

ALLIED ADMINISTRATORS, INC.

PAYER ID: 94177

PO BOX 2500

SAN FRANCISCO, CA 94126

SAN FRANCISCO: (415) 986-6276

SAN DIEGO: (619) 297-8235

MEMBER NAME
MEMBER ADDRESS
CITY, STATE ZIP

EXPLANATION OF BENEFITS											
Group Name		THE GROUP HEALTH PLAN					S.S. Number		Claim Number		
							XXX-XX-1234		208-123456		
Employee		MEMBER'S NAME					Prepared By		Group #		Date
Patient		PATIENT'S NAME					Claims Examiner		099		07/07/09
TREATMENT DATES	SERV CODE	CPT CODE	CHARGE AMOUNT	NOT COVERED	REASON CODE	PPO DISCOUNT	COVERED AMOUNT	DEDUCTIBLE AMOUNT	CO-PAY AMOUNT	PCT	PAYMENT AMOUNT
A) 07/01-07/01/09	WBI	90633	60.00	.00	BC	9.91	50.09	.00	.00	90	45.08
A) 07/01-07/01/09	WBI	90649	230.00	165.85	30,BC	30.91	33.24	.00	.00	90	29.92
			290.00	165.85			40.82	83.33	.00	.00	75.00
PATIENT ACCT: 123456789A9YZ						OTHER INSURANCE CREDITS OR ADJUSTMENTS				0.00	
Department: 001						TOTAL PAYMENT AMOUNT				75.00	
PATIENT'S RESPONSIBILITY						PAYMENT INFORMATION					
Amount Not Covered:			\$165.85			Plan Payments sent to:		Date	Check No.	Amount	
Co Pay Amount:			\$0.00			A)	MARK WELLS MD	07/07/09	2222	\$75.00	
Deductible:			\$0.00			EMP)	MEMBER'S NAME	07/07/09		\$0.00	
Co-Insurance:			\$8.33								
Patient's Total Responsibility			\$174.18								
(Other Insurance Payment			\$0.00)								
SERVICE CODE						REASON CODE					
WBI WELL BABY IMMUNIZATIONS						BC AMT IN EXCESS OF PPO PROV FEE ALLOWANCE 30 MAXIMUM BENEFITS HAVE BEEN PAID FOR THIS					
MESSAGES											
BLUE CROSS PPO PROVIDER IF YOU DISAGREE W/ THE OUTCOME OF THIS CLAIM YOU MAY APPEAL IN WRITING WITHIN 180 DAYS. PLEASE SEND YOUR APPEAL TO THE CLAIM/TRUST OFFICE.											
PLEASE RETAIN FOR TAX PURPOSES. COPIES ARE NOT AVAILABLE											