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201306031416

Electronic Service Requested

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SUMANA KETHA MD PA
2925 SKYWAY CIRCLE NORTH
IRVING, TX 75038-3510

56

REFERENCE NUMBER:
201306031416-751

1 OF 18 F

ENV 751

This package contains pages printed with information on both the front and back side. Please ensure that both sides are reviewed.

Total Number of Pages in Package: 18

Healthpayers USA Coversheet

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Get the power of electronic payments and remittance advices delivered at no cost to you!

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If you have a question regarding the processing of the claims enclosed in this package or need to change the delivery address, please contact the payer reflected on the specific enclosed documents.

These documents have been distributed via HealthPayers USA, a service provided by Emdeon.

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If you have received this package and it is not addressed to you, please contact a HealthPayers USA representative at 1-800-804-7430.

P616800500M

20130603141 6

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Forwarding Service Requested

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751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

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EXPLANATION OF BENEFITS - EOB
THIS IS NOT A BILL

PLEASE FAX RESPONSE TO 210-541-7393
For Customer Service, please call 1-866-761-6247
between hours of 8:00 AM-7:00 PM CST
or anytime at www.healthsmart.com

ENV 751

Claim #: 96812390-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24066Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/17-04/17/2013	99239	180.00	0.00		AV 65.03	114.97	0.00	0.00	114.97	100%	114.97
COLUMN TOTALS		180.00	0.00		65.03	114.97	0.00	0.00	114.97		114.97

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	114.97

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

DESCRIPTION OF REMARKS / MESSAGES

* You are entitled to a review of the benefit determination if you have questions or do not agree. To obtain a review, submit your request in writing to the office to which you submitted your initial request for benefits. Your request should include your name, Enrollee ID, and other identifying information shown above, the issues, and any data, documents and comments you would like to have considered. Written request for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge, upon request.

SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED

PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	ENROLLEE RESPONSIBILITY
SUMANA KETHA MD PA	00074894	114.97	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

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Beloit, WI 53511-6272

BLACKHAWK BANK

NO. 00074894
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812390-01
PATIENT ACCT. 24066Z5556			

***114.97

PAY EXACTLY ***ONE HUNDRED FOURTEEN DOLLARS AND 97 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Sassi
Authorized Signature
VOID AFTER 90 DAYS

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⑈00074894⑈ ⑆275971854⑆ 20078531⑈

7576531

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SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

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EXPLANATION OF BENEFITS - EOB
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or anytime at www.healthsmart.com

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ENV 751

Claim #: 96812393-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24059Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/10-04/10/2013		99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS			179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

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DESCRIPTION OF REMARKS / MESSAGES

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SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013

CHECK (S) ISSUED			ENROLLEE RESPONSIBILITY
PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	
SUMANA KETHA MD PA	00074895	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

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NO. 00074895
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812393-01
PATIENT ACCT. 24059Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Smith
Authorized Signature
VOID AFTER 90 DAYS

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or anytime at www.healthsmart.com

4 OF 18 F

ENV 751

Claim #: 96812398-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24063Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/14-04/14/2013		99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS			179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

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DESCRIPTION OF REMARKS / MESSAGES

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SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED

PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	ENROLLEE RESPONSIBILITY
SUMANA KETHA MD PA	00074898	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

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BLACKHAWK BANK

NO. 00074898
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812398-01
PATIENT ACCT. 24063Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Swann
Authorized Signature
VOID AFTER 90 DAYS

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IRVING, TX 75038-3510

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or anytime at www.healthsmart.com

ENV 751

Claim #: 96812403-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24057Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/08-04/08/2013		99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS			179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

DESCRIPTION OF REMARKS / MESSAGES

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SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED			ENROLLEE RESPONSIBILITY
PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	
SUMANA KETHA MD PA	00074900	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

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NO. 00074900
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812403-01
PATIENT ACCT. 24057Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Swan
Authorized Signature
VOID AFTER 90 DAYS

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751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

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EXPLANATION OF BENEFITS - EOB
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or anytime at www.healthsmart.com

6 OF 18 F

ENV 751

Claim #: 96812411-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24058Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/09-04/09/2013		99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS			179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

