

BLUE CROSS OF CALIFORNIA (CA) 3075 VANDERCAR WAY CINCINNATI, OH 45209

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

LA HABRA CA 90631-6300

BLUE CROSS OF CALIFORNIA (CA)

PAYMENT NUMBER

7700075778

DATE 08/11/23

 PROVIDER NAME
 SANDEEP KUMAR BANSI L MD I

 ADDRESS
 2121 W I MPERI AL HWY STE E494

 LA HABRA CA 90631-6300

 PROVIDER-NPI IDS
 XXXXX6347 - 1285271247

 TAX ID NO
 XXXXX6347

PAYMENT SUMMARY

TAT METER COMMITTEE			
GROSS APPROVED CLAIM AMOUNT	1, 268. 25	r> IRS WITHHELD	0. 00
INTEREST	0.00	STATE WITHHELD	0.00
PENALTY	0.00	AMOUNT PREVIOUSLY OVERPAID	0.00
LEVY/GARNISHMENT	0.00	AMOUNT DISBURSED	1, 268. 25
NET AMOUNT DUE	1, 268. 25	RECOUPMENT BALANCE	0.00



PROVIDER ID NO

XXXXX6347

SANDEEP KUMAR BANSIL MD I



0811AI 060156-013427

XXXXX6347

DATE 08/11/23

7700075778 3299958571

\$1,268.25

- Funds have been remitted via your preferred Zelis ePayment method. For questions regarding the payment method please contact Zelis at 877.828.8770, or visit Zelis.com to log into your Zelis account.
- If you prefer to receive payments directly from the health plan, it is easy to sign up for electronic funds transfer (EFT).
 Sign up at https://enrollsafe.payeehub.org.
- For claim inquiries, log onto Availity.com and use the Claims & Payments tab to access Claims Status.

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SANDEEP KUMAR BANSIL MD I PROVIDER ID NO: 203226347

CHECK/EFT DT: CHECK/EFT:

08/11/23 7700075778

PLEASE GO TO URL: enrollsafe.payeehub.org FOR ENROLLING INTO ELECTRONIC FUNDS TRANSFER (EFT).

IMPORTANT NOTE: YOU ARE NOT PERMITTED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ABOUT INDIVIDUALS THAT YOU ARE NOT CURRENTLY TREATING. THIS APPLIES TO PROTECTED HEALTH INFORMATION ACCESSIBLE IN ANY ANTHEM ONLINE TOOL, OR SENT IN ANY OTHER MEDIUM INCLUDING MAIL, EAX, OR OTHER ELECTRONIC TRANSMISSION.

84. 55														TOTAL NET PAID	
		331.45			_	_		_	_	_		_		INSURANCE COMPANY	AMOUNT PAID BY OTHER I
0. 00						_									INTEREST
84. 55		0.00			-	477. 25	0. 00	0.00	0.00	0.00	84. 55	900.00		TOTAL:	
16. 91		0.00	069 23	1 45	021	95.45	0. 00	0.00	0.00	0.00	16. 91	180.00	21	99232	05/29/2023 05/29/2023
16. 91		0.00	069 23	1 45	021	95.45	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/28/2023 05/28/2023
16. 91		0.00	069 23	1 45	021	95. 45	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/27/2023 05/27/2023
16. 91		0.00	069 23	1 45	021	95. 45	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/26/2023 05/26/2023
16. 91		0.00	069 23	1 45	021	95.45	0. 00	0. 00	0.00	0.00	16. 91	180.00	21	99232	05/25/2023 05/25/2023
					-			_					_		
				N/A	DRG RCVD:		PLAN TYPE: PPO		RI BER	SURED: SUBSCRI BER	RELATIONSHIP TO INSURED	REL		N NETWORK	NETWORK: IN NETWORK
	DMHC	APPEALS CODE: DMHC			EXPL CD:	EXF			99124	1	SERVICE PROVIDER ID			BANSIL, SANDEEP K	SERVICE PROVIDER NAME: B
FOR INQUIRIES CALL: (800) 284-1110	FOR IN	00, ANTHONY 08/08/2023	SAUCEDO, ANTHONY 08/08/202		NAME:	PATIENT NAME: RECEIVED DATE:			26A71546 2023220GG7344	92	INSURED'S ID			SAUCEDO, ANTHONY 406680Z930	INSURED'S NAME: SAUCEDO, AN PATIENT ACCOUNT#: 406680Z930
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	COEXPL EXPL	5	RACTUAL PROVIDER RESP		CO-INSURANCE CON	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	P _S	SERVICE F	SERVICE DATE(S)
101. 46														TOTAL NET PAID	
		397.74			-	_		_	_		_	_	_	NSURANCE COMPANY	AMOUNT PAID BY OTHER INSURANCE COMPANY
0. 00					_	_							_		INTEREST
101. 46		0.00			_	572. 70	0. 00	0.00	0.00	0.00	101.46	1, 080. 00		TOTAL:	
16. 91		0.00	069 23	1 45	021	95. 45	0. 00	0.00	0.00	0.00	16. 91	180.00	21	99232	06/18/2023 06/18/2023
16. 91		0.00	069 23	1 45		95. 45	0. 00	0. 00	0.00	0.00	16. 91	180.00	21	99232	06/17/2023 06/17/2023
16. 91		0.00	069 23	1 45	021	95.45	0. 00	0.00	0.00	0.00	16. 91	180.00	21	99232	06/16/2023 06/16/2023
16. 91		0.00	069 23			95.45	0. 00	0.00	0.00	0.00	16. 91	180.00	21	99232	06/15/2023 06/15/2023
16. 91		0.00	069 23	1 45	021	95.45	0. 00	0.00	0. 00	0.00	16. 91	180. 00	21	99232	06/14/2023 06/14/2023
16. 91		0.00	069 23	1 45	021	95. 45	0. 00	0.00	0.00	0. 00	16. 91	180. 00	21	99232	06/13/2023 06/13/2023
				2					_		NED HONORED	_ 4	_	N NE WORK	MET WORK. IN NET WORK
	DIVITO	ATTERES CODE: DMITC					DI ANITYDE: DI		77 124		OFFICE PROVIDER TO	D		א אור אויס פא	OEXACE EXCARGEX PARE: CHROLE, CAROCEL A
(800) 284-1110	DMHC	08/08/2023	08/0	,.	DATE	RECEIVED DATE:			2023220GG7722 84799124	٠	CLAIM NUMBER			106685Z930	PATIENT ACCOUNT#: 406685Z930
FOR INQUIRIES CALL:	FOR IN	THONY	SAUCEDO, ANTHONY		NAME:	PATIENT NAME:			1546	D'S ID: 926A71546	INSURED'S ID			SAUCEDO, ANTHONY	INSURED'S NAME: S
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	COEXP	[.] \f	PROVIDER RES	CO-INSURANCE CONTRACTUAL PROVIDER RESP. AMOUNT	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE F	SERVICE DATE(S)
														EMENT-PBP -	MEDI CARE SUPPLEMENT-PBP

