

201009162018



Coventry Health Care of Louisiana, Inc
CoventryCares of Louisiana
Address 1
City, ST 12345-0000

CHECK STOCK

TEST



Electronic Service Requested

ENV 1 2 OF 7 F



Provider Name
PO BOX 12345
CITY, ST 12345

Remittance Advice Check

Date:	01/05/2011
Provider Number:	4791
Provider Name:	Provider Name Here
Check Date:	01/05/2011
Check Number:	0000001
Check Amount:	\$805.20

Please retain this portion for your records

If you would like to return this check please mail to:
CoventryCares of Louisiana
Street Address
City, ST 12345-6789

If you would like to mail a refund please mail to:
CoventryCares of Louisiana
Street Address
City, ST 12345-6789



Check Number: 0000001 62-20
Check Date: 01/05/2011 311

Void After 90 Days

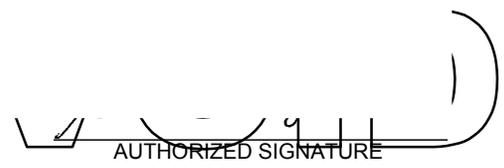
Pay: Eight Hundred Five & 20/100 Dollars

\$ 805.20**

AMOUNT IN U.S. DOLLARS
CDA 3xxxxxxx7

Pay To: Provider Name
PO BOX 12345
-
CITY, ST 12345

BANK NAME
BANK CITY, ST 12345


AUTHORIZED SIGNATURE

Remittance Advice Summary Coventry Care of Louisiana, Inc

Pay Date: 01/05/2011

Provider 4791: Provider Name NPI#:1588613343

Patient Name: Last, First L	Member #: 123456789*01	Claim #: 0000000001	Carrier: HEALTH PLAN INC
Account #: 281901-1766169	Date Received: 01/05/2010	Auth. #: 156513	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: SYED MD,JAVEED S	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
11/03/09-11/03/09	99239			HOSPITAL DISCH	N	\$111.00	\$51.87	\$59.13	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$51.87
Check #: 1120262						Claim Totals	\$111.00	\$51.87	\$59.13		\$0.00	\$0.00	\$0.00	\$0.00			\$51.87

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000002	Carrier: HEALTH PLAN INC
Account #: 252088-1790711	Date Received: 01/01/2010	Auth. #: 161930	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/23/09-12/23/09	99233			SUBSEQ HOSP C	N	\$152.00	\$52.45	\$99.55	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45
Check #: 1120262						Claim Totals	\$152.00	\$52.45	\$99.55		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000003	Carrier: HEALTH PLAN INC
Account #: 252088-1790720	Date Received: 01/01/2010	Auth. #: 161930	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/25/09-12/25/09	99238			HOSPITAL DISCH	N	\$89.00	\$35.81	\$53.19	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$35.81
Check #: 1120262						Claim Totals	\$89.00	\$35.81	\$53.19		\$0.00	\$0.00	\$0.00	\$0.00			\$35.81

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000004	Carrier: HEALTH PLAN INC
Account #: 252088-1790714	Date Received: 01/01/2010	Auth. #: 154419	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
10/05/09-10/05/09	99231			SUBSEQ HOSP C	N	\$75.00	\$20.36	\$54.64	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$20.36
Check #: 1120262						Claim Totals	\$75.00	\$20.36	\$54.64		\$0.00	\$0.00	\$0.00	\$0.00			\$20.36

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000005	Carrier: HEALTH PLAN INC
Account #: 252088-1790714	Date Received: 01/01/2010	Auth. #: 161930	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/24/09-12/24/09	99233			SUBSEQ HOSP C	N	\$152.00	\$52.45	\$99.55	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45
Check #: 1120262						Claim Totals	\$152.00	\$52.45	\$99.55		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45

VOID

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Remittance Advice Summary Coventry Health Care of Louisiana, Inc.

