

Community Health Plan
720 Olive way
Ste 300
Seattle, WA 98101



Forwarding Service Requested

**If you have any questions, contact
our Customer Service Department at
(800) 942-0247**

CHC OF KING COUNTY
PO BOX 3663
SEATTLE, WA 98124-3663

Payee: CHC OF KING COUNTY
Payee ID: PRV10000925967
Voucher #: 10000043
Provider: SKINNER, SUZANNE F
Provider ID: PRV10000929732
Provider TIN: 910884412

Remittance Advice Process Date: 2/19/2007

Patient: LATTIMER, MARY L			Subscriber Name: LATTIMER, MARY L			Encounter No: 07047000010							
Member ID: HP1000107000			Subscriber SSN:			PCP: CENTRAL WA FAMILY PHYSICIANS							
Patient Account No:			Program: Medicare Advantage Part D			Primary Diag Code: V77.1							
Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/02/2007-02/02/2007	82950	1	PAID	\$15.00	\$6.64	\$8.36	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$6.64	
02/02/2007-02/02/2007	82951	1	DENIED	\$15.00	\$0.00	\$15.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	CHP084
Totals for Encounter :				\$30.00	\$6.64	\$23.36	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$6.64	

Patient: LATTIMER, MARY L			Subscriber Name: LATTIMER, MARY L			Encounter No: 07047000014							
Member ID: HP1000107000			Subscriber SSN:			PCP: CENTRAL WA FAMILY PHYSICIANS							
Patient Account No:			Program: Medicare Advantage Part D			Primary Diag Code: 719.43							
Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/08/2007-02/08/2007	99213	1	DENIED	\$85.00	\$63.30	\$21.70	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	D77E
Totals for Encounter :				\$85.00	\$63.30	\$21.70	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

Explanation of Reason Codes:

[D77E]D77E-Provider type does not match authorized provider type

Patient: LATTIMER, MARY L			Subscriber Name: LATTIMER, MARY L			Encounter No: 07047000015							
Member ID: HP1000107000			Subscriber SSN:			PCP: CENTRAL WA FAMILY PHYSICIANS							
Patient Account No:			Program: Medicare Advantage Part D			Primary Diag Code: 719.43							
Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/09/2007-02/09/2007	99213	1	PAID	\$85.00	\$63.30	\$21.70	\$30.00	\$30.00	\$0.00	\$0.00	\$0.00	\$33.30	
02/09/2007-02/09/2007	81000	1	PAID	\$10.00	\$4.43	\$5.57	\$1.11	\$0.00	\$1.11	\$0.00	\$0.00	\$3.32	
Totals for Encounter :				\$95.00	\$67.73	\$27.27	\$31.11	\$30.00	\$1.11	\$0.00	\$0.00	\$36.62	

Totals for Provider:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Amount Paid
\$210.00	\$137.67	\$72.33	\$31.11	\$30.00	\$1.11	\$0.00	\$43.26

Totals for Vendor:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Advance Amount	Amount Paid
\$210.00	\$137.67	\$72.33	\$31.11	\$30.00	\$1.11	\$0.00	\$0.00	\$0.00	\$43.26

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CHC OF SNOHOMISH COUNTY
 DEPT 5035 PO BOX 34936
 SEATTLE, WA 98124-1936

Payee: CHC OF SNOHOMISH COUNTY
Payee ID: PRV10000927985
Voucher #:
Provider: TOCHER, THOMAS M
Provider ID: PRV10000929052
Provider TIN: 911255170

Remittance Advice **Process Date:** 2/19/2007

Patient: LATTIMER, MARY L **Subscriber Name:** LATTIMER, MARY L **Encounter No:** 07047000011
Member ID: HP1000107000 **Subscriber SSN:** **PCP:** CENTRAL WA FAMILY PHYSICIANS
Patient Account No: **Program:** Medicare Advantage Part D **Primary Diag Code:** V77.1

Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/05/2007-02/05/2007	82950	1	DENIED	\$50.00	\$6.64	\$0.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	M0020

Totals for Encounter :

\$50.00	\$6.64	\$0.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
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Explanation of Reason Codes:

[M0020]M0020-Benefit Visit Limit Exceeded

Totals for Provider:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Amount Paid
\$50.00	\$6.64	\$0.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00

Totals for Vendor:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Advance Amount	Amount Paid
\$50.00	\$6.64	\$0.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

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HARBORVIEW MEDICAL CENTER
 PO BOX 34001
 Seattle, WA 98124

Payee: HARBORVIEW MEDICAL CENTER
Payee ID: PRV20001358149
Voucher #: 10000044
Provider: HARBORVIEW MEDICAL CENTER
Provider ID: PRV10000928005
Provider TIN: 911631806

Remittance Advice **Process Date:** 2/19/2007

Patient: LATTIMER, MARY L **Subscriber Name:** LATTIMER, MARY L **Encounter No:** 07043E00045
Member ID: HP1000107000 **Subscriber SSN:** **PCP:** CENTRAL WA FAMILY PHYSICIANS
Patient Account No: 1426510001 **Program:** Medicare Advantage Part D **Primary Diag Code:** 738.8

Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
01/23/2007-01/23/2007	0320 73000 RT	1	PAID	\$95.00	\$46.90	\$48.10	\$11.72	\$0.00	\$11.72	\$0.00	\$0.00	\$35.18	

Totals for Encounter :

\$95.00	\$46.90	\$48.10	\$11.72	\$0.00	\$11.72	\$0.00	\$0.00	\$35.18
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Totals for Provider:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Amount Paid
\$95.00	\$46.90	\$48.10	\$11.72	\$0.00	\$11.72	\$0.00	\$35.18

Totals for Vendor:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Advance Amount	Amount Paid
\$95.00	\$46.90	\$48.10	\$11.72	\$0.00	\$11.72	\$0.00	\$0.00	\$0.00	\$35.18

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MULTICARE HEALTH SYSTEM
PO BOX 34697
SEATTLE, WA 98124

Payee: MULTICARE HEALTH SYSTEM
Payee ID: PRV10000927994
Voucher #: 10000045
Provider: KRAMP, STEPHEN G
Provider ID: PRV10000929172
Provider TIN: 911352172

Remittance Advice Process Date: 2/19/2007

Patient: LATTIMER, MARY L **Subscriber Name:** LATTIMER, MARY L **Encounter No:** 07047000012
Member ID: HP1000107000 **Subscriber SSN:** **PCP:** CENTRAL WA FAMILY PHYSICIANS
Patient Account No: **Program:** Medicare Advantage Part D **Primary Diag Code:** 719.43

Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/07/2007-02/07/2007	99213	1	PAID	\$85.00	\$58.74	\$26.26	\$30.00	\$30.00	\$0.00	\$0.00	\$0.00	\$28.74	

Totals for Encounter :

\$85.00	\$58.74	\$26.26	\$30.00	\$30.00	\$0.00	\$0.00	\$0.00	\$28.74
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Totals for Provider:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Amount Paid
\$85.00	\$58.74	\$26.26	\$30.00	\$30.00	\$0.00	\$0.00	\$28.74

Totals for Vendor:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Advance Amount	Amount Paid
\$85.00	\$58.74	\$26.26	\$30.00	\$30.00	\$0.00	\$0.00	\$0.00	\$0.00	\$28.74

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PUGET SOUND NEIGHBORHOOD HLTH
 905 SPRUCE ST STE 300
 SEATTLE, WA 98104-2474

Payee: PUGET SOUND NEIGHBORHOOD HLTH
Payee ID: PRV10000925972
Voucher #: 10000046
Provider: ANDERSON, BRITT ARICK
Provider ID: PRV10000931265
Provider TIN: 910893287

Remittance Advice Process Date: 2/19/2007

Patient: JONES, VERA L	Subscriber Name: JONES, VERA L	Encounter No: 07050000003
Member ID: HP1000051900	Subscriber SSN: 438345546	PCP: PENINSULA COMM HLTH SVC BREMERTON
Patient Account No:	Program: Medicare Advantage	Primary Diag Code: 252.00

Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
01/02/2007-01/02/2007	77078	1	PAID	\$147.75	\$147.75	\$0.00	\$29.55	\$0.00	\$29.55	\$0.00	\$0.00	\$118.20	
02/02/2007-02/02/2007	77081	1	DENIED	\$56.00	\$43.87	\$0.00	\$56.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	M0020
Totals for Encounter :													
				\$203.75	\$191.62	\$0.00	\$85.55	\$0.00	\$29.55	\$0.00	\$0.00	\$118.20	

Explanation of Reason Codes:

[M0020]M0020-Benefit Visit Limit Exceeded
 Paid at {benepercent} of contract amount.