07/0	SERVI		AMOU	INTEREST
07/01/2023 07/01/2023 99232 07/02/2023 07/02/2023 99232	INSURED'S NAME: SAUCEDO, ANTHONY PATIENT ACCOUNT#: 406692Z930 SERVICE PROVIDER NAME: BANSI L, SANDEEP K NETWORK: IN NETWORK	SERVICE DATE(S)	AMOUNT PAID BY OTHER I	REST
99232 99232	AUCEDO, ANTHONY 066927930 ANSI L, SANDEEP K N NETWORK	SERVICE CODES	INSURANCE COMPANY TOTAL NET PAID	TOTAL:
21		Pos	_	
180. 00 180. 00	REL	CHARGE	_	1, 080. 00
16. 91 16. 91	INSURED'S ID: 926A71546 CLAIM NUMBER: 2023220G SERVICE PROVIDER ID: 118A799124 RELATIONSHIP TO INSURED: SUBSCRI BER	ALLOWED DEDUCTIBLE	_	101. 46
o. o.	S ID: 926A71546 BER: 2023220G R ID: 1184799124 RED: SUBSCRI BER	DEDUCTIBLE	_	0. 00
0. 00 	26A71546 2023220G66421 184799124 UBSCRI BER	CO-PAY	_	0. 00
0. 00 ———		CO-PAY CO-INSURANCE CONTRACTUAL PROVIDER RESP	_	0. 00
o. o. oo	PLAN TYPE: PPO	CONTRACTUAL F		0. 00
95. 45 0 95. 45 0	PATIENT NAME: SA RECEIVED DATE: EXPL CD: O DRG RCVD: N/A	ROVIDER RESP. AMOUNT	_	572. 70
95. 45 021 45 069 23 95. 45 021 45 069 23	SAUCEI	EXPL/ANSI CODE(S)		
0. 0. 00	00,ANTHONY 08/08/2023 APPEALS CODE: DMHC	INSURED RESPONSIBILITY AMOUNT	397.74	0.00
		EXPL/ANSI CODE(S)		
16. 91 16. 91	FOR INQUIRIES CALL: (800) 284-1110	WHAT WE WILL PAY	101. 46	101. 46 0. 00