DESCRIPTION OF REMARKS / MESSAGES

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SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED

PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	ENROLLEE RESPONSIBILITY
SUMANA KETHA MD PA	00074904	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

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NO. 00074904
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812411-01
PATIENT ACCT. 24058Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Sasseni
Authorized Signature
VOID AFTER 90 DAYS

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P616800500M

HealthSmart

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Lubbock, TX 79493-3670

Forwarding Service Requested

MIXED ADC 750

751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

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EXPLANATION OF BENEFITS - EOB
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or anytime at www.healthsmart.com

ENV 751

Claim #: 96812394-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24065Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT		MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/16-04/16/2013		99232	125.00	0.00		AV	46.27	78.73	0.00	0.00	78.73	100%	78.73
04/16-04/16/2013		99356	156.00	0.00		AV	56.84	99.16	0.00	0.00	99.16	100%	99.16
COLUMN TOTALS			281.00	0.00			103.11	177.89	0.00	0.00	177.89		177.89

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	177.89

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

DESCRIPTION OF REMARKS / MESSAGES

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SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED

PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	ENROLLEE RESPONSIBILITY
SUMANA KETHA MD PA	00074896	177.89	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

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BLACKHAWK BANK

NO. 00074896
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812394-01
PATIENT ACCT. 24065Z5556			

***177.89

PAY EXACTLY ***ONE HUNDRED SEVENTY-SEVEN DOLLARS AND 89 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Smith
Authorized Signature
VOID AFTER 90 DAYS

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈00074896⑈ ⑆275971854⑆ 20078531⑈

757676536

ABF006

P616800500M

HealthSmart Benefit Solutions
PO Box 93670
Lubbock, TX 79493-3670

Forwarding Service Requested

MIXED ADC 750
751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

56

EXPLANATION OF BENEFITS - EOB
THIS IS NOT A BILL

PLEASE FAX RESPONSE TO 210-541-7393
For Customer Service, please call 1-866-761-6247
between hours of 8:00 AM-7:00 PM CST
or anytime at www.healthsmart.com

8 OF 18 F

ENV 751

Claim #: 96812407-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24060Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | DRG:

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/11-04/11/2013		99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS			179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

DESCRIPTION OF REMARKS / MESSAGES

* You are entitled to a review of the benefit determination if you have questions or do not agree. To obtain a review, submit your request in writing to the office to which you submitted your initial request for benefits. Your request should include your name, Enrollee ID, and other identifying information shown above, the issues, and any data, documents and comments you would like to have considered. Written request for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge, upon request.

SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED

PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	ENROLLEE RESPONSIBILITY
SUMANA KETHA MD PA	00074902	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

Hendricks Holding Co. & Affiliates
690 3rd Street
Suite 300
Beloit, WI 53511-6272

BLACKHAWK BANK

NO. 00074902
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812407-01
PATIENT ACCT. 24060Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Sussini
Authorized Signature
VOID AFTER 90 DAYS

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈00074902⑈ ⑆275971854⑆ 20078531⑈

P616800500M

HealthSmart

HealthSmart Benefit Solutions
PO Box 93670
Lubbock, TX 79493-3670

Forwarding Service Requested

MIXED ADC 750

751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

56

EXPLANATION OF BENEFITS - EOB
THIS IS NOT A BILL

PLEASE FAX RESPONSE TO 210-541-7393
For Customer Service, please call 1-866-761-6247
between hours of 8:00 AM-7:00 PM CST
or anytime at www.healthsmart.com

9 OF 18 F

ENV 751

Claim #: 96812408-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24062Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/13-04/13/2013		99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS			179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

DESCRIPTION OF REMARKS / MESSAGES

* You are entitled to a review of the benefit determination if you have questions or do not agree. To obtain a review, submit your request in writing to the office to which you submitted your initial request for benefits. Your request should include your name, Enrollee ID, and other identifying information shown above, the issues, and any data, documents and comments you would like to have considered. Written request for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge, upon request.

SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED			ENROLLEE RESPONSIBILITY
PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	
SUMANA KETHA MD PA	00074903	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

Hendricks Holding Co. & Affiliates
690 3rd Street
Suite 300
Beloit, WI 53511-6272

BLACKHAWK BANK

NO. 00074903
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812408-01
PATIENT ACCT. 24062Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Smith
Authorized Signature
VOID AFTER 90 DAYS

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈00074903⑈ ⑆275971854⑆ 20078531⑈

ABF006 7576538

P616800500M

HealthSmart Benefit Solutions
PO Box 93670
Lubbock, TX 79493-3670

Forwarding Service Requested

MIXED ADC 750
751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

56

EXPLANATION OF BENEFITS - EOB
THIS IS NOT A BILL

PLEASE FAX RESPONSE TO 210-541-7393
For Customer Service, please call 1-866-761-6247
between hours of 8:00 AM-7:00 PM CST
or anytime at www.healthsmart.com

10 OF 18 F

ENV 751

Claim #: 96812406-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24052Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/07-04/07/2013		99291	393.00	0.00		AV 146.46	246.54	0.00	0.00	246.54	100%	246.54
COLUMN TOTALS			393.00	0.00		146.46	246.54	0.00	0.00	246.54		246.54

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	246.54

DESCRIPTION OF REMARKS / MESSAGES

* You are entitled to a review of the benefit determination if you have questions or do not agree. To obtain a review, submit your request in writing to the office to which you submitted your initial request for benefits. Your request should include your name, Enrollee ID, and other identifying information shown above, the issues, and any data, documents and comments you would like to have considered. Written request for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge, upon request.

SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED			ENROLLEE RESPONSIBILITY
PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	
SUMANA KETHA MD PA	00074901	246.54	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

Hendricks Holding Co. & Affiliates
690 3rd Street
Suite 300
Beloit, WI 53511-6272

BLACKHAWK BANK

NO. 00074901
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812406-01
PATIENT ACCT. 24052Z5556			

***246.54

PAY EXACTLY ***TWO HUNDRED FORTY-SIX DOLLARS AND 54 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Swain
Authorized Signature
VOID AFTER 90 DAYS

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈00074901⑈ ⑆275971854⑆ 20078531⑈

7576539

ABF006

P616800500M

HealthSmart

HealthSmart Benefit Solutions
PO Box 93670
Lubbock, TX 79493-3670

Forwarding Service Requested

MIXED ADC 750

751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

56

EXPLANATION OF BENEFITS - EOB
THIS IS NOT A BILL

PLEASE FAX RESPONSE TO 210-541-7393
For Customer Service, please call 1-866-761-6247
between hours of 8:00 AM-7:00 PM CST
or anytime at www.healthsmart.com

ENV 751

Claim #: 96812400-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24061Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA **DRG:**

DATES OF SERVICE FROM THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/12-04/12/2013	99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS		179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

DESCRIPTION OF REMARKS / MESSAGES

* You are entitled to a review of the benefit determination if you have questions or do not agree. To obtain a review, submit your request in writing to the office to which you submitted your initial request for benefits. Your request should include your name, Enrollee ID, and other identifying information shown above, the issues, and any data, documents and comments you would like to have considered. Written request for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge, upon request.

SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED

PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	ENROLLEE RESPONSIBILITY
SUMANA KETHA MD PA	00074899	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

Hendricks Holding Co. & Affiliates
690 3rd Street
Suite 300
Beloit, WI 53511-6272

BLACKHAWK BANK

NO. 00074899
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812400-01
PATIENT ACCT. 24061Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Sasai
Authorized Signature
VOID AFTER 90 DAYS

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈00074899⑈ ⑆275971854⑆ 20078531⑈

757676540

ABF006

P616800500M

20130603141 6

HealthSmart

HealthSmart Benefit Solutions
PO Box 93670
Lubbock, TX 79493-3670

Forwarding Service Requested

MIXED ADC 750

751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING, TX 75038-3510

56

EXPLANATION OF BENEFITS - EOB
THIS IS NOT A BILL

PLEASE FAX RESPONSE TO 210-541-7393
For Customer Service, please call 1-866-761-6247
between hours of 8:00 AM-7:00 PM CST
or anytime at www.healthsmart.com

