**Payer**
CGS - DME MAC JURISDICTION C
P O BOX 20010
NASHVILLE TN, 372020010

**Payee**
[redacted]
**Group Number** [redacted]
**Check Number:** [redacted]

## SUMMARY OF BENEFITS

**Patient** [redacted] **Billed:** $17,640.00 **Paid:** $6,138.02 **Patient Resp:** $1,565.82

**Patient ID #:** [redacted]

**Provider:** **Other Provider Number:** Not Available

**Claim #:** [redacted] **Primary TCN:** 24101730296000 **Pay Date:** 04/22/2024

**Claim information forwarded to:** WPS - TRICARE FOR LIFE

| CPT | Units | Billed | Allow | Pay | Deduct | Coins | Copay | Oth PR | | Reas/Remk |
|---|---|---|---|---|---|---|---|---|---|---|
| Service Dates | | | Contr | WHold | Global | Cap | Oth CO | Denied | Incent | Reas/Remk |
| A6023,A1 | 30 | $17,550.00 | $7,790.10 | $6,107.44 | $0.00 | $1,558.02 | $0.00 | $0.00 | | PR2 |
| 03/06/2024 to 03/06/2024 | | | $9,884.54 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | CO45, CO253 |
| A6219,A1 | 30 | $90.00 | $39.00 | $30.58 | $0.00 | $7.80 | $0.00 | $0.00 | | PR2 |
| 03/06/2024 to 03/06/2024 | | | $51.62 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | CO45, CO253 |

- **CO253**: Sequestration - reduction in federal payment
- **CO45**: 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)
- **MA01**: Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
- **MA18**: Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
- **PR2**: Coinsurance Amount

**Total Payments for this claim:** $6,138.02

**Payer**
CGS - DME MAC JURISDICTION C
P O BOX 20010
NASHVILLE TN, 372020010

**Payee**
[redacted]

**Group Number:** [redacted]
**Check Number:** [redacted]

## SUMMARY OF BENEFITS

**Patient** [redacted]

**Billed:** $2,853.00 **Paid:** $994.98 **Patient Resp:** $253.82

**Patient ID #** [redacted]

**Provider:**

**Other Provider Number:** Not Available

**Claim #:** [redacted]

**Primary TCN:** 24101730292000 **Pay Date:** 04/22/2024

**Claim information forwarded to:** ANTHEM VA

| CPT | Units | Billed | Allow | Pay | Deduct | Coins | Copay | Oth PR | | Reas/Remk |
|---|---|---|---|---|---|---|---|---|---|---|
| Service Dates | | | Contr | WHold | Global | Cap | Oth CO | Denied | Incent | Reas/Remk |
| A6010,A1 | 30 | $2,850.00 | $1,267.80 | $993.96 | $0.00 | $253.56 | $0.00 | $0.00 | | PR2 |
| 03/11/2024 to 03/11/2024 | | | $1,602.48 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | CO45, CO253, N88 |
| A6219,A1 | 1 | $3.00 | $1.30 | $1.02 | $0.00 | $0.26 | $0.00 | $0.00 | | PR2 |
| 03/11/2024 to 03/11/2024 | | | $1.72 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | CO45, CO253, N88 |

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- **CO45**: 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)
- **MA01**: Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
- **MA18**: Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
- **N88**: Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
- **PR2**: Coinsurance Amount

**Total Payments for this claim:** $994.98

**Payer**
CGS - DME MAC JURISDICTION C
P O BOX 20010
NASHVILLE TN, 372020010

**Payee**
[redacted]

**Group Number:** [redacted]
**Check Number:** [redacted]

## SUMMARY OF BENEFITS

**Patient:** J. Hol **Billed:** $17,640.00 **Paid:** $6,138.02 **Patient Resp:** $1,565.82

**Patient ID #:** [redacted]

**Provider:** **Other Provider Number:** Not Available

**Claim #:** [redacted] **Primary TCN:** 24103723535000 **Pay Date:** 04/26/2024

**Claim information forwarded to:** UNITEDHEALTH GROUP

| CPT | Units | Billed | Allow | Pay | Deduct | Coins | Copay | Oth PR | | Reas/Remk |
|---|---|---|---|---|---|---|---|---|---|---|
| Service Dates | | | Contr | WHold | Global | Cap | Oth CO | Denied | Incent | Reas/Remk |
| A6023,A1 | 30 | $17,550.00 | $7,790.10 | $6,107.44 | $0.00 | $1,558.02 | $0.00 | $0.00 | | PR2 |
| 03/26/2024 to 03/26/2024 | | | $9,884.54 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | CO45, CO253 |
| A6219,A1 | 30 | $90.00 | $39.00 | $30.58 | $0.00 | $7.80 | $0.00 | $0.00 | | PR2 |
| 03/26/2024 to 03/26/2024 | | | $51.62 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | CO45, CO253 |

- **CO253**: Sequestration - reduction in federal payment
- **CO45**: 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)
- **MA01**: Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
- **MA18**: Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
- **PR2**: Coinsurance Amount

**Total Payments for this claim:** $6,138.02