	AMOUNT PAID BY OTHER INS		06/12/2023 06/12/2023 9	06/11/2023 06/11/2023 9	06/10/2023 06/10/2023 9	06/09/2023 06/09/2023 9		06/07/2023 06/07/2023 9	NETWORK: IN NETWORK	PATIENT ACCOUNT#: 406684Z930 SERVICE PROVIDER NAME: BANSI L, SANDEEP K	INSURED'S NAME: SAU	SERVICE DATE(S)	1	AMOUNT PAID BY OTHER INSURANCE COMPANY	INTEREST			06/05/2023 06/05/2023 9		06/03/2023 06/03/2023 9	06/02/2023 06/02/2023 9	06/01/2023 06/01/2023 9	_	SERVICE PROVIDER NAME: BANSIL, SA		- 1	SERVICE DATE(S)
TOTAL NET PAID	NSURANCE COMPANY	TOTAL:	99232	99232	99232	99232	99232	99232	NETWORK	406684Z930 BANSI L, SANDEEP K	SAUCEDO, ANTHONY	SERVICE CODES	TOTAL NET PAID	URANCE COMPANY		TOTAL:	99232	99232	99232	99232	99232	99232		BANSIL, SANDEEP K	SAUCEDO, ANTHONY 406682Z930		SERVICE CODES
			21	21	21	21	21	21				P _S		_	_		21	21	21	21	21	21	_				POS
		1, 080. 00	180. 00	180. 00	180. 00	180. 00	180. 00	180. 00	REL			CHARGE		_		1, 080. 00	180. 00	180. 00	180. 00	180. 00	180. 00	180. 00	_ ;	B E -			CHARGE
		101. 46	16. 91	16. 91	16. 91	16. 91	16. 91	16. 91	RELATIONSHIP TO INSURED:	CLAIM NUMBER: SERVICE PROVIDER ID:	INSURED'S ID	ALLOWED		_		101.46	16. 91	16. 91	16. 91	16. 91	16. 91	16.91		SERVICE PROVIDER ID:	CLAIM NUMBER		ALLOWED
		0. 00	0.00	0.00	0.00	0.00	0. 00	0. 00	RED: SUBSCRI BER	11	SID: 926A71546	DEDUCTIBLE		_		0.00	0. 00	0.00	0.00	0.00	0.00	0. 00					DEDUCTIBLE
		0. 00	0.00	0.00	0.00	0.00	0.00	0.00	l BER	2023220GG6883 84799124	546	CO-PAY		_		0.00	0.00	0.00	0.00	0.00	0.00	0.00		9124 91 RED	2023220GG6943	1	CO-PAY
		0. 00	0.00	0.00	0. 00	0. 00	0. 00	0.00				CO-INSURANCE CONTRACTUAL PROVIDER RESP		_	_	0.00	0. 00	0. 00	0. 00	0. 00	0.00	0. 00					CO-INSURANCE CONTRACTUAL PROVIDER RESP. AMOUNT
		0. 00	0. 00	0. 00	0. 00	0. 00	0. 00	0. 00	PLAN TYPE: PPO			CONTRACTUAL F		_		0. 00	0. 00	0. 00	0. 00	0. 00	0. 00	0. 00		DIANTYDE: DDO			CONTRACTUAL F
		572. 70	95. 45	95.45	95. 45	95. 45		95. 45	O DRG RCVD:	RECEIVED DATE: EXPL CD:	PATIENT NAME	ROVIDER RESP. AMOUNT		_		572. 70				95. 45	95. 45	95. 45		DBG BCVD:	RECEIVED DATE:	7	ROVIDER RESP. AMOUNT
			021 45 069	021 45 069	021 45 069	021 45 069	45 069	021 45 069	VD: N/A			EXPL/ANSI CODE(S)					021 45 069	021 45 069	069	021 45 069	021 45 069	021 45 069		V).	SAUCEL		EXPL/ANSI CODE(S)
	397.74	0.00	23 0.00	23 0.00	23 0.00		0.00			08/08/2023 APPEALS CODE: DMHC	SAUCEDO, ANTHONY	INSURED RESPONSIBILITY AMOUNT		397.74		0.00				23 0.00	23 0.00	23 0.00	_	APPEALS CODE: DMHC	08/08/2023	,	INSURED RESPONSIBILITY AMOUNT
										DMHC	FOR INC	EXPL/ANSI CODE(S)												DMHC			EXPL/ANSI CODE(S)
101. 46	0.00	101. 46	16. 91	16. 91	16. 91	16. 91	16. 91	16. 91		(800) 284-1110	FOR INQUIRIES CALL:	WHAT WE WILL PAY	101. 46		0. 00	101. 46	16. 91	16. 91	16. 91	16. 91	16. 91	16. 91			(800) 284-1110)	WHAT WE WILL PAY

MEDICARE SUPPLEMENT-PBP -



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SANDEEP KUMAR BANSIL MD I PROVIDER ID NO: 203226347

CHECK/EFT DT: CHECK/EFT:

