Relationship:** Child **Claim No:** 20210325-739
Plan Name: ILWU-PMA Welfare Plan **Provider:** Sagebrush, LLC DBA THE EDGE TREATM **Paid Date:** 04/07/2021

Service Dates	Service Type	Charge Amount	PPO/ Other Insurance/ Medicare Discount	Not Covered	Less Deductible	Less Co-Insurance	Basic Paid Amount	Major Medical Paid Amount	Major Medical Paid At	Benefit Amount	Remark Code
03/09/21-03/09/21	906 SA - Outpatient I	67.11	0.00	67.11	0.00	0.00	0.00	0.00	0%	0.00	TC3REV
03/09/21-03/09/21	906 VISIT	3027.89	0.00	3027.89	0.00	0.00	0.00	0.00	0%	0.00	TC3REV