

PROVIDER CLAIM SUMMARY

DATE: [REDACTED]
 PROVIDER NUMBER: [REDACTED]
 CHECK NUMBER: [REDACTED]
 TAX IDENTIFICATION NUMBER: [REDACTED]

[REDACTED]

Let's work together to make the transition.
 Have EFT, ERA, EPS questions? Visit Electronic
 Commerce online at www.bcbsok.com/providers.html.

ANY MESSAGES WILL BEGIN ON PAGE 36

CONTINUED FROM PREVIOUS PAGE; PATIENT NAME: [REDACTED]

FROM / TO DATES	PS* TS**	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
12/30-12/30/10	03	006 99396	185.00	118.83	66.17 (7)	20.00 (4)	98.83
			185.00	118.83	66.17	20.00	98.83

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$98.83

DEDUCTIONS/OTHER INELIGIBLE

CONTRACT DEDUCTIBLE/COPAY: 20.00
 DEDUCTIONS/OTHER INELIGIBLE: \$20.00
 TOTAL SERVICES NOT COVERED: 66.17
 PATIENT'S SHARE: \$20.00

PATIENT: [REDACTED]
 PERF PRV: [REDACTED]
 CLAIM NO: [REDACTED]
 IDENTIFICATION NO: [REDACTED]
 PATIENT NO: [REDACTED] CLAIM TYPE: CHC

FROM / TO DATES	PS* TS**	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
12/21-12/21/10	03	006 99397	205.00	132.60	72.40 (7)	0.00	132.60
			205.00	132.60	72.40	0.00	132.60

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$132.60

DEDUCTIONS/OTHER INELIGIBLE

TOTAL SERVICES NOT COVERED: 72.40
 PATIENT'S SHARE: \$0.00

PATIENT: [REDACTED]
 PERF PRV: [REDACTED]
 CLAIM NO: [REDACTED]
 IDENTIFICATION NO: [REDACTED]
 PATIENT NO: [REDACTED] CLAIM TYPE: CHC



BlueCross BlueShield
of Oklahoma

P.O. Box 3283
1215 S. Boulder
Tulsa, Oklahoma 74102-3283
(800) 496-5774

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[REDACTED]

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CONTINUED FROM PREVIOUS PAGE; PATIENT NAME: [REDACTED]

FROM / TO DATES	PS* TS**	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
12/10-12/10/10	01 003	59510	2,900.00	2,422.75	477.25 (1)	726.82 (2)	1,695.93
			2,900.00	2,422.75	477.25	726.82	1,695.93

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$1,695.93

DEDUCTIONS/OTHER INELIGIBLE

CONTRACT COINSURANCE: 726.82
DEDUCTIONS/OTHER INELIGIBLE: \$726.82
TOTAL SERVICES NOT COVERED: 477.25
PATIENT'S SHARE: \$726.82

PATIENT: [REDACTED]
PERF PRV: [REDACTED]
CLAIM NO: [REDACTED]

THIS IS AN ADJUSTMENT TO A PREVIOUSLY CONSIDERED CLAIM
IDENTIFICATION NO: [REDACTED]
PATIENT NO: [REDACTED] CLAIM TYPE: CHC

FROM / TO DATES	PS* TS**	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
10/04-10/04/10	03 006	99395	165.00	165.00	0.00	115.00 (14)	50.00
10/04-10/04/10	03 008	81002	16.00	16.00	0.00	16.00 (14)	0.00
			181.00	181.00	0.00	131.00	50.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$50.00

DEDUCTIONS/OTHER INELIGIBLE

PORTION ELIGIBLE FOR PAYMENT BY ANOTHER CARRIER/MEDICARE: 131.00
DEDUCTIONS/OTHER INELIGIBLE: \$131.00
TOTAL SERVICES NOT COVERED: 72.88
PATIENT'S SHARE: \$78.78

[REDACTED]

[REDACTED]

PROVIDER CLAIM SUMMARY

DATE: [REDACTED]
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CHECK NUMBER: [REDACTED]
TAX IDENTIFICATION NUMBER: [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

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CONTINUED FROM PREVIOUS PAGE.

