9B-8820*02*000003-PM-16105-120*C07ASOJPMCTOPS

UnitedHealthcare Service LLC
BUFFALO SERVICE CENTER
PO BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare
A UnitedHealth Group Company

PROVIDER REMITTANCE ADVICE

CHECK DATE: 04/14/16
TIN:
NPI:
PAYEE NAME:
CHECK NUMBER:
CHECK AMOUNT:
GROUP NUMBER:
GROUP NAME:

United Healthcare allowed the full fee charged of $425.00

PATIENT:

SUBSCRIBER ID: SUBSCRIBER NAME: CLAIM NUMBER:
CLAIM DATE: 11/04/15-12/28/15 DATE RECEIVED: PRODUCT: CHOYC+
REND PROV ID: REND PROV:

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
02	12/28/15 - 12/28/15		30520			1							0	Y3
03	12/28/15 - 12/28/15		30130	RT		1				0	PR	242	0	Y3
04	12/28/15 - 12/28/15		30130	LT		1				0	PR	59	0	EC
01	11/04/15 - 11/04/15		99243			1							0	Y3
06	11/04/15 - 11/04/15		99248			1					PR	96	$0.00	O9, N362
05	12/28/15 - 12/28/15		30999			1		$425.00	$425.00				$425.00	Y3
	12/28/15 - 12/28/15		30520			1		$0.00					$0.00	O9
CLAIM#							SUBTOTAL							MA15

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

SUBSCRIBER ID: SUBSCRIBER NAME: CLAIM NUMBER:
CLAIM DATE: 12/28/15-12/28/15 DATE RECEIVED: 03/15/16 PRODUCT: CHOYC+
REND PROV ID: REND PROV:

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
0000007710									$0.00	

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
08	12/28/15 - 12/28/15		30130	RT		1					PR	96	$0.00	O9, N362