WHITE STOCK

Pay Date: 01/05/2011

Provider 4791: Provider Name NPI#:1588613343

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000006	Carrier: HEALTH PLAN INC
Account #: 252088-1788634	Date Received: 12/28/2009	Auth. #: 161930	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/22/09-12/22/09	99223			INITIAL HOSP/PE	N	\$237.00	\$98.26	\$138.74	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$98.26
Check #: 1120262				Claim Totals		\$237.00	\$98.26	\$138.74			\$0.00	\$0.00	\$0.00	\$0.00			\$98.26

Patient Name: Last, First M	Member #: 123456789*01	Claim #: 0000000007	Carrier: HEALTH PLAN INC
Account #: 286687-1791887	Date Received: 01/04/2010	Auth. #: 162137	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/27/09-12/27/09	99238			HOSPITAL DISCH	N	\$89.00	\$35.81	\$53.19	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$35.81
Check #: 1120262				Claim Totals		\$89.00	\$35.81	\$53.19			\$0.00	\$0.00	\$0.00	\$0.00			\$35.81

Patient Name: Last, First M	Member #: 123456789*01	Claim #: 0000000008	Carrier: HEALTH PLAN INC
Account #: 286687-1791881	Date Received: 01/04/2010	Auth. #: 162137	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/23/09-12/23/09	99223			INITIAL HOSP/PE	N	\$237.00	\$98.26	\$138.74	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$98.26
Check #: 1120262				Claim Totals		\$237.00	\$98.26	\$138.74			\$0.00	\$0.00	\$0.00	\$0.00			\$98.26

Patient Name: Last, First M	Member #: 123456789*01	Claim #: 0000000009	Carrier: HEALTH PLAN INC
Account #: 286687-1791883	Date Received: 01/04/2010	Auth. #: 162137	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/24/09-12/24/09	99233			SUBSEQ HOSP C	N	\$152.00	\$52.45	\$99.55	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45
Check #: 1120262				Claim Totals		\$152.00	\$52.45	\$99.55			\$0.00	\$0.00	\$0.00	\$0.00			\$52.45

Patient Name: Last, First M	Member #: 123456789*01	Claim #: 0000000010	Carrier: HEALTH PLAN INC
Account #: 286687-1791886	Date Received: 01/04/2010	Auth. #: 162137	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/26/09-12/26/09	99233			SUBSEQ HOSP C	N	\$152.00	\$52.45	\$99.55	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45
Check #: 1120262				Claim Totals		\$152.00	\$52.45	\$99.55			\$0.00	\$0.00	\$0.00	\$0.00			\$52.45

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Remittance Advice Summary Coventry Health Care of Louisiana, Inc

WHITE STOCK

Pay Date: 01/05/2011

Provider 4791: Provider Name NPI#:1588613343

Patient Name: Last, First M	Member #: 123456789*01	Claim #: 0000000011	Carrier: HEALTH PLAN INC
Account #: 286687-1791884	Date Received: 01/04/2010	Auth. #: 162137	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/25/09-12/25/09	99233			SUBSEQ HOSP C	N	\$152.00	\$52.45	\$99.55	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45
Check #: 1120262				Claim Totals		\$152.00	\$52.45	\$99.55			\$0.00	\$0.00	\$0.00	\$0.00			\$52.45

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000012	Carrier: HEALTH PLAN INC
Account #: 2513	Date Received: 12/31/2009	Auth. #: 101598	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: KARMAN MD,STEPHEN J	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
02/19/09-02/19/09	99233			SUBSEQ HOSP C	N	\$152.00	\$52.45	\$99.55	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$52.45
Check #: 1120262				Claim Totals		\$152.00	\$52.45	\$99.55			\$0.00	\$0.00	\$0.00	\$0.00			\$52.45

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000013	Carrier: HEALTH PLAN INC
Account #: 251	Date Received: 12/31/2009	Auth. #: 101598	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: KARMAN MD,STEPHEN J	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
02/18/09-02/18/09	99223			INITIAL HOSP/PE	N	\$237.00	\$98.26	\$138.74	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$98.26
Check #: 1120262				Claim Totals		\$237.00	\$98.26	\$138.74			\$0.00	\$0.00	\$0.00	\$0.00			\$98.26