ENV 751

Claim #: 96812396-01
Group #: 2023900
Group Name: HHC-FEDERAL HEATH SIGN COMPANY
Location: 0015
Location Name: EULESS
Enrollee: JOHN STODDARD
Enrollee Id: *****1347
Plan #: 02391
Patient: JOHN STODDARD
Relationship: SELF
Patient Acct: 24064Z5556
Paid Date: 05/30/2013
Plan Sponsor: HENDRICKS HOLDING CO.-REPORTING COR

Provider: SUMANA KETHA | **DRG:**

DATES OF SERVICE FROM	THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
04/15-04/15/2013		99233	179.00	0.00		AV 65.93	113.07	0.00	0.00	113.07	100%	113.07
COLUMN TOTALS			179.00	0.00		65.93	113.07	0.00	0.00	113.07		113.07

Your cooperation is needed to stop fraud! If these services were not rendered, please contact HealthSmart immediately at the number above.

BENEFIT DEDUCTIBLE	0.00
ADJUSTED PAYMENT / OTHER INSURANCE	0.00
TOTAL PAID	113.07

DESCRIPTION OF REMARKS / MESSAGES

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SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET ALL OF YOUR INDIVIDUAL IN-NETWORK OUT OF POCKET FOR 2013.
YOU HAVE MET ALL OF YOUR FAMILY IN-NETWORK DEDUCTIBLE FOR 2013.
YOU HAVE MET $2,500.00 OF YOUR $4,500.00 FAMILY IN-NETWORK OUT OF POCKET FOR 2013.

CHECK (S) ISSUED			ENROLLEE RESPONSIBILITY
PAYEE NAME	CHECK NUMBER	CHECK AMOUNT	
SUMANA KETHA MD PA	00074897	113.07	0.00

AV GWH-CIGNA PPO discount applied. Member not liable

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

Hendricks Holding Co. & Affiliates
690 3rd Street
Suite 300
Beloit, WI 53511-6272

BLACKHAWK BANK

NO. 00074897
79-7185/2759

GROUP NAME	HHC-FEDERAL HEATH SIGN COMPANY	GROUP #	2023900
ENROLLEE	JOHN STODDARD	DATE	05/30/2013
PATIENT	JOHN STODDARD	CLAIM #	96812396-01
PATIENT ACCT. 24064Z5556			

***113.07

PAY EXACTLY ***ONE HUNDRED THIRTEEN DOLLARS AND 07 CENTS

PAY TO THE ORDER OF
SUMANA KETHA MD PA
2925 SKYWAY CIR
IRVING TX 75038- -

Carla Swan
Authorized Signature
VOID AFTER 90 DAYS

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈00074897⑈ ⑆275971854⑆ 20078531⑈

ABF006 7576541

P784402800A

Superior Health Plan
2100 South IH-35
Suite 202
Austin, TX 78704

(877)391-5921

Forwarding Service Requested

MIXED ADC 750

751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIR N
IRVING, TX 75038-3510

56

RUN DATE:	05/31/13
CHECK #:	001163975
PAYEE ID:	H906
IRS#:	201401614

ENV 751

STATEMENT TOTAL

Beginning Negative Services Balance:	
Beginning Prepayment Balance:	.00
Total Beginning Balance:	.00
Claims Paid This Run:	87.58
Check Amount:	87.58

Remittance Advice and Explanation of Payment

Insured Name: ROBERTSON, SHARON LYNN — Member ID#: 524114075 -01 — Claim No: M148TXE21323
Patient Name: ROBERTSON, SHARON LYNN — PCN: 25468Z5556 — Carrier: LT — Provider ID: 168813
Service Provider: DR SUMANA KETHA — NPI: 1962447805 — Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	050913	4011	99204	1.0	297.68	87.58	.00	.00	.00	.00	.00	.00	92	87.58
									.00					
			Sub-total		297.68	87.58	87.58	.00	.00	.00	.00	.00		87.58
							.00		.00	.00				

Insured Name: ROBINSON, NOAH — Member ID#: 520587270 -01 — Claim No: M149TXE09659
Patient Name: ROBINSON, NOAH — PCN: 25692Z5556 — Carrier: LT — Provider ID: 168813
Service Provider: DR SUMANA KETHA — NPI: 1962447805 — Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	052113	70723	G0179	1.0	75.43	.00	.00	.00	.00	.00	.00	75.43	NB	.00
									.00					
			Sub-total		75.43	.00	.00	.00	.00	.00	.00	75.43		.00
							.00		.00	.00				
			TOTAL		373.11	87.58	.00	.00	.00	.00	.00	75.43		87.58
							.00		.00	.00				

