REMITTANCE PAYMENT SUMMARY

NET DEPOSIT	PAYMENT DATE	TRACE / EFT #	PAYMENT METHOD
$45.75	01/01/2010	10100000000	ACH

PAYER

NYSDOH
OFFICE OF HEALTH INSURANCE PROGRAMS
ALBANY, NY 122370080

PAYEE

MAJOR MEDICAL PROVIDER
,
NPI: 9999999995

FINANCIAL SUMMARY

Total Submitted Charges	$102.50
Less Payer Adjustments:	
Contractual Obligations (CO)	$56.75
Patient Responsibility (PR)	$0.00
Payer-Initiated Reductions (PI)	$0.00
Other Adjustments (OA)	$0.00
Corrections & Reversals (CR)	$0.00
Net Claim Paid Amount	$45.75
Provider-Level Adj. (PLB)	$0.00
Net Payment / Deposit Total	$45.75

AUDIT SUMMARY

Total Claims Processed	3
Claims w/ Balance Review Flags	0

835 BALANCE REVIEW: Net Claim Paid $45.75 - PLB $0.00 = $45.75 vs BPR02 $45.75 [BALANCED]

X12 tracking - ISA: 006000600 GS: 6000600 ST: 1740

BATCHED CLAIMS REMITTANCE SUMMARY

X12 TRACKING DATA

ISA:006000600 **GS:**6000600 **ST:**1740

835 PAYMENT TRACKING

TRANSACTION HANDLING CODE:	Remittance Information Only
ACTUAL PROVIDER PAYMENT:	$45.75
CREDIT / DEBIT FLAG CODE:	Credit
PAYMENT METHOD CODE:	Automated Clearing House (ACH)
PAYMENT FORMAT CODE:	Cash Concentration/Disbursement plus Addenda (CCD+)
PAYOR ABA TRANSIT ROUTING NUMBER:	111
PAYOR BANK ACCOUNT NUMBER:	33
PAYOR IDENTIFIER:	1234567890
PAYOR SUPPLEMENTAL CODE:	(n/a)
RECEIVER ABA TRANSIT ROUTING NUMBER:	111
RECEIVER ACCOUNT NUMBER QUALIFIER:	Demand Deposit
RECEIVER ACCOUNT NUMBER:	22
CHECK ISSUE / EFT EFFECTIVE DATE:	01/01/2010
CHECK / EFT TRACE NUMBER:	10100000000
CURRENCY CODE:	(n/a)
CURRENCY RATE:	(n/a)
RECEIVER ID NUMBER:	ETIN
ADJUDICATION SYSTEM VERSION CODE - LOCAL:	(n/a)
ADJUDICATION CYCLE PRODUCTION DATE:	01/01/2010

PAYOR	PAYEE
NYSDOH OFFICE OF HEALTH INSURANCE PROGRAMS CORNING TOWER, EMPIRE STATE PLAZA ALBANY, NY 122370080 PHONE: (800) 343-9000	MAJOR MEDICAL PROVIDER NPI: 9999999995 FED TAX ID: 000000000

PAYMENT ADJUSTMENTS

Payer-Assigned Provider ID	Fiscal Period End Date	Adjustment Reason	Adjustment ID	Adjustment Amount
NO TRANSACTION ADJUSTMENTS REPORTED				

835 CLAIM REMITTANCE ADVICE

SUBMITTER CLAIM ID	**PATIENT**	**SUBMITTED CHARGES**	**CHECK / EFT EFFECTIVE DATE**
MEDICAL RECORD NUMBER	**PATIENT MEMBER ID**	**CONTRACTUAL OBLIG**	**CHECK / EFT TRACE #**
DATE OF SERVICE(S)	**SUBSCRIBER**	**PAYOR INIT REDUCTIONS**	
	SUBSCRIBER MEMBER ID	**CORRECTION & REVERSAL**	
PAYOR	**GROUP / POLICY #**	**PATIENT RESPONSIBILITY**	
PAYOR CLAIM ID	**TYPE OF CLAIM**	**OTHER ADJUSTMENTS**	**RENDERING PROVIDER**
PAYOR AUTHORIZATION #	**TYPE OF BILL**	**PAYOR PAID**	**RENDERING PROVIDER ID**
PATIENT ACCOUNT NUMBER	SUBMITTED LAST, SUBMITTED FIRST	$34.25	01/01/2010
PATIENT ACCOUNT NUMBER	LL99999L	$0.00	10100000000
01/01/2010 - 01/01/2010	SUBMITTED LAST, SUBMITTED FIRST	$0.00	
	LL99999L	$0.00	
NYSDOH	(n/a)	$0.00	
1000210000000030	MC	$0.00	MAJOR MEDICAL PROVIDER
(n/a)	11	$34.25	(n/a)

