



PO BOX 18
NEWARK, NJ 07101-0018

MERCK
1-877-663-7258
MON-FRI 8AM-11PM ET
HORIZONBLUE.COM/MERCK

DATE: 12/30/2020 PAGE 3 OF 9

EXPLANATION OF BENEFITS

THIS IS NOT A BILL



SUBSCRIBER NAME: SENTHIL K MURUGAN

SUBSCRIBER ID: 3HZN39743510

SUMMARY INFORMATION

PATIENT NAME RIYA SENTHIL	RELATION DEPENDENT	CLAIM NUMBER 780262034928145 00	GROUP NUMBER 000076091	TOTAL CHARGE 120.00	HORIZON PAID 71.76
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DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
12/11/20	L CORBETT THERAPEUTIC PROCEDURE	120.00	89.70	17.94				71.76		17.94
	TOTAL:	120.00	89.70	17.94				71.76	Z028 Y755 Z084c Y049c Y125c Y126c Y127c	17.94

SUMMARY INFORMATION

PATIENT NAME RIYA SENTHIL	RELATION DEPENDENT	CLAIM NUMBER 780262035629178 00	GROUP NUMBER 000076091	TOTAL CHARGE 120.00	HORIZON PAID 71.76
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DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
12/18/20	L CORBETT THERAPEUTIC PROCEDURE	120.00	89.70	17.94				71.76		17.94
	TOTAL:	120.00	89.70	17.94				71.76	Z028 Y755 Z084d Y049d Y125d Y126d Y127d	17.94





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SUBSCRIBER NAME: SENTHIL K MURUGAN

SUBSCRIBER ID: 3HZN39743510

SUMMARY INFORMATION

PATIENT NAME SENTHIL K MURUGAN	RELATION SELF	CLAIM NUMBER 780262034924752 00	GROUP NUMBER 000076091	TOTAL CHARGE 97.00	HORIZON PAID 0.00
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DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
12/03/20	LMG FAMILY PRACTICE PC OFFICE/OUTPT VISIT	97.00	73.00		73.00			0.00		73.00
	TOTAL:	97.00	73.00		73.00			0.00	Z028 Y755 Z084a Y049a Y125a Y126a Y127a	73.00

SUMMARY INFORMATION

PATIENT NAME RIYA SENTHIL	RELATION DEPENDENT	CLAIM NUMBER 780262034360064 00	GROUP NUMBER 000076091	TOTAL CHARGE 120.00	HORIZON PAID 71.76
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DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
12/04/20	L CORBETT THERAPEUTIC PROCEDURE	120.00	89.70	17.94				71.76		17.94
	TOTAL:	120.00	89.70	17.94				71.76	Z028 Y755 Z084b Y049b Y125b Y126b Y127b	17.94

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DATE: 12/09/2020 PAGE 2 OF 5

EXPLANATION OF BENEFITS

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SUBSCRIBER NAME: SENTHIL K MURUGAN

SUBSCRIBER ID: 3HZN39743510

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
RIYA SENTHIL	DEPENDENT	780262033154896 00	000076091	120.00	71.76

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
11/24/20	L CORBETT THERAPEUTIC PROCEDURE	120.00	89.70	17.94				71.76		17.94
	TOTAL:	120.00	89.70	17.94				71.76	Z028 Y755 Z084a Y049a Y125a Y126a Y127a	17.94

MESSAGE CODE EXPLANATION

Z028 IF YOU ARE COVERED BY MORE THAN ONE HEALTH PLAN, YOU OR YOUR PROVIDER SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN. YOU SHOULD ALSO GIVE EACH PLAN INFORMATION REGARDING THE OTHER PLANS UNDER WHICH YOU ARE COVERED.

Y755 HORIZON PROVIDES ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

Z084a YOUR TOTAL COST SHARE FOR THIS CLAIM IS \$17.94. THIS INCLUDES ANY APPLICABLE DEDUCTIBLES, COINSURANCE, COPAYMENTS AND ANY OTHER AMOUNTS NOT COVERED BY YOUR HEALTH PLAN, INCLUDING ANY AMOUNT PAID BY ANOTHER CARRIER. PLEASE DO NOT SEND THIS AMOUNT TO HORIZON BCBSNJ. YOU MAY RECEIVE A BILL FROM YOUR HEALTH CARE PROFESSIONAL OR FACILITY IF YOU HAVE NOT YET PAID THIS AMOUNT.

Y049a YOUR HEALTH PLAN HAS AN ANNUAL IN-NETWORK INDIVIDUAL OUT-OF-POCKET MAXIMUM OF \$4500.00. YOU HAVE SATISFIED \$688.21 OF THIS AMOUNT FOR 2020.

Y125a YOU HAVE SATISFIED \$1058.21 OF YOUR \$9000.00 ANNUAL IN-NETWORK FAMILY OUT-OF-POCKET MAXIMUM FOR 2020.

Y126a YOU HAVE SATISFIED \$500.00 OF YOUR ANNUAL IN-NETWORK INDIVIDUAL DEDUCTIBLE FOR 2020.

Y127a YOU HAVE SATISFIED \$870.00 OF YOUR ANNUAL IN-NETWORK FAMILY DEDUCTIBLE FOR 2020.

PAYMENT HAS BEEN MADE TO PROVIDER OF SERVICES.