08/11/23 7700075778

	,								CHECK/EFT	=======================================	//00	//000/5//8		
SERVICE DATE(S)	SERVICE CODES	S	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CO-INSURANCE CONTRACTUAL PROVIDER RESP. AMOUNT	ROVIDER RESP. AMOUNT	SA A	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: SAUC	SAUCEDO, ANTHONY 406692Z930			INSURED'S ID:		6421			PATIENT NAME: RECEIVED DATE:		SAUCEDO, ANTHONY 08/08/2023	THO!	FOR INQ (800)	FOR INQUIRIES CALL: (800) 284-1110
SERVICE PROVIDER NAME: BANSIL, SAI NETWORK: IN NETWORK	SIL, SANDEEP K JETWORK		REL	SERVICE PROVIDER ID RELATIONSHIP TO INSURED	JER ID: 1184799124 JURED: SUBSCRI BER	9124 I BER		PLAN TYPE: PPO	EXPL CD: DRG RCVD:	N/A		APPEALS CODE:	DMHC	
07/03/2023 07/03/2023 99	99232	21	180. 00	16. 91	0. 00	0. 00	0. 00	0. 00	95. 45 021	1 45	069 23	0. 00		16. 91
07/04/2023 07/04/2023 99	99232	21	180. 00 180. 00	16. 91 16. 91	o o. 00	0.00	o o 0 0 0 0	o o 80	95. 45 021 95. 45 021		069 23	0 0 00		16. 91 16. 91
	99232	21	180.00	16. 91	0.00	0.00	0 0 0	0 0 0				0 0		16. 91
INTEREST AMOUNT PAID BY OTHER INSURANCE COMPANY	RANCE COMPANY							9				397.74		0. 00
Т0	TOTAL NET PAID													101. 46
SERVICE DATE(S)	SERVICE CODES	Pos	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CO-INSURANCE CONTRACTUAL PROVIDER RESP. AMOUNT	ROVIDER RESP. AMOUNT	CCEXP	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: SAUC	SAUCEDO, ANTHONY			INSURED'S ID	92	6A71546 2023220GG6206			PATIENT NAME:		SAUCEDO, ANTHONY	O, ANTHONY 08/08/2023	FOR INQ	FOR INQUIRIES CALL: (800) 284-1110
	BANSIL, SANDEEP K IN NETWORK		REU	SERVICE PROVIDER ID: RELATIONSHIP TO INSURED:	SU 11	9124 I BER		PLAN TYPE: PPO		N/A		ALS CODE:	DMHC	
06/25/2023 06/25/2023 99	99232	21	180. 00	16. 91	0. 00	0.00	0. 00	0. 00				0. 00		16. 91
06/26/2023 06/26/2023 99	99232 99232	21	180. 00 180. 00	16. 91 16. 91	o. o.	o. oo	o o 0 0 0 0	o o 00 00	95. 45 021 95. 45 021	1 1 45	069 23 069 23	0.00		16. 91 16. 91
06/28/2023	99232	21	180. 00	16. 91	0.00	0.00	0.00	0. 00				0.00		16. 91
06/30/2023 06/30/2023 99	99232	21	180. 00	16. 91	0.00	0.00	0.00	0. 00	95. 45 021	1 45	069 23	0.00		16. 91
INTEREST INTEREST INTEREST INCIDENCE COMPANY	CIDANICE COMPANY		, 080. 00	101.40					5/2. /0			307 0.00		0. 00
To	TOTAL NET PAID	-												101. 46
SERVICE DATE(S)	SERVICE CODES	Pos	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CO-INSURANCE CONTRACTUAL PROVIDER RESP	ROVIDER RESP. AMOUNT	CC	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: SAUCEDO PATIENT ACCOUNT#: 406695Z SERVICE PROVIDER NAME: BANSI L, NETWORK: IN NETW	SAUCEDO, ANTHONY 406695Z930 BANSI L, SANDEEP K I N NETWORK		REL	INSURED'S ID. CLAIM NUMBER: SERVICE PROVIDER ID. RELATIONSHIP TO INSURED	92 11 SU	6A71546 2023220GG6148 84799124 BSCRI BER		PLAN TYPE: PPO	PATIENT NAME: RECEIVED DATE: EXPL CD: DRG RCVD:		UCED	3 EALS CODE:	FOR INQ	FOR INQUIRIES CALL: (800) 284-1110
07/07/2023 07/07/2023 99 07/08/2023 07/08/2023 99	99232 99232 TOTAL:	21	180. 00 180. 00 360. 00	16. 91 16. 91 33. 82	0.00	0. 00 0. 00	o. oo	o. o. o.	95. 45 021 95. 45 021 190. 90	1 45	069 23 069 23	0. 0. 00		16. 91 16. 91 33. 82
AMOUNT PAID BY OTHER INSURANCE COMPANY TOTAL NET PAID	SURANCE COMPANY											132.58		33. 82
SERVICE DATE(S)	SERVICE CODES	Pos	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CO-INSURANCE CONTRACTUAL PROVIDER RESP	ROVIDER RESP. AMOUNT	CEX	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
	SAUCEDO, ANTHONY 406671Z930 BANSI L, SANDEEP K		}	INSURED'S ID: CLAIM NUMBER: SERVICE PROVIDER ID:	11 92	6A71546 2023220G66016 84799124			PATI RECE	:	UCED	O,ANTHONY 08/08/2023 APPEALS CODE: DMHC		FOR INQUIRIES CALL: (800) 284-1110
NETWORK IN N	NE WORK	2		RELATIONSHIP TO INSURED	''		3	TAN TYPE: PEO	DRG R		8			
05/02/2023 05/02/2023 99 05/03/2023 05/03/2023 99	99232 99232	21	180. 00	16. 91 16. 91	0.00	0.00	0.00	0.00	95. 45 021 95. 45 021	1 45 1 45	069 23 069 23	0.00		16. 91 16. 91

