P947802801S

SelectCare Health Plans, Inc. dba
TexasFirst Health Plan Claims Acct
P.O. Box 741107
Houston, TX 77274-1107

Return Service Requested

TexanPlus® HMO

201302130114

For questions please call:
(800) 958-2707

1 OF 3 F

ENV 8217

3-DIGIT 750

8217 0.7130 AT 0.381

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

71

PAYMENT SUMMARY

Paid To: SUMANA KETHA MD PA
Provider #: 201401614100
Payment Date: 02/12/13
Check #: 245640
Check Amount: 165.38
Reference #: 2013021210200409
Prior Overpayment: 0.00
Overpayment Incurred This Period: 0.00
Recovered This Check: 0.00
Outstanding Overpayment: 0.00

TO - TF - TXF0

HMO Explanation of Payment

Member ID #: 026203432-0
Member Plan: CHN05100
Claim #: 130045844800

Patient Name: Mary A Kinson
Pat Acct #: 21083Z5556
Provider: 888000023124

Explanation:

Provider: KETHA, SUMANA

Service Dates	Rev	Proc	Units	Amount Billed	Allowed	Prov Resp	Remark Codes	Patient Resp	Copay	Co-Ins	Patient Deductible	COB Applied	Net Amount
02/07/13-02/07/13		99204	1	250.00	165.38	84.62	809	0.00	0.00	0.00	0.00	0.00	165.38
		ClaimTotals:		250.00	165.38	84.62		0.00	0.00	0.00	0.00	0.00	165.38

Interest Amount: 0.00
Prompt Pay Discount: 0.00
Subscriber Payment: 0.00
Previous Amount Paid: 0.00
Net Payment: 165.38

Provider Group Summary Totals

Provider Name	Amount Billed	Allowed	Prov Resp	Patient Resp	Member OOP	COB Applied	Net Amount	Interest Amount	Prompt Payment Discount	Subscriber Payment	Prior Paid	Over-payment	Total Payment
KETHA, SUMAN	250.00	165.38	84.62	0.00	0.00	0.00	165.38	0.00	0.00	0.00	0.00	0.00	165.38
Totals:	250.00	165.38	84.62	0.00	0.00	0.00	165.38	0.00	0.00	0.00	0.00	0.00	165.38

Amounts Recovered:	0.00
Check Amount:	165.38
Remaining Balance:	0.00

Remark Explanations and Clinical Edits

Claim ID	Line	Code	Explanation
		809	Reimbursement Based on Medicare's Allowable

Participating Providers

A Participating Provider holds a contract with Universal American to provide care to members who are enrolled in a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or a Network Private Fee-for-Service (NPFFS) plan.

Any Disputes or Appeals for a Contracted or Participating Provider are dictated under the Terms of the contract that the Provider holds with Universal American. If there are any questions around the specifics of those provisions within your contract or if you believe you have not been given the appropriate dispute or appeal rights on an overpayment please contact your Provider Relations Representative or Provider Customer Service directly at (800) 958-2707 between the hours of 8:00am to 8:00pm in your local time zone.

Non-Participating or Deemed Providers

For a Non-contracted Provider, Dispute as well as Appeal rights are available to a Provider who does not have a contract with Universal American, but who provides care to a Plan member.

Non-contracted or Deemed Provider Payment Appeal Process

The Centers for Medicare and Medicaid Services (CMS) guidance provides that non-contracted and deemed providers have Appeal rights which include the CMS Independent Review Entity (IRE) process.A Provider has the right to an Appeal whena denial of a service rendered occurs, or upon receipt of an initial claim or Revised Payment Determination which results in a zero payment to the Provider.

Timeframes for filing a Reconsideration request are limited. A Reconsideration request must be filed within sixty (60)calendar days from the date of the notice ofnon-payment or Revised Payment Determinationis initially received by the Provider. In filing an Appeal with the Plan, please include a copy of this letter as well as relevant supporting documentation to the address provided below.

Non-contracted and deemed Providers may Appeal aninitial claim decision or revised payment determination providing they formally waive any right to payment from the patient. To process an Appeal request, the Provider must submit a completed Waiver of Liability (WOL) formalong with all supporting documentation needed to support the Appeal to the Plan. Please fax the WOL form as well as all supporting documentation for the Appeal directly to 1-800-817-3516 or mail to the address listed below.

In accordance with CMS regulations, if the signed Waiver of Liability form is not received within sixty (60) days of receipt of an Appeal, a request for dismissal of the Appeal will be forwarded to CMS' IRE, Maximus Federal Services, Inc. (Maximus).You may obtain a blank WOL form in the Appendix section of the provider manual at http://www.universal-american-medicare.com/. It is also important to note that by signing the WOL form you are not waiving your rights to payment from Universal American if the Appeal determination is favorable.

Following review of your Appeal, should thePlan uphold its original decision to deny payment for the services rendered, the Plan is required to automatically forward all adverse or unfavorable decisions to Maximus for an independent review of that decision. They will notify you and the Plan directly of their decision.

Non-contracted or Deemed Provider Payment Disputes on Initial Claims and Revised Payment Determinations

Non-contracted or Deemed Providers have the right to file a Dispute as a result of a reduction in payment on an initial claim or upon receipt of a Revised PaymentDetermination. Disputes are subject to CMS' IRE process including any decisions where a Non-contracted Provider contends that the amount paid by the organization for a covered service is less than the amount that would have been paid under Original Medicare.

Non-contracted or Deemed Providers have 120 calendar days from the initial claim payment or Revised Payment Determination to file a written request for a Dispute with the Plan. The Plan is required to resolve each non-contracted Provider Claim Payment Dispute within *30 calendar days* of receipt of the written request.

if the Plan fails to respond to a filed Dispute within thirty (30) days, you may send a written request directly to the CMS Independent Review Entity, C2C Solutions, Inc. (C2C), using the standard Payment Dispute Decision (PDD) form available at C2C's website http://www.C2Cinc.com. Please refer to QIC PDRC information and PDD Form Instructions on the C2C website.

Upon receipt of the Plan's decision, if you disagree with the decision made, you may request a Second Level IREreview by providing such to CMS' Provider Dispute Resolution contractor, C2C, directly by email, fax or mail within 180 calendar days of written notice from the Plan. Please referto the C2C website (www.C2Cinc.com) for forms, timeframes and instructions.

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Universal American
PO Box 742608
Houston, TX 77274

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ENV 8217 3 OF 3 F

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

SelectCare Health Plans, Inc.
dba TexasFirst Health Plan
Claims Account
P.O. Box 741107
Houston, TX 77274-1107

88-130
1119

CHECK NO.: 245640

CHECK DATE: 02/12/13

AMOUNT
*****$165.38

PAY One Hundred Sixty Five And 38/100

TO THE ORDER OF **SUMANA KETHA MD PA**

Bank of America
Houston, TX

T M Carpenter
John M. Swartz

ABF006 97725564

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

⑈0000245640⑈ ⑆111901302⑆ 0023309456 55⑈

WARNING - DO NOT CASH CHECK WITHOUT NOTING WATERMARK, HOLD AT ANGLE TO VERIFY WATERMARK

X_____

SIGNATURE

KNOW YOUR ENDORSER
REQUIRE IDENTIFICATION

DO NOT WRITE, STAMP OR SIGN BELOW THIS LINE

This document contains the following security features: A Void Pantograph on the face. Micro-Line Printing on the face. A Blue Ink check face. A Warning band above check on face, and an Artificial Watermark on the back. All must be present for validating this negotiable document.