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000014	Carrier: HEALTH PLAN INC
Account #: 251	Date Received: 12/31/2009	Auth. #: 101598	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/05/2010	Claim Provider: KARMAN MD,STEPHEN J	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
02/20/09-02/20/09	99239			HOSPITAL DISCH	N	\$111.00	\$51.87	\$59.13	1197		\$0.00	\$0.00	\$0.00	\$0.00			\$51.87
Check #: 1120262				Claim Totals		\$111.00	\$51.87	\$59.13			\$0.00	\$0.00	\$0.00	\$0.00			\$51.87

Patient Name: Last, First L	Member #: 123456789*01	Claim #: 0000000015	Carrier: HEALTH PLAN INC
Account #: 243151-1765926	Date Received: 01/01/2010	Auth. #:	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: OUTPT HOSPITAL	Processed Date: 01/01/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
11/02/09-11/02/09	99217			OBSERVATION C	N	\$103.00	\$0.00	\$103.00	0229		\$0.00	\$0.00	\$0.00	\$0.00			\$0.00
Check #:				Claim Totals		\$103.00	\$0.00	\$103.00			\$0.00	\$0.00	\$0.00	\$0.00			\$0.00

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Remittance Advice Summary Coventry Health Care of Louisiana, Inc.

WHITE STOCK

Pay Date: 01/05/2011

Provider 4791: Provider Name NPI#:1588613343

Patient Name: Last, First L	Member #: 123456789*01	Claim #: 0000000016	Carrier: HEALTH PLAN INC
Account #: 243151-1764573	Date Received: 01/01/2010	Auth. #:	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: OUTPT HOSPITAL	Processed Date: 01/01/2010	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
11/01/09-11/01/09	99215			OFFICE/OP VISIT	N	\$144.00	\$0.00	\$144.00	0229		\$0.00	\$0.00	\$0.00	\$0.00			\$0.00
Check #:				Claim Totals		\$144.00	\$0.00	\$144.00			\$0.00	\$0.00	\$0.00	\$0.00			\$0.00

Patient Name: Last, First L	Member #: 123456789*01	Claim #: 0000000017	Carrier: HEALTH PLAN INC
Account #: 243151-1778740	Date Received: 12/25/2009	Auth. #:	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: OUTPT HOSPITAL	Processed Date: 12/28/2009	Claim Provider: ROGERSROLLINGS MD,DI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
11/29/09-11/29/09	99217			OBSERVATION C	N	\$103.00	\$0.00	\$103.00	0229		\$0.00	\$0.00	\$0.00	\$0.00			\$0.00
Check #:				Claim Totals		\$103.00	\$0.00	\$103.00			\$0.00	\$0.00	\$0.00	\$0.00			\$0.00

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000018	Carrier: HEALTH PLAN INC
Account #: 252088-1550707	Date Received: 01/01/2010	Auth. #: 109132	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 01/01/2010	Claim Provider: DEVABHAKTUNI MD,NALI	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
03/09/09-03/09/09	99223			INITIAL HOSP/PE	N	\$237.00	\$0.00	\$237.00	0212		\$0.00	\$0.00	\$0.00	\$0.00			\$0.00
Check #:				Claim Totals		\$237.00	\$0.00	\$237.00			\$0.00	\$0.00	\$0.00	\$0.00			\$0.00

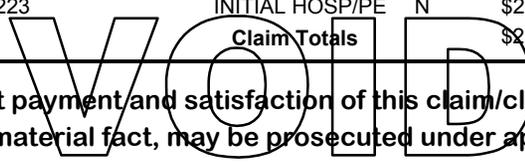
Patient Name: Last, First H	Member #: 123456789*01	Claim #: 0000000019	Carrier: HEALTH PLAN INC
Account #: 220081	Date Received: 12/24/2009	Auth. #: 155352	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: OUTPT HOSPITAL	Processed Date: 12/29/2009	Claim Provider: SYED MD,JAVEED S	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
10/12/09-10/12/09	99220			INITIAL OBSERV/	N	\$210.00	\$78.10	\$210.00	0226		\$0.00	\$0.00	\$0.00	\$0.00			\$0.00
Check #:				Claim Totals		\$210.00	\$78.10	\$210.00			\$0.00	\$0.00	\$0.00	\$0.00			\$0.00