Payment Code	Description
92	PAID IN FULL
NB	DENY: SERVICE IS NOT A COVERED BENEFIT OF TEXAS MEDICAID

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

Superior HealthPlan, Inc.
Texas Claims Account
7700 Forsyth Boulevard
St. Louis, MO 63105

BANK OF AMERICA, N.A. 2-3/710 IL

Date	Check Number
05/31/13	001163975
Check Amount	
$*****87.58	

PAY Eighty Seven & 58/100 Dollars

TO THE ORDER OF SUMANA KETHA MD PA
2925 SKYWAY CIR N
IRVING, TX 75038

Second Signature Required if Greater Than $100,000

Authorized Signature

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

7576542

ABF006

⑈001163975⑈ ⑆071000039⑆ 580 036 6444⑈

P784402800A
201306031416

Superior Health Plan
2100 South IH-35
Suite 202
Austin, TX 78704

Forwarding Service Requested

14 OF 18 F
ENV 751

****IMPORTANT INFORMATION****

FOR CLAIM INQUIRIES:
(877) 391-5921

SEND CLAIMS SUBMISSIONS TO:
Superior HealthPlan
Claims Department
P.O. Box 3003
Farmington, MO 63640-3803

SEND APPEALS TO:
Superior HealthPlan
Appeals Department
P.O. Box 3000
Farmington, MO 63640-3800

*NOTICE TO PROVIDERS: EOPs are now combined into one single EOP for CHIP, STAR, STAR+ and Perinate.

If you would like to report provider or client fraud or abuse, please call (512) 424-6519.

In our efforts towards Going Green, an electronic copy of the Provider Newsletter will be posted quarterly at www.superiorhealthplan.com on the Provider Home page, or you can request a hard copy by calling (877) 391-5921 and selecting option 3.

P784402800A

Superior Health Plan
2100 South IH-35
Suite 202
Austin, TX 78704

Forwarding Service Requested

MIXED ADC 750

751 3.9842 MB 1.337

SUMANA KETHA, MD
2925 SKYWAY CIR N
IRVING, TX 75038-3510

56

(877)391-5921

RUN DATE:	05/31/13
CHECK #:	001164297
PAYEE ID:	168813
IRS#:	201401614

ENV 751

STATEMENT TOTAL

Beginning Negative Services Balance:	
Beginning Prepayment Balance:	.00
Total Beginning Balance:	.00
Claims Paid This Run:	86.91
Check Amount:	86.91

Remittance Advice and Explanation of Payment

Insured Name: FINLEY, THEDO — Member ID#: 421447901 -01 — Claim No: M149TXE09653
Patient Name: FINLEY, THEDO — PCN: 22504Z5556 — Carrier: LT — Provider ID: 168813
Service Provider: DR SUMANA KETHA — NPI: 1962447805 — Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	022713	4011	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	187.26	K6	.00
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	187.26		.00

Insured Name: MORGAN, GERALD — Member ID#: 528216046 -01 — Claim No: M149TXE09654
Patient Name: MORGAN, GERALD — PCN: 16239Z5556 — Carrier: LT — Provider ID: 168813
Service Provider: DR SUMANA KETHA — NPI: 1962447805 — Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	083112	25000	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	187.26	29	.00
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	187.26		.00

Insured Name: MORGAN, GERALD — Member ID#: 528216046 -01 — Claim No: M149TXE10984
Patient Name: MORGAN, GERALD — PCN: 14994Z5556 — Carrier: LT — Provider ID: 168813
Service Provider: DR SUMANA KETHA — NPI: 1962447805 — Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

Superior HealthPlan, Inc.
Texas Claims Account
7700 Forsyth Boulevard
St. Louis, MO 63105