STATUS: PROCESSED AS PRIMARY

CLAIM SUMMARY DATA

COVERAGE AMOUNT: $34.25

PAYOR	PAYEE
NYSDOH OFFICE OF HEALTH INSURANCE PROGRAMS CORNING TOWER, EMPIRE STATE PLAZA ALBANY, NY 122370080 PHONE: (800) 343-9000	MAJOR MEDICAL PROVIDER NPI: 9999999995 FED TAX ID: 000000000

SERVICE ADJUSTMENTS

LN	DOS	Procedure / Service Code	REV	PAID QTY	CHRGS	ALLOW	CONTR OBLIG	PAYOR INIT	CORR & REV	PAT RESP	OTHER ADJ	PAYOR PAID	REASON/ REMARKS
00	01/01/2010	V2020 RB		1	$6.00	$6.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.00	
00	01/01/2010	V2700 RB		1	$2.75	$2.75	$0.00	$0.00	$0.00	$0.00	$0.00	$2.75	
00	01/01/2010	V2103 RB		1	$5.50	$5.50	$0.00	$0.00	$0.00	$0.00	$0.00	$5.50	
00	01/01/2010	S0580		2	$20.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	$20.00	
TOTAL SERVICE ADJUSTMENTS:					$34.25	$34.25	$0.00	$0.00	$0.00	$0.00	$0.00	$34.25	
TOTAL CLAIM ADJUSTMENTS:							$0.00	$0.00	$0.00	$0.00	$0.00		
NET REMITTANCE ADJUSTMENT TOTALS:					**$34.25**	**$34.25**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$34.25**	

REASON / REMARK CODE DESCRIPTIONS

835 CLAIM REMITTANCE ADVICE

SUBMITTER CLAIM ID	**PATIENT**	**SUBMITTED CHARGES**	**CHECK / EFT EFFECTIVE DATE**
MEDICAL RECORD NUMBER	**PATIENT MEMBER ID**	**CONTRACTUAL OBLIG**	**CHECK / EFT TRACE #**
DATE OF SERVICE(S)	**SUBSCRIBER**	**PAYOR INIT REDUCTIONS**	
	SUBSCRIBER MEMBER ID	**CORRECTION & REVERSAL**	
PAYOR	**GROUP / POLICY #**	**PATIENT RESPONSIBILITY**	
PAYOR CLAIM ID	**TYPE OF CLAIM**	**OTHER ADJUSTMENTS**	**RENDERING PROVIDER**
PAYOR AUTHORIZATION #	**TYPE OF BILL**	**PAYOR PAID**	**RENDERING PROVIDER ID**
PATIENT ACCOUNT NUMBER	SUBMITTED LAST, SUBMITTED FIRST	$34.00	01/01/2010
PATIENT ACCOUNT NUMBER	LL88888L	$34.00	10100000000
01/01/2010 - 01/01/2010	SUBMITTED LAST, SUBMITTED FIRST	$0.00	
	LL88888L	$0.00	
NYSDOH	(n/a)	$0.00	
1000220000000020	MC	$0.00	MAJOR MEDICAL PROVIDER
(n/a)	11	$0.00	(n/a)

STATUS: PROCESSED AS SECONDARY

PAYOR	PAYEE
NYSDOH OFFICE OF HEALTH INSURANCE PROGRAMS CORNING TOWER, EMPIRE STATE PLAZA ALBANY, NY 122370080 PHONE: (800) 343-9000	MAJOR MEDICAL PROVIDER NPI: 9999999995 FED TAX ID: 000000000

