

INDEPENDENT CARE HEALTH PLAN - EXPLANATION OF PAYMENT

K J HEALTHCARE, MD 9999 IRS#: 111111111
 4961 COLUMBIA RD 835 Trace #: 555
 CEDARBURG, WI 53012

Patient Name: JANE DOE
 Patient Control No: 22222 Age: 19 DRG#: ID: 44444444-01 Acct: 020202020
 Control No: 060331M00001

Serv	Dates From To	Di ag#	Proc# Days/Cnt Proc2	Auth#	Charged	Allowed	Expl ain Codes	Deni ed	Ded&Coplay Interest	Di scount Late Fee	Ri sk Med Al low	TPP Med Pai d	Payment
0100	011106-011106	V268	90772 1		6.00	6.00	89	6.00	.00 .00	.00	.00	.00	.00
Sub-total					6.00	6.00		6.00	.00 .00	.00 .00	.00 .00	.00 .00	.00

Patient Name: JOHN DOE
 Patient Control No: 55555 Age: 22 DRG#: ID: 33333333-01 Acct: 202020202
 Control No: 060331M00002

Serv	Dates From To	Di ag#	Proc# Days/Cnt Proc2	Auth#	Charged	Allowed	Expl ain Codes	Deni ed	Ded&Coplay Interest	Di scount Late Fee	Ri sk Med Al low	TPP Med Pai d	Payment
0100	010906-010906	6259	99213 1		98.00	30.00	06	.00	.00 .00	.00	.00	.00	30.00
Sub-total					98.00	30.00		.00	.00 .00	.00 .00	.00 .00	.00 .00	30.00
888	-0002 / KAREN HEALTHCARE				104.00	36.00		6.00	.00 .00	.00 .00	.00 .00	.00 .00	30.00
TOTAL					104.00	36.00		6.00	.00 .00	.00 .00	.00 .00	.00 .00	30.00

Explanation Code Description
 89 DENY-NOT COVERED, PROCEDURE NOT LISTED IN STATE FEE SCHED. FOR PROVIDER
 06 FEE SCHEDULE-PAYMENT IN FULL

All decisions with regard to payment are subject to appeal. Independent Care Health Plan will accept written appeals and requests for reconsiderations from providers who disagree with Independent Care Health Plan's payment/denial determination, if the provider submits the dispute in writing and within 60 days of the initial payment/denial notice. Independent Care Health Plan has 45 days from the date of receipt of the request for reconsideration to respond in writing to the provider. Please submit all provider appeals to: Independent Care Health Plan, 1555 North River Center Drive, Suite 202A, Milwaukee Wisconsin, 53212. If Independent Care Health Plan fails to respond within 45 days, or if the provider is not satisfied with Independent Care Health Plan's response, the provider may request a final determination from the Department of Health and Family Services in writing, within 60 days of Independent Care Health Plan's final decision.

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NEGATIVE SERVICES BALANCE USED: \$.00
 PREPAYMENT BALANCE USED: \$.00

 TOTAL CURRENT BALANCES USED: \$.00
 CLAIMS PAID THIS RUN: \$ 30.00

 CHECK AMOUNT: \$ 30.00