CFPA00-980-915

A **MEDICA SELF-INSURED - A THIRD PARTY ADMINISTRATOR FOR SELF-FUNDED GROUP MEDICAL PLANS**

B
DULUTH SERVICE CENTER
PO BOX 30990
SALT LAKE CITY, UT 84130
PHONE: (800) 458-5512

MEDICA®

D
DATE: 03/10/2006
TIN: 88-8888888
GROUP NUMBER: 55555
GROUP NAME: ABC COMPANY
CHECK NUMBER: 11-11111111
CHECK AMOUNT: $95.00

C
WELBY MEDICAL CLINIC
MARCUS A WELBY, MD
1234 ANYSTREET
ANYTOWN, US 12345-6789

PROVIDER EXPLANATION OF BENEFITS

PATIENT DETAIL

1 PRODUCT	2 MEM. ID	3 PATIENT NAME	4 PAT REL	5 PATIENT ACCOUNT	6 MEMBER NAME	7 CONTROL NUMBER	8 DATE RECEIVED	9 PROVIDER OF SERVICE
CHOICE	A-999999999	JANE SMITH	EE	XXXXXXXXXX	JANE SMITH	XXXXXXXXXX	03/06/06	M. A. WELBY MD

SERVICE DETAIL

3 PATIENT NAME	10 DATES OF SERVICE	11 DESCRIPTION OF SERVICE	12 AMOUNT CHARGED	13 NOT COVERED	14 PROV ADJ DISCOUNT	15 AMOUNT ALLOWED	16 DEDUCT/ COPAY	17 PLAN COV	18 PAID TO PROVIDER	19 RMK CD	20 PATIENT RESP.
JANE SMITH	02/28/06	85610	175.00		45.00	130.00	35.00		95.00	D2	
		SUBTOTAL	175.00		45.00	130.00	35.00		95.00		35.00

TOTAL PAID TO PROVIDER $95.00

REMARKS 21

(D2) THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE AMOUNTS AND AMOUNTS OVER THE ANNUAL BENEFIT LIMITS FOR THIS SERVICE, UP TO THE ELIGIBLE EXPENSE.

DESCRIPTIONS KEY

A Legal name of company/entity under which the product is sold (e.g., Medica Health Plans, Medica Self-Insured, etc).

B Processing site name and claim submission address.

C Mailing name and address for the provider of the service.

D **Date:** Check date.
TIN: Servicing provider's Federal Tax Identification Number.
Group Number: 5- or 6-digit group number.
Group Name: Name of employer group through which patient is enrolled.
Check Number: Check number generated for reimbursement.
Check Amount: Total amount of check for this Provider EOB.

1 **PRODUCT:** Member product name.

2 **MEM. ID:** Nine-digit member ID number (located on identification card). The "A" signifies that this is an alternate identification number (alt ID).

3 **PATIENT NAME:** The name of the person who received the medical care.

4 **PAT REL:** Relationship of the patient to the subscriber of the plan (e.g., EE= self, SP= spouse, CH= child).

5 **PATIENT ACCOUNT:** Account number submitted on the claim.

6 **MEMBER NAME:** Subscriber of the plan's name.

Descriptions key continues on next page…

DESCRIPTIONS KEY *(continued)*

7. **CONTROL NUMBER:** Claim identification number. This number is assigned in the claim adjudication system and should be referenced when requesting adjustments.

8. **DATE RECEIVED:** Date the claim was received by Medica.

9. **PROVIDER OF SERVICE:** Provider name.

10. **DATES OF SERVICE:** Date service(s) performed.

11. **DESCRIPTION OF SERVICE:** If provider only submits a CPT code submitted, CPT code will be listed. Otherwise description of the service provided (e.g., "office visit").

12. **AMOUNT CHARGED:** Total dollar amount billed for the procedure(s) performed.

13. **NOT COVERED:** Services that are not covered and determined to either be provider or member responsibility. Refer to the remark code to determine if the denial is member or provider responsibility.

14. **PROV ADJ DISCOUNT:** Amount of discount defined within a provider's contract for services. This amount is not member responsibility and is a provider write-off.

15. **AMOUNT ALLOWED:** The dollar amount in the "Not Covered" field plus the dollar amount in the "Prov Adj Discount" field. This may include non-covered amounts denied as either member liability or provider liability.

16. **DEDUCT/COPAY:** Amount member is required to pay for covered services under their benefit document. This amount is member responsibility.

17. **PLAN COV:** If amount in "Deduct/Copay" field is a coinsurance amount, this field will show the percentage that the benefit document states is covered (e.g. if 80%, then member would be responsible for a 20% coinsurance).

18. **PAID TO PROVIDER:** Amount Medica paid the provider for the service.

19. **RMK CD:** The code providing an explanation of how the claim was processed. A description of the remark code will be listed in the service detail section.

20. **PATIENT RESP.:** The amount the member is responsible for paying the provider. Will include denied, deductible, copayment and coinsurance amounts.

21. **REMARKS:** Description of remark code listed in field 19.