How to read your EOB

P5921005000

ENV 37412
1 OF 1

THIS IS NOT A BILL

ABC Health

200503090105

Network Claims Administration
P.O. Box 828
Colorado Sprgs, CO 80901

Return Service Requested

Questions? Ask for Customer Relations at (888) 385-9014 or (800) 207-1018

3-DIGIT 809

37412 0.3840 AT 0.292

1

John Smith
5482 Main St.
Colorado Springs, CO 80922

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1 **Enrollee: JOHN SMITH**

2 **Patient: JOHN SMITH**

Member ID: 999999

3 **Group:** ABC HEALTH GROUP

Group #: 123

4 **Claim #:12345678-01**

5 **Patient #: 5868915**

Date:1/1/09

Explanation of Benefits for Services Provided By:

6 7 8 9

Dates of Service	Service Code	Total Charge	Ineligible	Reason Code	Covered By Plan	Deductible Amount	Co-Pay Amount	Balance	Paid At	Payment Amount
09/05/08	70	847.00	163.40	H	683.60	200.00	50.00	433.60	100%	433.60
09/05/08	87	51.00	51.00	SV	0.00	0.00	0.00	0.00	0%	0.00
	TOTAL	898.00	214.40		683.60	200.00	50.00	433.60	100%	433.60

10 11 12

Other Credits or Adjustments	0.00
Other Copay	50.00
Total Benefit Paid	433.60
This is the patient's financial responsibility to the provider all or part of this amount may have been paid at the time of service.	250.00

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Payment To:	Check No.	Amount
PLUTO FAMILY PRACTICE	000526741	433.60

Service Code

7

70 Physician Charge
87 Ineligible Charges

Reason Code Description

H – Providers contractual amount, patient is not responsible for this amount

SV – Service included in primary CP\Patient is not responsible for this amount.

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1	Member	The name of the contract holder who meets all applicable eligibility requirements.
2	Patient	The name of the person who received the service(s). This could be you, your spouse, and your dependent child who has coverage under your health plan.
3	Group	Group Name and Number.
4	Claim Number	The number assigned to the claim for tracking purposes.
5	ID Number	Unique number assigned by employer to identify enrollee and all dependents.
6	Date of Service	The date or dates the service was performed.
7	Service Code	This is a description of the service or supply provided.
8	Total Charges	Charges reported by the provider.
9	Ineligible Amounts	The amount, if any, for non-covered services or the amount that is above the allowed charge.
10	Non-Covered Charges	Charges that are written off by the provider.
11	Covered By Plan	The customary amount for a service from which your coinsurance, if applicable, will be determined.
12	Less Patients Share	Services that patients are responsible for – Includes certain non-covered charges, deductibles, copays, and coinsurance.
13	Provider of Services	Name of physician, hospital, or health-care facility that performed the service.
14	Reason Code Description	This is an explanation of non-covered amounts and payment determination for a particular service.