BANK OF AMERICA, N.A 2-3/710 IL

Date	Check Number
05/31/13	001164297
Check Amount	
$*****86.91	

PAY Eighty Six & 91/100 Dollars

TO THE ORDER OF SUMANA KETHA, MD
2925 SKYWAY CIR N
IRVING, TX 75038

Second Signature Required if Greater Than $100,000

Authorized Signature

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈001164297⑈ ⑆071000039⑆ 580 036 6444⑈

7576543

ABF006

P784402800A

Superior Health Plan
2100 South IH-35
Suite 202
Austin, TX 78704

Forwarding Service Requested

(877)391-5921

RUN DATE:	05/31/13
CHECK #:	001164297
PAYEE ID:	168813
IRS #:	201401614

ENV 751

Remittance Advice and Explanation of Payment
Continued from Previous Page

0100	043012	25060	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	187.26	29	.00
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	187.26		.00

Insured Name: SMITH, LAURA
Patient Name: SMITH, LAURA
Service Provider: DR SUMANA KETHA
Member ID#: 506991339 -01
PCN: 19892Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE10972
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	111212	4019	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	187.26	29	.00
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	187.26		.00

Insured Name: SMITH, LAURA
Patient Name: SMITH, LAURA
Service Provider: DR SUMANA KETHA
Member ID#: 506991339 -01
PCN: 15365Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE10976
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	073112	4539	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	187.26	29	.00
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	187.26		.00

Insured Name: SMITH, LAURA
Patient Name: SMITH, LAURA
Service Provider: DR SUMANA KETHA
Member ID#: 506991339 -01
PCN: 19237Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE10991
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	113012	4539	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	187.26	29	.00
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	187.26		.00

Insured Name: SMITH, LAURA
Patient Name: SMITH, LAURA
Service Provider: DR SUMANA KETHA
Member ID#: 506991339 -01
PCN: 23388Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE10994
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	031513	4539	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	.00	92	86.91
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	.00		86.91

Insured Name: SMITH, LAURA
Patient Name: SMITH, LAURA
Service Provider: DR SUMANA KETHA
Member ID#: 506991339 -01
PCN: 22658Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE11002
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	013113	4539	99375	1.0	187.26	86.91	.00	.00	.00 .00	.00	.00	187.26	29	.00
				Sub-total	187.26	86.91	86.91 .00	.00	.00 .00	.00 .00	.00	187.26		.00

P784402800A

201306031416

Superior Health Plan
2100 South IH-35
Suite 202
Austin, TX 78704

(877)391-5921

RUN DATE:	05/31/13
CHECK #:	001164297
PAYEE ID:	168813
IRS #:	201401614

ENV 751

Remittance Advice and Explanation of Payment
Continued from Previous Page

0100	113012	25002	99375	1.0	187.26	86.91	.00	.00	.00	.00	.00	187.26	29	.00
									.00					
			Sub-total		187.26	86.91	86.91	.00	.00	.00	.00	187.26		.00
							.00		.00	.00				

Insured Name: WATSON, DAWN EVE
Patient Name: WATSON, DAWN EVE
Service Provider: DR SUMANA KETHA
Member ID#: 520857816 -01
PCN: 19899Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE09663
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	111012	25002	99375	1.0	187.26	86.91	.00	.00	.00	.00	.00	187.26	29	.00
									.00					
			Sub-total		187.26	86.91	86.91	.00	.00	.00	.00	187.26		.00
							.00		.00	.00				

Insured Name: WATSON, DAWN EVE
Patient Name: WATSON, DAWN EVE
Service Provider: DR SUMANA KETHA
Member ID#: 520857816 -01
PCN: 14930Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE09665
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	043012	49310	99375	1.0	187.26	86.91	.00	.00	.00	.00	.00	187.26	29	.00
									.00					
			Sub-total		187.26	86.91	86.91	.00	.00	.00	.00	187.26		.00
							.00		.00	.00				

Insured Name: WATSON, DAWN EVE
Patient Name: WATSON, DAWN EVE
Service Provider: DR SUMANA KETHA
Member ID#: 520857816 -01
PCN: 13870Z5556
NPI: 1962447805
Carrier: LT
Claim No: M149TXE11019
Provider ID: 168813
Group: STAR PLUS - DALLAS