PATIENT: [REDACTED] THIS IS AN ADJUSTMENT TO A PREVIOUSLY CONSIDERED CLAIM
PERF PRV: [REDACTED] IDENTIFICATION NO: [REDACTED]
CLAIM NO: [REDACTED] PATIENT NO: [REDACTED] CLAIM TYPE: PRF

FROM / TO DATES	PS* TS**	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
08/09-08/09/10	03 005	76817	271.00	120.64	150.36 (1)	0.00	120.64
			271.00	120.64	150.36	0.00	120.64

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$120.64

DEDUCTIONS/OTHER INELIGIBLE

TOTAL SERVICES NOT COVERED: 150.36
PATIENT'S SHARE: \$0.00

RECOUPMENTS TAKEN

PAT NAME	PAT ACCT NO	GROUP-SUBS NUMBER	CLAIM NUMBER	FROM/TO DATES	AMOUNT REASONS
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	\$73.95 CORRECTED CLAIM

PROVIDER CLAIMS AMOUNT SUMMARY

NUMBER OF CLAIMS:	68	AMOUNT PAID TO SUBSCRIBER:	\$0.00
AMOUNT BILLED:	\$32,617.00	AMOUNT PAID TO PROVIDER:	\$14,979.32
AMOUNT OVER MAXIMUM ALLOWANCE:	\$9,424.20	RECOUPMENT AMOUNT:	\$73.95
AMOUNT OF SERVICES NOT COVERED:	\$17,637.68	NET AMOUNT PAID TO PROVIDER:	\$14,905.37
AMOUNT PREVIOUSLY PAID:	\$0.00		

- * PLACE OF SERVICE (PS)
- 01. HOSPITAL INPATIENT.
 - 02. HOSPITAL OUTPATIENT.
 - 03. PHYSICIAN'S OFFICE.

- ** TYPE OF SERVICE (TS)
- 00J. MEDICAL/SURG SUPPLIES.
 - 001. SURGERY.
 - 003. OBSTETRICAL.
 - 005. DIAGNOSTIC RADIOLOGY.
 - 006. MEDICAL.

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CONTINUED FROM PREVIOUS PAGE.

| 008. LABORATORY/PATHOLOGY.

CLAIM TYPE

CHC. BLUE CHOICE
PRF. BLUE PREFERRED
TRD. BLUE TRADITIONAL

MESSAGES:

- (1). CHARGES EXCEED THE ALLOWED AMOUNT FOR THIS SERVICE. SERVICES PROVIDED BY A PARTICIPATING/NETWORK PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.
- (2). A CONTRACT CO-INSURANCE HAS BEEN TAKEN.
- (3). THE BLUE SHIELD CLAIM AUDITING SYSTEM CONSIDERS THIS SERVICE/PROCEDURE INCIDENTAL TO THE MORE COMPLEX PRIMARY SERVICE/PROCEDURE. PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE PRIMARY SERVICE/PROCEDURE. AS A PARTICIPATING PROVIDER, THE PATIENT MAY NOT BE BILLED FOR THIS SERVICE/PROCEDURE.
- (4). A CONTRACT COPAY/DEDUCTIBLE HAS BEEN TAKEN.
- (5). CHARGE EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE. SERVICES PROVIDED BY A NON-PARTICIPATING PROVIDER. PATIENT IS RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.
- (6). PROGRAM REQUIREMENTS AS IDENTIFIED BY THE MEMBER'S CONTRACT HAVE NOT BEEN FULFILLED. THIS IS THE PATIENT'S LIABILITY.
- (7). SUBMITTED CHARGE(S) EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE. SERVICES PROVIDED BY A PARTICIPATING / NETWORK PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.
- (8). SERVICES COVERED ONLY IF PERFORMED OR RECEIVED BY A " PPO " PROVIDER.
- (9). THE BLUE SHIELD CLAIM AUDITING SYSTEM HAS FOUND SERVICES CONSIDERED MUTUALLY EXCLUSIVE. THE CLINICALLY MORE INTENSE SERVICE HAS BEEN REIMBURSED. THESE ARE NOT CONSIDERED "NON COVERED" OR "NOT IN BENEFIT". AS A PARTICIPATING PROVIDER, THE PATIENT MAY NOT BE BILLED FOR THE MUTUALLY EXCLUSIVE SERVICE.