101.40												TOTAL NET PAID	
_		397.74	_	_	_	_	_	_	_	_	_	BY OTHER INSURANCE COMPANY	AMOUNT PAID BY OTHER IN
0. 00				_									INTEREST
101. 46		0.00		572. 70	0. 00	0. 00	0.00	0.00	101. 46	1, 080. 00		TOTAL:	
16. 91		0.00	1 45 069 23	95. 45 021	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/18/2023 05/18/2023
16. 91		0.00	1 45 069 23	95. 45 021	0. 00	0. 00	0.00	0.00	16. 91	180. 00	21	99232	05/17/2023 05/17/2023
16. 91		0.00	1 45 069 23	95. 45 021	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/16/2023 05/16/2023
16. 91		0.00	45 069		0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/15/2023 05/15/2023
16. 91		0.00	45 069		0.00	0.00	0.00	0.00	16.91	180.00	_	99232	05/14/2023 05/14/2023
16. 91		0.00	45 069		0.00	0. 00	0.00	0.00	16. 91	180. 00	21	99232	05/13/2023 05/13/2023
			· N/A	DRG RCVD:	PLAN TYPE: PPO		र। BER	SURED: SUBSCRI BER	RELATIONSHIP TO INSURED:	REL		N NETWORK	NETWORK: IN NETWORK
	DMHC	APPEALS CODE: DMHC		EXPL CD:			99124	1	SERVICE PROVIDER ID:			ANSIL, SANDEEP K	
FOR INQUIRIES CALL: (800) 284-1110	FOR IN	0, ANTHONY 08/08/2023	SAUCED	PATIENT NAME: RECEIVED DATE:			6A71546 2023220GG5867	92	INSURED'S ID: CLAIM NUMBER:			SAUCEDO, ANTHONY 406678Z930	INSURED'S NAME: S/ PATIENT ACCOUNT#: 40
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	OVIDER RESP. AMOUNT	CONTRACTUAL PROVIDER RESP DIFFERENCE AMOUNT	CO-INSURANCE C	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	P _S	SERVICE CODES	SERVICE DATE(S)
101. 46												TOTAL NET PAID	
		397.74		_	_	_	_	_	_	_	_	NSURANCE COMPANY	AMOUNT PAID BY OTHER INSURANCE COMPANY
0. 00											_		INTEREST
101. 46		0.00		572. 70	0. 00	0. 00	0.00	0.00	101.46	1, 080. 00		TOTAL:	
16. 91		0.00	1 45 069 23	95. 45 021	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	06/24/2023 06/24/2023
16. 91		0.00	45 069	45	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	06/23/2023 06/23/2023
16. 91		0.00	45 069	95. 45 021	0. 00	0.00	0.00	0.00	16.91	180.00	21	99232	06/22/2023 06/22/2023
16. 91		0.00	45 069	95. 45 021	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	06/21/2023 06/21/2023
16. 91		0.00	45 069		0. 00	0.00	0.00	0.00	16.91	180. 00	21	99232	06/20/2023 06/20/2023
16. 91		0.00	1 45 069 23	95. 45 021	0. 00	o. 00	0.00	0.00	16. 91	180. 00	21	99232	06/19/2023 06/19/2023
											_ _		
			· N/A	DRG RCVD:	PLAN TYPE: PPO		र। BER	SURED: SUBSCRI BER	RELATIONSHIP TO INSURED:	REL		N NETWORK	NETWORK: IN NETWORK
	DMHC	APPEALS CODE:	•	EXPL CD:			99124)ER ID: 1184799124	SERVICE PROVIDER ID:			BANSI L, SANDEEP K	SERVICE PROVIDER NAME: B/
(800) 284-1110		08/08/2023		RECEIVED DATE:			2023220GG6008		CLAIM NUMBER:			406686Z930	
FOR INQUIRIES CALL:	FOR INC	THONY	SAUCEDO, ANTHONY	PATIENT NAME:			1546	D'S ID: 926A71546	INSURED'S ID:			SAUCEDO, ANTHONY	INSURED'S NAME: S/
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	OVIDER RESP. AMOUNT	CONTRACTUAL PROVIDER RESP DIFFERENCE AMOUNT	CO-INSURANCE (CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
101. 46												TOTAL NET PAID	
		397. 74										BY OTHER INSURANCE COMPANY	A D
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101 46		0 9	400	572 70	o :	9 9	0 0	0 9	101 46	1 080 00	<u> </u>	TOTAL:	
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16.91		0 00	45 069		0 00	o 9	0 00	0 00	16.91	180 00	21	99232	05/05/2023 05/05/2023
16. 91		0. 00	1 45 069 23	95. 45 021	0. 00	0. 00	0.00	0. 00	16. 91	180. 00	21	99232	5/04/2023 05/04/2023
-	DMHC	APPEALS CODE:		EXPL CD: DRG RCVD:	PLAN TYPE: PPO		99124 रा BER	SURED: 1184799124 SURED: SUBSCRI BER	SERVICE PROVIDER ID: RELATIONSHIP TO INSURED:	REL	-	BANSIL, SANDEEP K IN NETWORK	SERVICE PROVIDER NAME: BANSI L, SA NETWORK: I N NETWORK
FOR INQUIRIES CALL: (800) 284-1110	FOR INI (800	THONY	: SAUCEDO, ANTHONY : 08/08/2023	PATIENT NAME: RECEIVED DATE:			926A71546 2023220GG6016		INSURED'S ID: CLAIM NUMBER:			SAUCEDO, ANTHONY 406671Z930	INSURED'S NAME: S/ PATIENT ACCOUNT#: 40
WHAT WE WILL PAY	CODE(S)	RESPONSIBILITY AMOUNT	CODE(S)	AMOUNT	DIFFERENCE AMOUNT	CO-INSURANCE C	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	CODES	SERVICE DATE(S)
		INSURED			7017							2	

SANDEEP KUMAR BANSIL MD I PROVIDER ID NO: 203226347

CHECK/EFT DT: CHECK/EFT:

08/11/23 7700075778



MEDI CARE SUPPLEMENT-PBP

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SANDEEP KUMAR BANSIL MD I PROVIDER ID NO: 203226347

