Check Date: 07/05/2011
Payee ID: A01000010323
Payee Name: SUMANA KETHA, MD
Payee Address: 2925 SKYWAY CIR N
IRVING, TX 75038

EXPLANATION OF PAYMENT
Medical Claims
Line Of Business: SHL Medicare Supplement

AcctEopMedical
PERSONAL & CONFIDENTIAL

M547

ADJUSTED CLAIMS

Patient Name: HALL, LOTTIE M. **Account Number:** A2238T728 **Claim Number:** 111051780E01 **Member Number:** 050930197-0 **Plan Type:** SHL TX - Indiv Medicare Supp

	Service Dates	Procedure	Charged Amount	Contract Discount	Disallowed Amount	Medicare Allowable*	NonCovered Services	CoInsur Amount	Deductible Amount	Risk W/H	Medicare Payment		Paid Amount	Message Codes
Old	07/21/10 07/21/10	99223 Init Hosp L3 Comphnsv I	120.00	96.00	0.00	24.00	0.00	0.00	0.00	0.00	0.00	0.00	24.00	
Old	07/22/10 07/22/10	99233 Sub Hosp L3 Dtl H&E Hi	120.00	99.66	0.00	20.34	0.00	0.00	0.00	0.00	0.00	0.00	20.34	
Old	07/23/10 07/23/10	99232 Sub Hosp L2 Exp Prob H	175.00	160.84	0.00	14.16	0.00	0.00	0.00	0.00	0.00	0.00	14.16	
Old	07/24/10 07/24/10	99238 Hospital Discharge Day M	82.99	69.07	0.00	13.92	0.00	0.00	0.00	0.00	0.00	0.00	13.92	
		Old Claim Totals	**497.99**	**425.57**	**0.00**	**72.42**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**		**72.42**	
New	07/21/10 07/21/10	99223 Init Hosp L3 Comphnsv	196.50	0.00	0.00	30.00	0.00	0.00	0.00	0.00	0.00	0.00	30.00	TR6
New	07/22/10 07/22/10	99233 Sub Hosp L3 Dtl H&E	120.00	0.00	0.00	18.32	0.00	0.00	0.00	0.00	0.00	0.00	18.32	TR6
New	07/23/10 07/23/10	99232 Sub Hosp L2 Exp Prob	175.00	0.00	0.00	26.73	0.00	0.00	0.00	0.00	0.00	0.00	26.73	TR6
New	07/24/10 07/24/10	99238 Hospital Discharge Day	82.99	0.00	0.00	12.67	0.00	0.00	0.00	0.00	0.00	0.00	12.67	TR6
		Adjusted Claim Totals	**574.49**	**0.00**	**0.00**	**87.72**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**		**87.72**	

Less Prior Paid: 72.42 -
Net Amount: **15.30**

*** Reimbursement is based on Medicare Allowable**

MESSAGE CODES

Message Code	Description
TR6	Covered amount has been reduced to reflect primary carrier's payment.

Please see reverse side for additional information.

TOTALS

	Charged Amount	Contract Discount	Disallowed Amount	Medicare Allowable*	NonCovered Services	CoInsur Amount	Deductible Amount	Risk W/H	Medicare Payment	Paid Amount
New Claims	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Adjusted Claims	574.49	0.00	0.00	87.72	0.00	0.00	0.00	0.00	0.00	87.72
Totals	**574.49**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**87.72**

Prior Paid: 72.42 -
Check Amount: **15.30**
Check Number: **2582441**

***** END OF STATEMENT *****

SHL:
As a provider you have the right to appeal if you believe your fee for services was denied, or was paid incorrectly, or if you feel an authorization for services was not appropriately approved.

If you want to file an appeal, you may do so within 60 days from the date of this notice by calling **877-221-9430,** or submitting a written request to SHL, PO Box 15645, Las Vegas, NV 89114-5645.