Patient Name: Last, First	Member #: 123456789*01	Claim #: 0000000020	Carrier: HEALTH PLAN INC
Account #: 286387-1789215	Date Received: 12/28/2009	Auth. #:	Network/Division: PRIMARY CARE PHYSICIAN
Place of Service: INPT HOSPITAL	Processed Date: 12/28/2009	Claim Provider: AHMED MD,IFTIKHAR	Product: MCAD-VHP

Service Dates	Proc Code	Mod Code	DRG/ APC	Procedure Description	Cap	Total Charges	Allowed Amount	Ineligible Amount	Inelig DC	COB DC	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Mbr DC	Adj RC	Paid Amt
12/22/09-12/22/09	99223			INITIAL HOSP/PE	N	\$237.00	\$0.00	\$0.00			\$0.00	\$0.00	\$0.00	\$237.00	0218		\$0.00
Check #:				Claim Totals		\$237.00	\$0.00	\$0.00			\$0.00	\$0.00	\$0.00	\$237.00			\$0.00

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Remittance Advice Summary Coventry Health Care of Louisiana, Inc

WHITE STOCK

Pay Date: 01/05/2011

Provider 4791: Provider Name NPI#:1588613343

Provider Summary:

	Total Charges	Allowed Amount	Ineligible Amount	Deductible Amount	CoPay Amount	Mbr. Coins.	Mbr Respons	Paid Amt
Non-Statistical Claims Line Totals	\$3,132.00	\$883.30	\$2,089.80	\$0.00	\$0.00	\$0.00	\$237.00	\$805.20
Provider Claims Total	\$3,132.00	\$883.30	\$2,089.80	\$0.00	\$0.00	\$0.00	\$237.00	\$805.20

Provider Check Summary:

Check Number	Check Date	Check Amount
0000001	01/05/2010	\$805.20

Remark Code Descriptions are located at: <http://www.wpc-edi.com/codes/remittanceadvice>

Ineligible Disposition Codes (Remark Codes)

Description (Inelig DC, COB DC, ADJ RC):

0226	(N54)	REJ-CLAIMS DATA MISMATCH AGAINST AUTHORIZATION
0212		REJ-TIME LIMIT FOR FILING HAS EXPIRED
0229		REJ-SERVICES NOT AUTHORIZED
1197		REJ-AMOUNT IN EXCESS OF THE MEDICAID ALLOWED AMOUNT

Member Disposition Codes (Remark Codes)

Description (Mbr DC):

0218	REJ-MEMBER EFFECTIVE DATE ERROR
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TEST

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VOID





Coventry Health Care of Louisiana, Inc.
CoventryCares of Louisiana
Address 1
City, ST 12345-0000

WHITE STOCK

TEST

THIS IS NOT A BILL
EXPLANATION OF BENEFITS



6 OF 7 F
ENV 1

Electronic Service Requested

Our organization processes the claims submitted from your health care provider(s). You have received this Explanation of Benefits (EOB) as our notification to you explaining how your claim(s), including payments or denials, are being processed.



Insured Name
ADDRESS 1
CITY, ST 12345

Payments made on behalf of:	
CoventryCares of Louisiana	
Insured:	Insured Name
Patient:	Last, First M
Group Name:	Group Name
ID Number:	98765432101
Date:	01/05/2011

****Payments made at the time services were rendered are not reflected on this statement.****

Claim Number:	890000000	Provider:	SERVICE PROVIDER NAME
Plan Paid:	\$0.00	Provider Billing Address:	123 MAIN ST PROVIDER CITY, ST 12345-8048
Member Responsibility:	\$0.00	**Provider billing address may differ from physical office location**	

Service Date From - To Proc Code / Description	Billed Amount	Contractual Adjustment	Approved Amount	Member's Responsibility to Provider				Plan Paid	Cont./Rmk	Other Rmk
				Copay	Coins	Deduct.	Other			
12/23/09-12/23/09 99213 /OFFICE VISIT - F/U	\$90.00	\$90.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0229	
TOTALS:	\$90.00	\$90.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		

Contractual Remarks:

0229 - SERVICES NOT AUTHORIZED

To ensure that your health plan was properly billed, please review the services listed on your explanation of benefits. If you believe any of the services were incorrectly billed, contact a customer service representative using the toll free number listed on your insurance card.

VOID