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16. 91 16. 91		0.00	069 23 069 23	021 45 021 45	95. 45 0 95. 45 0	0. 00	0.00	0.00	0. 00	16. 91 16. 91	180. 00	21	99232 99232	05/07/2023 05/07/2023 05/08/2023 05/08/2023
FOR INQUIRIES CALL: (800) 284-1110	FOR INQL	3 EALS CODE:	UCED		PATIENT NAME: RECEIVED DATE: EXPL CD: DRG RCVD:	PLAN TYPE: PPO		6A71546 2023220GG5759 84799124 BSCRI BER	92 SU	INSURED'S ID. CLAIM NUMBER. SERVICE PROVIDER ID. RELATIONSHIP TO INSURED.	REL		SAUCEDO, ANTHONY 406673Z930 BANSI L, SANDEEP K I N NETWORK	INSURED'S NAME: SAUCEDO, AN PATIENT ACCOUNT#: 406673Z930 SERVICE PROVIDER NAME: BANSI L, SA NETWORK: IN NETWORK
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	COEXP	OVIDER RESP.	CONTRACTUAL PROVIDER RESP. DIFFERENCE AMOUNT	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
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16. 91		0.00				0. 00	0. 00	0.00	0.00	16. 91	180. 00	21	99232	
16. 91		0.00				0.00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/21/2023 05/21/2023
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		9				3	8	0	8	16 01	180	2	000000	05 /18 /2022 05 /18 /2022
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(800) 284-1110		08/08/2023 APPEALS CODE: DMHC			RECEIVED DATE:			2023220GG5821 84799124	: =	CLAIM NUMBER SERVICE PROVIDER ID	ļ		406679Z930 BANSI L, SANDEEP K	
FOR INQUIRIES CALL:	FOR INQL	THONY	SAUCEDO, ANTHONY		PATIENT NAME:			546	D'S ID: 926A71546	INSURED'S ID:			SAUCEDO, ANTHONY	INSURED'S NAME: S
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	COEXP	OVIDER RESP.	CONTRACTUAL PROVIDER RESP DIFFERENCE AMOUNT	CO-INSURANCE CONT	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	8	SERVICE CODES	SERVICE DATE(S)
101. 46													TOTAL NET PAID	
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16. 91		0.00				0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	04/28/2023 04/28/2023
16. 91		0.00	069 23	021 45	95. 45 0	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	04/27/2023 04/27/2023
16. 91		0. 00				0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	04/26/2023 04/26/2023
16. 91		0.00	069 23		45	0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	04/25/2023 04/25/2023
16. 91		0. 00	069 23	021 45	95. 45 0	0. 00	0. 00	0. 00	0.00	16. 91	180. 00	21	99232	04/24/2023 04/24/2023
		_		VD: N/A	DRG RCVD:	PLAN TYPE: PPO		A BER	SURED: SUBSCRIBER	RELATIONSHIP TO INSURED		-	N NE IWORK	NETWORK: IN NETWORK
	DMHC	APPEALS CODE: DMHC			EXPLCD	1		19124		SERVICE PROVIDER ID	!		BANSI L, SANDEEP K	SERVICE PROVIDER NAME: B
FOR INQUIRIES CALL: (800) 284-1110	FOR INQL	0, ANTHONY 08/08/2023	SAUCEDO, ANTHONY 08/08/202		PATIENT NAME: RECEIVED DATE:			6A71546 2023220GG5856	92	INSURED'S ID: CLAIM NUMBER:			SAUCEDO, ANTHONY 406668Z930	INSURED'S NAME: S PATIENT ACCOUNT#: 4
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	SEX SEX	AMOUNT	CO-INSURANCE CONTRACTUAL PROVIDER RESP AMOUNT	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)
		141511010												

SANDEEP KUMAR BANSIL MD I

PROVIDER ID NO: 203226347

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33. 82													TOTAL NET PAID	
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	DMHC	APPEALS CODE: DMHC		EXPL CD:				99124		SERVICE PROVIDER ID:			ANSI L, SANDEEP K	SERVICE PROVIDER NAME: BANSI L, SANDEEP K
(800) 284-1110		/2023	08/08/2023	RECEIVED DATE:	RECEIV			2023220GG5389		CLAIM NUMBER			36681Z930	PATIENT ACCOUNT#: 406681Z930
FOR INDUIRIES CALL:	FOR IN	ANOF	SAUCEDO ANTHONY	PATIENT NAME	PATIF			1546	ID: 926A71546	INSURED'S ID			SAUCEDO ANTHONY	INSURED'S NAME: S
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI R CODE(S)	RESP.	RACTUAL PROVIDER RESP	CO-INSURANCE CONTRACTUAL	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	POS	SERVICE CODES	SERVICE DATE(S)
101. 46													TOTAL NET PAID	
_		397.74	_	_	_		_		_	_	_		NSURANCE COMPANY	AMOUNT PAID BY OTHER INSURANCE COMPANY
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101. 46		0.00		. 70	572. 70	0. 00	0.00	0.00	0.00	101.46	1, 080. 00		TOTAL:	
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16. 91		0.00	45 069 23	95. 45 021		0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/11/2023 05/11/2023
16. 91		0.00	45 069 23	95. 45 021		0. 00	0.00	0.00	0.00	16. 91	180. 00	21	99232	05/10/2023 05/10/2023
16. 91		0.00	45 069 23	95. 45 021	95	0. 00	0. 00	0.00	0.00	16. 91	180. 00	21	99232	05/09/2023 05/09/2023
			N/A	DRG RCVD: N/A		PLAN TYPE: PPO		RI BER	RED: SUBSCRI BER	RELATIONSHIP TO INSURED:	ᇛ		V NETWORK	NETWORK: IN NETWORK
		APPEALS CODE: DMHC		EXPL CD:				99124		SERVICE PROVIDER ID			ANSI L, SANDEEP K	SERVICE PROVIDER NAME: BANSI L, SANDEEP K
FOR INQUIRIES CALL: (800) 284-1110	FOR IN	HONY	SAUCEDO, ANTHONY 08/08/2023	PATIENT NAME:	PATIE. RECEIV			926A71546 2023220GG5759		INSURED'S ID:			SAUCEDO, ANTHONY 406673Z930	INSURED'S NAME: SAUCEDO, AN PATIENT ACCOUNT#: 406673Z930
WHAT WE WILL PAY	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI R CODE(S)	RESP.	PROVIDER AMOU	CO-INSURANCE CONTRACTUAL PROVIDER RESP. AMOUNT	CO-INSURANCE	CO-PAY	DEDUCTIBLE	ALLOWED	CHARGE	Pos	SERVICE CODES	SERVICE DATE(S)

