ABC PROVIDER
12345678
123456789
20200820
$42,000.24

ABC HEALTH PLAN
1880 JFK BLVD, SUITE 1200
PHILADELPHIA, PA. 19103

EXPLANATION OF PAYMENT

Payment Date:	**August 20, 2020**
Payee ID:	**123456789**
Reference Number:	**1234567 2**
Claim Count:	**3**
Total Charges:	**$375,003.00**
Total Claim Payment:	**$0.00**
Total Provider Adj:	**$42,000.24**
Payment Amount:	**$42,000.24**

If you have any questions, please call (800) 621-3724.

2000001 02 AB 0.416 **AUTO T1 1 6767 83201-276806-C01-P00000-I123

ABC PROVIDER
123 MAIN STREET
PHILADELPHIA, PA 19309-2768

Register for ERA/EFT at https://register.instamed.com/eraeft and enter Registration Code: Q12345

Provider Claim Summary

Date of Service From	To	Procedure (Modifier)	No. of Units	Amount Billed	Allowed	Paid	Patient Responsibility	Other Ins. Paid	Non Covered	Withhold	Adjustment Reason	Remarks
Patient: 123456789 SMITH JANE					**Member:** 123456789 SMITH JANE				**Claim ID:** 12345			
Patient Account Number: 123456789					**Provider:** 1093818239 PATRICK BURTON				**Interest:**			
07/23/2020	07/23/2020	99213	1	$125,001.00	$14,000.08	$14,000.08	$0.00	$111,000.92	$111,000.92	$0.00	OA-23	
Total for Claim				**$125,001.00**	**$14,000.08**	**$14,000.08**	**$0.00**	**$111,000.92**	**$111,000.92**	**$0.00**		
Patient: 123456789 SMITH PAT					**Member:** 123456789 SMITH PAT				**Claim ID:** 12345			
Patient Account Number: 123456789					**Provider:** 123456789 JOHN HOLMSTEAD				**Interest:**			
07/27/2020	07/27/2020	99213	1	$125,001.00	$14,000.08	$14,000.08	$0.00	$111,000.92	$111,000.92	$0.00	OA-23	
Total for Claim				**$125,001.00**	**$14,000.08**	**$14,000.08**	**$0.00**	**$111,000.92**	**$111,000.92**	**$0.00**		
Patient: 123456789 SMITH TONY					**Member:** 123456789 SMITH TONY				**Claim ID:** 12345			
Patient Account Number: 123456789					**Provider:** 123456789 TIM SCOTT							
07/27/2020	07/27/2020	99213	1	$125,001.00	$14,000.08	$14,000.08	$0.00	$111,000.92	$111,000.92	$0.00	OA-23	
Total for Claim				**$125,001.00**	**$14,000.08**	**$14,000.08**	**$0.00**	**$111,000.92**	**$111,000.92**	**$0.00**		

ABC HEALTH PLAN
1880 JFK BLVD, SUITE 1200
PHILADELPHIA, PA. 19103

24-84/1230

No. 0123456

08/20/2020

$42,000.24

VOID VOID VOID

Void after 180 days from date of issue

FORTY TWO THOUSAND AND 24/100

PAY
TO
THE
ORDER
OF

ABC PROVIDER
123 MAIN STREET
PHILADELPHIA, PA 19309-2768

⑈0000000000000⑈ ⑆000000000000⑆ 0000000000000⑈

6767-01-00-2000001-0001-0000001

ABC Health Plan Legal Text

You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a review to ABC Health Plan. Requests for review or appeal may be mailed to ABC Health Plan 1880 JFK Blvd 12th Floor Philadelphia, PA 19103, ATTN: Claims Appeal or sent via fax to (215) 789-3680, ATTN: Claims Appeal. The request should include any issues outlining the basis of the appeal. As pertinent to the appeal, a review of the plan and its administration may occur.

A request for review must be filed within 60 days after receipt of the written notice of denial of a claim. A decision will be rendered by ABC Health Plan no later than 30 days after receipt of a request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after ABC Health Plan's review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent provisions on which the decision was based.

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Adjustment Reason CODES

Remarks CODES

Code	Description	Code	Description
OA-23	The impact of prior payer(s) adjudication including payments and/or adjustments.		