P.O. BOX 999999
HARTFORD, CT 06115-0431
USA

# EXPLANATION OF BENEFITS

*Please Retain for Future Reference*
1 Ellen Smith MD/ PIN: 0001111111


| | |
|---|---|
| **Date Printed:** | 01/17/2005 |
| **Tax Identification Number:** 3 | 222222222 |
| 4 **Check Number:** | 576/36369854 |
| **Check Amount:** 5 | **$150.00** |

2
**ELLEN SMITH, MD**
**1000 MIDDLE STREET**
**MIDDLETOWN CT 06457**

6 **Notes:** *The benefits listed below reflect your portion of this payment.*
*For Participating Physicians and Facilities Only - If your practice has a change of address and/or telephone number please contact Aetna online at: https://www.aetna.com/providerehealthoffice/"*

## 7 *Patient Name: JOHN DOE*

Patient Account: 659987412554 8 Patient ID # 8888888888 9
10 Member ID: W101010101

13 AETNA LIFE INSURANCE COMPANY
14 Group Number: 660379-10-001 AB DAMG7D
17 Product: PPO Medical
20 Network ID: 00124 MASS/NEW HAMPSHIRE

11 Relation: Self
Diag: 7964 15
18 APC/DRG:

12 Member: John Doe
Group Name: ABC Company 16
19 Claim ID: EK5P5T25L00 Recd: 01/15/05

| SERVICE DATES | PL | SERVICE CODE | NUM. SVCS | SUBMITTED CHARGES | NEGOTIATED OR ALLOWED AMOUNT | COPAY AMOUNT | NOT PAYABLE | SEE REMARKS | DEDUCTIBLE | CO INSURANCE | PATIENT RESP | PAYABLE AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01/08/05 | 11 | 99213-00 | 1 | 110.00 | 90.00 | 20.00 | | | | 7.00 | 27.00 | 63.00 |
| 01/08/05 | 11 | 86021-00 | 1 | 140.00 | 96.67 | | | | | 9.67 | 9.67 | 87.00 |
| 01/08/05 | 11 | 82541-00 | 1 | 110.00 | 90.00 | | 90.00 | 1 | | | 90.00 | |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 |
| TOTALS | | | | 360.00 | 276.67 | 20.00 | 90.00 | | | 16.67 | 126.67 | 150.00 |

34

35 **ISSUED AMT: $150.00**

36 ***Remarks:***
***1 -*** *We have paid the maximum allowed by your plan of benefits for this service. The balance is the member's responsibility.*

37
**For Questions Regarding This Claim:**
P.O. Box 2250, Anytown, USA 12345-6789
***CALL 1-800-777-7777** FOR ASSISTANCE*
*Note: All Inquiries should reference the ID number above for prompt response.*

Total Patient Responsibility: 38 $126.67
Claim Payment: 39 $150.00

40

***TOTAL PAYMENT TO ELLEN SMITH, MD:*** 41 ***$150.00***

42 Protecting the privacy of member health information is a top priority at Aetna. When contacting us about this statement of for help with other questions, please be prepared to provide your Aetna provider number, tax identification number (TIN), or Social Security number (SSN), in addition to the Aetna member's ID number.

**Field Descriptions for Provider EOBs (Medical)**

1

1 – **PIN.** The name and unique provider ID number assigned by Aetna.

2 – **[Mailing Address].** The name and mailing address for the servicing physician/hospital or other practitioner.

3 – **Tax Identification Number.** The federal tax ID number for the physician/hospital or other practitioner.

4 – **Check Number.** The bank ID and check number or the EFT trace number.

5 – **Check Amount.** The amount of the check being issued.

6 – **[Notes].** Informational message display area.

7 – **Patient Name.** The full first and last name of the patient, with middle initial.

8 – **Patient Account.** A unique number supplied and used by the physician/hospital or other practitioner.

9 – **Patient ID.** The Social Security number for the member.

10 – **Member ID.** Aetna's unique Customer Member ID for the member.

11 – **Relation.** Relationship of patient to member.

12 – **Member.** The full first and last name of the member, with middle initial.

13 – **Legal Entity Name.** Name of entity that underwrites or administers this plan.

14 – **Group Number.** The group (control) number for the plan sponsor.

15 – **Diag.** Diagnosis code associated with the services.

16 – **Group Name.** The name of the plan sponsor.

17 – **Product.** The member's plan name.

18 – **APC/DRG.** The APC (Ambulatory Procedure Category) for outpatient hospital services or the DRG (Diagnostic Related Group) for inpatient hospital services. Only one of the two displays.

19 – **Claim ID/ Recd.** Claim ID Number used internally by Aetna, followed by date the claim was received.

20 – **Network ID.** Identifying number and name for the network.

21 – **Service Dates.** Month/day/year service was provided.

22 – **PL (Place).** Industry standard code that identifies the location where services were provided.

23 – **Service Code.** The procedure code that identifies the service being performed.

24 – **Num Svcs.** The number of services, procedures, days, units, etc.

25 – **Submitted Charges.** The amount billed for this service.

26 – **Negotiated or Allowed Amt.** When the physician/hospital or other practitioner is participating (in network), the rate that has been negotiated for the service. Otherwise, the amount recognized under the member's plan.

27 – **Copay Amount.** The copayment owed by the patient for this service.

28 – **Pending or Not Payable.** The amount being pended or denied. The next field (29) points to the reason.

29 – **See Remarks.** Corresponds to the remark with this number in field 36.

30 –**Deductible.** Patient deductible applied to either Field 25 or 26, depending on physician/hospital/practitioner network status and the plan.

31 – **Coinsurance.** The portion of the charge, in addition to any copay or deductible, for which the patient is responsible.

32 – **Patient Resp.** Amount for which the patient is responsible, including copay, deductible, coinsurance and any amount not covered. This can be adjusted by dollars in Field 34, in which case final patient responsibility is in Field 38.

33 – **Payable Amount.** Amount the plan pays for this service in absence of any amount identified in Field 34.

34 – **[Claim Adjustments]**. An adjustment that may impact the amount the plan will pay. Examples: amount paid by other carrier, or amount previously paid on same claim.

35 – **Issued Amt.** The plan benefit for these services after any adjustments made in Field 34.

36 – **Remarks.** Explanation of denied or pended charges, or any additional information. Corresponds to expense line above with the same number in Field 29, or the entire claim if no number is present.

*The following (37-41) appear after each patient. If a patient has more than one claim, the Total Payment Box appears at the end of the last claim.*

**37 – For Questions Regarding This Claim.** The address/telephone number that should be used for any questions.

**38 – Total Patient Responsibility.** The total amount for which the patient is responsible, after any adjustments in Field 34.

**39 – Claim Payment.** The total amount payable for this patient.

**40 – [Payment Level Adjustment].** Withhold amount, if appropriate (for single physician/hospital/practitioner EOB only).

**41 – Total Payment To.** The final payment after any adjustments in Field 40.

**42 – Privacy Message.** Message regarding ID numbers.