Provider Claim Summary — PPO/POS

The Provider Claim Summary (PCS) is a notification statement sent to contracting providers with Blue Cross and Blue Shield of Oklahoma after a claim has been processed. The content of each Provider Claim Summary may vary based on the insured's benefit plan and the services provided. You should note that forms and checks are not color-coded.

It is important to review your Provider Claim Summaries to ensure your records are current and accurate. To inquire about patient membership, benefits and claim status information, call Blue Cross and Blue Shield of Oklahoma customer service at 1-800-94-Blues (800-942-5837).

Features of the PCS:

- Patients over 65 are noted (indicating Medigap)
- Combined reporting: paid, denied, or zero payable claims on one PCS
- 8-1/2 x 11 size
- Reject messages recapped on final page

The patient's share may include:

- Any portion of the billed amount that is not covered
- The patient's deductible, including copayment amounts

PHYSICIAN CLAIM SUMMARY FIELD EXPLANATIONS

1	Date	Date the summary was finalized
2	Provider Number	The physician's Blue Shield Provider number
3	Check Number	The number assigned to the check for this summary
4	Tax Identification Number	The number which identifies your taxable income
5	Provider or Group Name & Address	The provider/group address where the services were rendered
6	Patient	The name of the individual who received the service
7	Perf Prv	In a clinic/group practice, the actual performing provider number
8	Claim Number	The Blue Shield number assigned to the claim
9	Identification Number	Number that identifies the employer group and insured
10	Patient Number	The patient's account number assigned by the provider
11	Claim Type	Code for type of claim (benefit plan) — see field 29
12	From/To Dates	Beginning and ending dates of services rendered
13	PS	Place of service code — see field 27
14	PAY	Reimbursement payment rate that was applied in relationship to the member's policy type. (See list of value codes on the next page.)
15	Procedure Code	Procedure Code for procedure/service
16	Amount Billed	The amount billed for each procedure/service
17	Contract Allowable	The amount allowed under the negotiated contract
18	Services Not Covered	Non-covered services according to the member contract
19	Deductions/Other Ineligible	Program deductions, copayments and coinsurance amounts
20	Amount Paid	Amount paid for each procedure/service
21	Amount Paid to Provider for This Claim	The amount Blue Shield paid to provider for this claim

Blue Cross Blue Shield of Oklahoma

10.559 (2/06)

22	Contract Deductible/Copay	The deductible/copay amount applied to this claim (patient's responsibility)
23	Deductions/Other Ineligible	Same as field 18
24	Total Services Not Covered	Total amount of non-covered services
25	Patient's Share	Amount patient pays (physician may bill this amount to the patient)
26	Provider Claims Amount Summary	Total for claim(s) processed on this summary
27	Place of Service (PS)	The description for the place of service code in field 13
28	Claim Type	The description for the type of claim in field 11
29	Messages/Reasons	The description for messages relating to: •Non-covered services •Program deductions •PPO reductions

"PAY" Value	Description	Plan
CAR	Caring	Oklahoma
EPP	Blue Preferred	Oklahoma
HMO	BlueLincs HMO	Oklahoma
NOP	Not A Network	All
PAR	Blue Traditional	Oklahoma
PPO	BlueChoice PPO	Oklahoma
SPN	Medicare Supplemental Network	Oklahoma

SAMPLE PROVIDER CLAIM SUMMARY

PROVIDER CLAIM SUMMARY

BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, An Association of Independent Blue Cross and Blue Shield Plans

DATE: MM/DD/YY 1
PROVIDER NUMBER: 0000001122 2
CHECK NUMBER: 12345678 3
IDENTIFICATION NUMBER: 987654321 4

5 XYZ PLASTIC SURGERY
456 SOUTH DRIVE
ANYTOWN, TX 77777

ANY MESSAGES BEGIN ON PAGE 1

**********OUT-PATIENT

6 PATIENT: JANE
7 PERF PRV: 0000000000000012345X 9 IDENTIFICATION NO: 00000-ABC123456789
8 CLAIM NO: 0000011122233344C 10 PATIENT NO: 11 CLAIM TYPE: MCP

12 FROM / TO DATES	13 PS*	14 PAY**	15 PROC CODE	16 AMOUNT BILLED	17 CONTRACT ALLOWABLE	18 SERVICES NOT COVERED	19 DEDUCTIONS/OTHER INELIGIBLE	20 AMOUNT PAID
11/10-11/20/03	03	006	99202	66.00	64.85	0.00	15.00 (1)	49.85
				66.00	64.85	0.00	15.00	49.85

21 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $49.85

DEDUCTIONS/OTHER INELIGIBLE

22 CONTRACT DEDUCTIBLE/COPAY: $15.00
23 DEDUCTIONS/OTHER INELIGIBLE: $15.00
24 TOTAL SERVICES NOT COVERED: 0.00
25 PATIENT'S SHARE: $15.00

PROVIDER CLAIMS AMOUNT SUMMARY

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NUMBER OF CLAIMS:	1	AMOUNT PAID TO SUBSCRIBER:	$0.00
AMOUNT BILLED:	$66.00	AMOUNT PAID TO PROVIDER:	$49.85
AMOUNT OVER MAXIMUM ALLOWANCE:	$0.00	RECOUPMENT AMOUNT:	$0.00
AMOUNT OF SERVICES NOT COVERED:	$15.00	NET AMOUNT PAID TO PROVIDER:	$49.85
AMOUNT PREVIOUSLY PAID:	$0.00		

27 * PLACE OF SERVICE (PS)
03. PHYSICIAN'S OFFICE

28 CLAIM TYPE
MCP. MANAGED CARE (PCP REQUIRED)

29 MESSAGES
30 (1). A CONTRACT DEDUCTIBLE HAS BEEN TAKEN.

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