**Blue Shield of California**
PO BOX 241012
LODI, CA 95241-9512

blue of california

**Blue Shield of California**
An Independent Member of the Blue Shield Association
**www.blueshieldca.com/provider**



**------ manifest line ---------**

ISSUE DATE: 11 27 24
EOB NUMBER: 24332B10002145572405
PARTICIPATING PROVIDER NO
PROVIDER NUMBER: PG0041686003
PROVIDER NPI: 1497042840

HOUSE CALL MD INC
1171 S ROBERTSON BLVD STE 242
LOS ANGELES, CA 90035-1403

**CORRESPONDENCE:**
P. O. BOX 272540, CHICO, CA 95927-2540
PHONE: (800) 541-6652

# EXPLANATION OF BENEFITS
## THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

016379 1/1

| PATIENT NAME<br>I.D.NUMBER<br>GROUP NUMBER | PATIENT<br>ACCOUNT NUMBER<br>CLAIM NUMBER | DATES<br>OF<br>SERVICE | PROCEDURE<br>NUMBER | UNITS<br>OF<br>SERVICE | BILLED<br>AMOUNT | ALLOWED<br>AMOUNT | CONTRACTUAL<br>ADJUSTMENT<br>AMOUNT | NOTES | DEDUCTIBLE | CO-PAY<br>AMOUNT | AMOUNT<br>PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **RECEIPT DATE:** | **11/26/24** | | | | | | | | | | |
| JOY N FRASIER<br>980598609<br>W80023651000 | 19568019B<br>246341207100 | 11/13/24 | 99310 | 1 | 154.24 | 154.24 | | | 0.00 | 38.56 | 113.37 |
| **TOTALS:** | | | | | **154.24** | | **0.00** | | **0.00** | **38.56** | **115.68** |

**NOTES:**

NOW VIEW OR DOWNLOAD YOUR EOBS ONLINE! SEARCH FOR ELIGIBILITY BENEFITS CLAIMS OR AUTHORIZATIONS ONLINE FOR BLUE SHIELD OTHER BLUE PLAN AND FEDERAL EMPLOYEE PROGRAM MEMBERS. USE OUR BLUECARD CLAIMS ROUTING TOOL TO QUICKLY FIND OUT WHERE TO SEND BLUECARD CLAIMS. FIND ALL THIS AND MORE AT BLUESHIELDCA.COM/PROVIDER.

A REDUCTION IN PAYMENT OF $2.31 HAS BEEN APPLIED DUE TO SEQUESTRATION.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **RECEIPT DATE:** | **11/26/24** | | | | | | | | | | |
| JOY N FRASIER<br>980598609<br>W80023651000 | 19564832B<br>246341206700 | 10/11/24 | 99310 | 1 | 154.24 | 154.24 | | | 0.00 | 38.56 | 113.37 |
| **TOTALS:** | | | | | **154.24** | | **0.00** | | **0.00** | **38.56** | **115.68** |

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A REDUCTION IN PAYMENT OF $2.31 HAS BEEN APPLIED DUE TO SEQUESTRATION.

— no inserts —

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **STATEMENT TOTALS:** | | | **308.48** | **308.48** | **0.00** | | **0.00** | **77.12** | **226.74** |

| STATEMENT<br>NUMBER | EFT<br>NUMBER | PAYMENT<br>AMOUNT | BILLED<br>AMOUNT | ALLOWED<br>AMOUNT | CONTRACTUAL<br>ADJUSTMENT<br>AMOUNT | DEDUCTIBLE | CO-PAY<br>AMOUNT | AMOUNT<br>PAID |
|---|---|---|---|---|---|---|---|---|
| 24332B1000214557240 | 29413597 | $226.74 | 308.48 | 308.48 | 0.00 | 0.00 | 77.12 | 226.74 |

**TOTAL PAID:** **$226.74**

Dear Provider,

Your claim(s) has been processed in accordance with the services reported and the benefits, exclusions and limitations of the patient's Medicare Advantage Blue Shield plan. In some instances there may be one or more reasons why benefits cannot be provided. If you have questions about your claim, you should contact Blue Shield's Customer Service Department by calling (800) 541-6652.

**NON CONTRACTED PROVIDER REQUEST FOR APPEAL**

If you are not satisfied with the Customer Services Department response to your inquiry, you may initiate an appeal within 60 calendar days from the remittance notification date.

Non Contracted providers must include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal.

Non Contracted providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. Please mail your reconsideration request along with the information above to:

Medicare Provider Appeals Department

P.O. Box 272640

Chico, CA 95927-2640

## WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number: _____

Enrollee's Name: _____

Provider: _____

Date of Service: _____

Health Plan: _____

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature: _____ Date: _____