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DATE: 11/18/2020 PAGE 2 OF 7

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NEWARK, NJ 07101-0018

SUBSCRIBER NAME: SENTHIL K MURUGAN

SUBSCRIBER ID: 3HZN39743510

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
RIYA SENTHIL	DEPENDENT	780262030738562 00	000076091	120.00	71.76

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
10/29/20	L CORBETT THERAPEUTIC PROCEDURE	120.00	89.70	17.94				71.76		17.94
TOTAL:		120.00	89.70	17.94				71.76	Z028 Y755 Z084a Y049a Y125a Y126a Y127a	17.94

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
RIYA SENTHIL	DEPENDENT	780262031433201 00	000076091	120.00	71.76

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
11/06/20	L CORBETT THERAPEUTIC PROCEDURE	120.00	89.70	17.94				71.76		17.94
TOTAL:		120.00	89.70	17.94				71.76	Z028 Y755 Z084b Y049b Y125b Y126b Y127b	17.94

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Invoice Details

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This invoice was edited on Oct 6, 2020 at 6:27 PM PDT

INVOICE

Sandra Corbett Feite, MS LPC NCC

Sandra Corbett Feite
157 Upper Church Road
CHALFONTE, PA 18914
United States

Phone: 610-405-1472
Fax: 215-822-7606
sandy.feite@gmail.com
www.sandrafteitecounseling.com
NPI# 1154523967

Paid

Invoice #: 0181
Invoice date: Oct 1, 2020
Reference: RS04
Due date: Oct 1, 2020

Amount due:
\$0.00

Bill To:

ra*****@gmail.com

Ship To:

Description	Hours	Rate	Amount
Session date 9/25/2020			
RE: Riya Senthil / Service code 90837	1	\$17.94	\$17.94
Patient Liability of co-insurance after deductible met: \$17.94			
		Subtotal	\$17.94
		Shipping	\$0.00
		Total	\$17.94
		Amount paid	-\$17.94
		Amount due	\$0.00 USD

Notes

***If you are having financial difficulties due to the CoVID19 crisis, please let me know and we can discuss options regarding payment. If therapy is helping Riya, it is important to me that she continues and will make sure it is manageable financially for you.

Terms and Conditions

Payment due immediately, please remit no later than 30 days
Thank you

Invoice Details



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INVOICE

Sandra Corbett Feite, MS LPC NCC

Sandra Corbett Feite
157 Upper Church Road
CHALFON, PA 18914
United States

Phone: 610-405-1472
Fax: 267-477-1172
sandy.feite@gmail.com
www.sandrafeitecounseling.com
NPI# 1154523967

Paid

Invoice #: 0180
Invoice date: Aug 27, 2020
Reference: RS04
Due date: Aug 27, 2020

Amount due:
\$0.00

Bill To:

Ship To:

ra*****@gmail.com

Description	Hours	Rate	Amount
Session date 7/18/2020 RE: Riya Senthil / Service code 90837 Patient Liability of co-insurance after deductible met: \$17.94	1	\$17.94	\$17.94
Session date 8/23/2020 RE: Riya Senthil / Service code 90837 Patient Liability of co-insurance after deductible met: \$17.94	1	\$17.94	\$17.94
		Subtotal	\$35.88
		Shipping	\$0.00
		Total	\$35.88
		Amount paid	-\$35.88
		Amount due	\$0.00 USD

Notes

***If you are having financial difficulties due to the CoVID19 crisis, please let me know and we can discuss options regarding payment. If therapy is helping Riya, it is important to me that she continues and will make sure it is manageable financially for you.

Terms and Conditions

Payment due immediately, please remit no later than 30 days
Thank you

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SENTHIL MURUGAN
110 GALWAY CIR
CHALFONT, PA 18914-3900

Merck & Co, Inc
RE: SA1942129
Date: 03/10/2021

Final Notice – Immediate Action Required – Your Debit Card Has Been Suspended

Dear Senthil,

Thank you for using your Horizon *MyWay*® debit card. Our records indicate that we have not received a response to two previous letters regarding the expense(s) listed below. **In accordance with both your debit card's Terms and Condition and IRS regulations, your card has been suspended.**

<u>Claim Number</u>	<u>Plan Name</u>	<u>Transaction Date</u>	<u>Merchant</u>	<u>Claim Amount</u>
2449215LQRTSFLPT	Health FSA	09/07/2020	PAYPAL *SANDYFEITE	\$35.88
2449215M9RS826H9Q	Health FSA	10/06/2020	PAYPAL *SANDYFEITE	\$17.94
Total: \$53.82				

If you have the required documentation, please immediately return this letter along with either your receipt(s) from the provider of service or Explanation of Benefits (EOB) from your insurance carrier with includes:

- | | |
|--|--|
| - Provider Name | -Date of Service |
| - Patient Name | -Amount of the debit card transaction (out-of-pocket cost) |
| - Service(s) received or item(s) purchased | |

You can easily and securely submit this information online by signing in to your Horizon *MyWay* FSA at HorizonBlue.com/merckfsa.

You can also mail or fax your documentation. If you choose one of these methods, please include this letter with your information.

Fax: **866-231-0214**

Mail:

**P.O. Box 982814
El Paso, TX 79998-2814**

If you do not have the required documentation, please return this letter with your payment for the amount listed in the "claim amount" column. Your account balance will be credited for this amount as soon as your payment has been processed. **Your debit card will only be reactivated once this matter is resolved.**

In accordance with the Merck Health Care Flexible Spending Accounts Summary Plan Description, you have a right to review all documentation that was used to make a decision about your claim. If you disagree with Horizon BCBS' decision, you will have 180 days after receiving a notice of denial to file a written appeal to Horizon BCBS at the address above. Please refer to your SPD for additional information.

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