TOTAL APPROVED AMOUNT

TOTAL INTEREST GROSS APPROVED CLAIM AMOUNT

1, 268. 25 0. 00 1, 268. 25

1, 268. 25 0. 00 1, 268. 25

TOTAL NET AMOUNT DUE: MEDICARE SUPPLEMENT-PBP

TOTAL INTEREST

NET AMOUNT DUE

EXPL CODES EXPLANATION

23 45 9 021 THIS AMOUNT INCLUDES A PORTION OF BENEFITS PAID BY MEDICARE OR APPLIED TO YOUR MEDICARE DEDUCTIBLE. PLEASE REFER TO YOUR EXPLANATION OF MEDICARE BENEFITS (E.O.M.B.) TO This was processed and adjusted because these charges were paid by Medicare or Medicaid. For additional information visit www.medicare.gov or contact the state Medicaid agency for additional information. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGI SLATED FEE ARRANGEMENT. THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION.

THE IMPACT OF PRIOR PAYER(S) ADJUDICATION INCLUDING PAYMENTS AND/OR ADJUSTMENTS. DETERMINE YOUR LIABILITY.

APPEALS CODE APPEALS

DMHC

Explanation of claims review procedures
If you believe that your claim is wrongfully in whole or in part, rejected or denied you may request a review from the Department of Managed Health Care at the following

980 Ninth Street, Suite 500, Sacramento, California 95814-2725

address and phone number: Department of Managed Health Care Help Center: 1-888-HMO-2219



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PROVIDER ID NO: 203226347 SANDEEP KUMAR BANSIL MD I

CHECK/EFT DT: CHECK/EFT:

08/11/23

Provider dispute resolution mechanism for Providers: lf you have questions regarding this Remittance Advice, please contact our Custom Service Department.

Help Center (a state agency) at of the dispute, and whether this is a single dispute or a substantially similar multiple claims dispute. Disputes involving a claim, or billing or overpayment must also Department at the telephone number shown on the member's ID card. If you disagree with an Anthem Blue Cross claim or billing determination, or Anthem Blue Cross If you are a contracting provider with Anthem Blue Cross (Anthem) you are required to follow dispute resolution process in your contract. If you have a dispute with referenced of the member's identification card. If the dispute is not resolved to your satisfaction, you may contact the California Department of Managed Health Care include the service "From/To" date. Further instructions and forms are available via Anthem Blue Cross website at www.anthem.com/ca or call the customer service number Angeles, CA 90060-0007. The written notice must include the provider name, tax identification number, patient name, health plan identification number, description request for reimbursement of an overpayment, or if you have a contract dispute, you may submit a provider by mailing a written notice to us at P.O. Box 60007, Los issue, you may request binding arbitration as specified in your provider contract. See your contract for more detailed information, or contact the Custom Service Anthem Blue Cross regarding your contract, you may ask for a "meet and confer" unless your contract specifies otherwise. If the "meet and confer" does not resolve them Blue Cross regarding your contract specifies otherwise.

www. Heal thHelp. gov.com. State dispute resolution requirements are preempted by Federal Taw. 1-888-HMO-2218 for assistance. They may also be contacted by mail at 980 North Street , Suite 500, Sacramento, California 95814-2725. Their website is

You or your authorized representative may have the right to request an independent medical review (IMR) of disputed health care services from the California Department of Managed Health Care if you believe that services have been improperly denied, modified, or delayed. A disputed health care service is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by your health plan, in whole or in part because the service is not medically

earlier review is warranted or if there exists an imminent or serious threat to your health that requires an expedited review of your case. In other circumstances, IMR Such IMR may be available to you immediately without going through our appeal or grievance process if the California Department of Managed Health Care determines that an it. If you need assistance with identifying whether your grievance is urgent or non-urgent you may call is available only after you have filed a grievance with us and we uphold our original decision, or your grievance remains unresolved thirty days after you have filed

Department of Managed Care at the following address: Please be aware that failing to apply for an IMR may forfeit other statutory rights to pursue legal action against your plan regarding the disputed health care service Your application may be barred if not submitted within six months of being denied the disputed health care service. You may submit an IMR application to the California

California Department of Managed Health Care Help Center 980 Ninth Street, Suite 500

Sacramento, California 95814-2725



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Blue Cross

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Cross name and symbol are registered marks of the Blue Cross Association.