SERVICE ADJUSTMENTS

LN	DOS	Procedure / Service Code	REV	PAID QTY	CHRGS	ALLOW	CONTR OBLIG	PAYOR INIT	CORR & REV	PAT RESP	OTHER ADJ	PAYOR PAID	REASON/ REMARKS
00	01/01/2010	V2020		0	$12.00	$0.00	$12.00	$0.00	$0.00	$0.00	$0.00	$0.00	CO29
00	01/01/2010	V2103		0	$22.00	$0.00	$22.00	$0.00	$0.00	$0.00	$0.00	$0.00	CO29
TOTAL SERVICE ADJUSTMENTS:					$34.00	$0.00	$34.00	$0.00	$0.00	$0.00	$0.00	$0.00	
TOTAL CLAIM ADJUSTMENTS:							$0.00	$0.00	$0.00	$0.00	$0.00		
NET REMITTANCE ADJUSTMENT TOTALS:					**$34.00**	**$0.00**	**$34.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

REASON / REMARK CODE DESCRIPTIONS

CO (Contractual Obligation) 29 - The time limit for filing has expired.

835 CLAIM REMITTANCE ADVICE

SUBMITTER CLAIM ID	**PATIENT**	**SUBMITTED CHARGES**	**CHECK / EFT EFFECTIVE DATE**
MEDICAL RECORD NUMBER	**PATIENT MEMBER ID**	**CONTRACTUAL OBLIG**	**CHECK / EFT TRACE #**
DATE OF SERVICE(S)	**SUBSCRIBER**	**PAYOR INIT REDUCTIONS**	
	SUBSCRIBER MEMBER ID	**CORRECTION & REVERSAL**	
PAYOR	**GROUP / POLICY #**	**PATIENT RESPONSIBILITY**	
PAYOR CLAIM ID	**TYPE OF CLAIM**	**OTHER ADJUSTMENTS**	**RENDERING PROVIDER**
PAYOR AUTHORIZATION #	**TYPE OF BILL**	**PAYOR PAID**	**RENDERING PROVIDER ID**
PATIENT ACCOUNT NUMBER	SUBMITTED LAST, SUBMITTED FIRST	$34.25	01/01/2010
PATIENT ACCOUNT NUMBER	LL77777L	$22.75	10100000000
01/01/2010 - 01/01/2010	SUBMITTED LAST, SUBMITTED FIRST	$0.00	
	LL77777L	$0.00	
NYSDOH	(n/a)	$0.00	
1000230000000020	MC	$0.00	MAJOR MEDICAL PROVIDER
(n/a)	11	$11.50	(n/a)

STATUS: PROCESSED AS SECONDARY

CLAIM SUMMARY DATA

COVERAGE AMOUNT: $11.50

PAYOR	PAYEE
NYSDOH OFFICE OF HEALTH INSURANCE PROGRAMS CORNING TOWER, EMPIRE STATE PLAZA ALBANY, NY 122370080 PHONE: (800) 343-9000	MAJOR MEDICAL PROVIDER NPI: 9999999995 FED TAX ID: 000000000

SERVICE ADJUSTMENTS

LN	DOS	Procedure / Service Code	REV	PAID QTY	CHRGS	ALLOW	CONTR OBLIG	PAYOR INIT	CORR & REV	PAT RESP	OTHER ADJ	PAYOR PAID	REASON/ REMARKS
001	01/01/2010	V2020 RB		1	$6.00	$6.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.00	
002	09/17/2013	V2103 RB		1	$5.50	$5.50	$0.00	$0.00	$0.00	$0.00	$0.00	$5.50	
003	01/01/2010	V2700 RB		0	$2.75	$0.00	$2.75	$0.00	$0.00	$0.00	$0.00	$0.00	CO251 HEN206
004	01/01/2010	S0580		0	$20.00	$0.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	CO251 HEN206
TOTAL SERVICE ADJUSTMENTS:					$34.25	$11.50	$22.75	$0.00	$0.00	$0.00	$0.00	$11.50	
TOTAL CLAIM ADJUSTMENTS:							$0.00	$0.00	$0.00	$0.00	$0.00		
NET REMITTANCE ADJUSTMENT TOTALS:					**$34.25**	**$11.50**	**$22.75**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$11.50**	

REASON / REMARK CODE DESCRIPTIONS

CO (Contractual Obligation) 251 - The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or
RARC N206 - The supporting documentation does not match the information sent on the claim.