Serv	Dates	Diag# Drug#	Proc# Proc2	Days Ct./ Qty	Charged	Allowed	Deduct / Copay	Coinsurance	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	051412	49310	99375	1.0	187.26	86.91	.00	.00	.00	.00	.00	187.26	29	.00
									.00					
			Sub-total		187.26	86.91	86.91	.00	.00	.00	.00	187.26		.00
							.00		.00	.00				
			TOTAL		3183.42	1477.47	.00	.00	.00	.00	.00	2996.16		86.91
							.00		.00	.00				

Payment Code	Description
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
92	PAID IN FULL
K6	DENY: CLAIM IS THE RESPONSIBILITY OF MEDICARE

P9916028005

United Teacher Associates Insurance Co.
P.O. Box 30010
Austin, TX 78755-0310

Return Service Requested

MIXED ADC 750

751 3.9842 MB 1.337

SUMANA KETHA MD PA
2925 SKYWAY CIRCLE NORTH
IRVING, TX 75038-3510

56

If you have any questions about this claim, please contact:
United Teacher Associates Insurance Co
Medicare Supplement Claims Department
ClientServicesGASB@gafri.com
(866)459-1755
P.O. Box 30010
Austin, Tx 78755-3010

Need to Submit a Claim? - We automatically receive Medicare claims electronically so there is NO NEED TO SUBMIT PAPER CLAIMS. We can also receive 837-COB claims via our Emdeon Payer ID: #13193.

Need to Verify Benefits/Check Claims Status? – Simply log on to www.MyProviderHQ.com or if you are an existing Emdeon customer, you can utilize Real Time Eligibility Verification/Real Time Claim Status.

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We have contracted with Emdeon to deliver EFT services for both Professional and Institutional claims. Electronic Remittance Advice (ERA) files in the postable 835 format are available for Professional claims and are coming soon for Institutional claims. Sign-up today at no additional cost to you by going to www.emdeon.com/epayment for more information. Enrollment is available online or by calling 1.866.506.2830 and selecting Option 1. PLEASE REFERENCE PAYER ID # 58086.

Date: *06/01/2013*
Tax ID: *201401614*
NPI:
Check #: *020137721*
Control #: *1315231716*

Service Dates	Type of Service	Billed Charge	Medicare Approved	Medicare Payment	Not Covered Amount	Remark Code	Our Payment	Patient Responsibility
Insured: GOLDIE DAVIS			**Pat. Acct #:** 23459Z5556			**Clm #:** 162011951	**Pol #:** AZ00108870	
03/14/13-03/14/13	PROCDURES/PR	$75.43	$41.90	$33.52	$0.00		$8.38	
	Totals:	$75.43	$41.90	$33.52	$0.00		$8.38	$0.00
Insured: GOLDIE DAVIS			**Pat. Acct #:** 24663Z5556			**Clm #:** 162011952	**Pol #:** AZ00108870	
01/13/13-01/13/13	PROCDURES/PR	$75.43	$41.90	$33.52	$0.00		$8.38	
	Totals:	$75.43	$41.90	$33.52	$0.00		$8.38	$0.00
STATEMENT TOTALS:		$150.86	$83.80	$67.04	$0.00		$16.76	$0.00

Remarks Code Descriptions

*** If you wish to dispute the company's decision on this claim, you may submit your dispute in writing to the address of the company listed above.

*** The company does not waive any defenses or rights to conduct additional inquiries, nor does the company waive any rights or defenses with regard to the contract or applicable law.

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UNITED TEACHER ASSOCIATES INSURANCE CO
P.O. BOX 30010
AUSTIN, TX 78755-3010

50-937
213

CHECK NO.: 020137721
CHECK DATE: 06/01/2013

PY-02304366

AMOUNT
*****$16.76

PAY Sixteen & 76/100 Dollars

TO THE ORDER OF **SUMANA KETHA MD PA**
2925 SKYWAY CIRCLE NORTH
IRVING, TX 75038

VOID UNLESS PRESENTED WITHIN 180 DAYS FROM DATE HEREOF

JP MORGAN CHASE BANK, NA
SYRACUSE, NY.

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⑈020137721⑈ ⑆021309379⑆ 4779312 86⑈

ABF006 75776544