RECOUPMENT NOTIFICATION

PROVIDER: SPAYEE ID: NEG BAL REF #: DATE: CHECK AMT: SANDEEP KUMAR BANSIL MD I 203226347

08/11/23 1,268.25

ON THE ENCLOSED REMITTANCE ADVICE. THIS IS A DETAILED NOTIFICATION OF THE RECOUPMENT PROCESSED BY ANTHEM FOR OVERPAYMENTS MADE TO YOUR ACCOUNT AS INDICATED

THE 'NEGATIVE BALANCE DEFERRED' SECTION SHOWS DEFERRED (FUTURE) RECOUPMENTS WHERE REFUNDS ARE DUE. THESE ARE NOT REFLECTED ON THIS REMITTANCE ADVICE.
A SEPERATE LETTER HAS BEEN SENT WITH FURTHER DETAILS AND OVERPAYMENT RECOVERY WILL COMMEMCE FOLLOWING EXISTING PROCESSES IF A REFUND IS NOT RECEIVED.
IF YOU HAVE QUESTIONS REGARDING A RECOUPMENT, PLEASE CONTACT PROVIDER SERVICE AT NUMBER NOTED ON REMITTANCE ADVICE. THE "ORIGINAL NEGATIVE CLAIM NUMBER" COLUMN CONTAINS THE ORIGINAL CLAIM ID THAT CREATED THE NEGATIVE BALANCE. THE CORRESPONDING PRIOR AND CURRENT RECOUPMENT SECTIONS BELOW SHOW THE RECOUPMENT DETAILS FOR EACH ORIGINAL NEGATIVE CLAIM LISTED IN THE NEGATIVE BALANCE HISTORY.

LETTER ID	AMT		RECOVERED		SERVICE CLAIM NUMBER	SERVICE	REFUND ID				DATE
RECOVERY		ADJ CD CHARGE	CREDITS	CLAIM AMOUNT	CLAIM NUMBER/ DATE OF ORIGINAL NEGATIVE	DATE OF	CLAIM NUMBER/	SUBSCRIBER ID	PATIENT ACCT	PATIENT NAME	REMIT.

NEGATI VE BALANCE HI STORY:

PRI OR RECOUPMENT:

CURRENT RECOUPMENT:

DATE				REFUND ID	SERVICE	SERVICE CLAIM NUMBER	RECOUP DATE	,,,	AMT	LETTER ID	
REMIT	PATIENT NAME	PATIENT ACCT	SUBSCRIBER ID	CLAIM NUMBER/ DATE OF ORIGINAL NEGATI	DATE OF	ORIGINAL NEGATIVE	CLAIM AMOUNT EXPECTED ADJ CD	ADJ CD	CHARGE	CHARGE RECOVERY	
											1

15067958	1, 080. 00	424.38- 09/07/23	2023118DI 411998 03/20/23 2023118DI 411998	491A73964	396069Z930	LARRY	08/10/23 MI TCHELL
15061433	1, 080. 00	424.38- 09/07/23	2023118DI 406798 03/08/23 2023118DI 406798	491A73964	396065 Z 930	LARRY	08/10/23 MITCHELL
15061433	1, 080. 00	424.38- 09/07/23	2023117BZ675798 02/13/23 2023117BZ675798	491A73964	395579 Z 930	LARRY	08/10/23 MI TCHELL
15061433	720. 00	282.92- 09/07/23	2023117BZ582598 02/25/23 2023117BZ582598	491A73964	395581 Z 930	LARRY	08/10/23 MITCHELL
15061433	1, 080. 00	424.38- 09/07/23	2023117BZ156798 02/19/23 2023117BZ156798	491A73964	395580 Z 930	LARRY	08/10/23 MI TCHELL
15061433	360.00	141.46- 09/07/23	2023091BI 938098 02/09/23 2023091BI 938098	491A73964	391369Z930	LARRY	08/10/23 MI TCHELL
15061433	1, 080. 00	424.38- 09/07/23	2023091BI 876398 02/01/23 2023091BI 876398	491A73964	391368Z930	LARRY	08/10/23 MI TCHELL

RECOUPMENT NOTIFICATION

			RECOUPME	RECOUPMENT NOTIFICATION	PAGE	2			
REMIT. PATIENT NAME DATE	PATIENT ACCT	SUBSCRIBER ID	CLAIM NUMBER/ REFUND ID	CLAIM NUMBER/ DATE OF ORIGINAL NEGATIVE REFUND ID SERVICE CLAIM NUMBER	CLAIM AMOUNT EXPECTED ADJ CD RECOUP DATE	ADJ CD	CHARGE AMT	CHARGE RECOVERY AMT LETTER ID	
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	396067Z930	491A73964	2023118DI 516598	2023118DI 516598 03/14/23 2023118DI 516598	424.38- 09/07/23		1, 080. 00	15061433	
08/10/23 MITCHELL LARRY	396071Z930	491A73964	2023118DI 544898	2023118DI 544898 03/26/23 2023118DI 544898	353.65- 09/07/23		900.00 15061433	15061433	_
	396064Z930	491A73964	2023118DI 576698	2023118DI 576698 03/01/23 2023118DI 576698	424.38- 09/07/23		1, 080. 00	15061433	
	396501Z930	491A73964	2023123BG339098	2023123BG339098 04/01/23 2023123BG339098	437.10- 09/07/23		1, 080. 00	15067958	
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TOTAL NEGATI VE BALANCE
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