Totals for Provider:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Amount Paid
\$203.75	\$191.62	\$0.00	\$85.55	\$0.00	\$29.55	\$0.00	\$118.20

Totals for Vendor:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Advance Amount	Amount Paid
\$203.75	\$191.62	\$0.00	\$85.55	\$0.00	\$29.55	\$0.00	\$0.00	\$0.00	\$118.20

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RONALD L ACKERMAN
1826 Space Ave
Seattle, WA 98101

Payee: RONALD L ACKERMAN
Payee ID: PRV20001358206
Voucher #: 10000048
Provider: JETSON, GEORGE T
Provider ID: PRV20001358206
Provider TIN: 789456123

Remittance Advice Process Date: 2/19/2007

Patient: ACKERMAN, RONALD L			Subscriber Name: ACKERMAN, RONALD L			Encounter No: 07050000004							
Member ID: HP1000029700			Subscriber SSN: 537382182			PCP: 45TH STREET CLINIC							
Patient Account No:			Program: Medicare Advantage			Primary Diag Code: 466.19							
Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/14/2007-02/14/2007	99213	1	PAID	\$50.00	\$50.00	\$0.00	\$25.00	\$25.00	\$0.00	\$0.00	\$0.00	\$25.00	
02/14/2007-02/14/2007	81000	1	PAID	\$32.00	\$4.43	\$27.57	\$0.89	\$0.00	\$0.89	\$0.00	\$0.00	\$3.54	
Totals for Encounter :				\$82.00	\$54.43	\$27.57	\$25.89	\$25.00	\$0.89	\$0.00	\$0.00	\$28.54	

Patient: ACKERMAN, RONALD L			Subscriber Name: ACKERMAN, RONALD L			Encounter No: 07050000005							
Member ID: HP1000029700			Subscriber SSN: 537382182			PCP: 45TH STREET CLINIC							
Patient Account No:			Program: Medicare Advantage			Primary Diag Code: 799.9							
Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/19/2007-02/19/2007	G0364	1	PAID	\$85.00	\$13.04	\$71.96	\$2.61	\$0.00	\$2.61	\$0.00	\$0.00	\$10.43	
Totals for Encounter :				\$85.00	\$13.04	\$71.96	\$2.61	\$0.00	\$2.61	\$0.00	\$0.00	\$10.43	

Patient: ACKERMAN, RONALD L			Subscriber Name: ACKERMAN, RONALD L			Encounter No: 07050000006							
Member ID: HP1000029700			Subscriber SSN: 537382182			PCP: 45TH STREET CLINIC							
Patient Account No:			Program: Medicare Advantage			Primary Diag Code: 799.9							
Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
02/02/2007-02/02/2007	G0364	1	DENIED	\$85.00	\$0.00	\$0.00	\$85.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	CHP010
Totals for Encounter :				\$85.00	\$0.00	\$0.00	\$85.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

Explanation of Reason Codes:
[CHP010]CHP010-No referral/authorization on file

Totals for Provider:	Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Amount Paid
	\$252.00	\$67.47	\$99.53	\$113.50	\$25.00	\$3.50	\$0.00	\$38.97

Totals for Vendor:	Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Advance Amount	Amount Paid
	\$252.00	\$67.47	\$99.53	\$113.50	\$25.00	\$3.50	\$0.00	\$0.00	\$0.00	\$38.97

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SOUTH SOUND RADIOLOGISTS INC PS
 3417 ENSIGN RD NE
 OLYMPIA,WA 98506-5064

Payee: SOUTH SOUND RADIOLOGISTS INC PS
Payee ID: PRV10000925971
Voucher #: 10000047
Provider: BENNETT, LAWRENCE N
Provider ID: PRV10000930191
Provider TIN: 910890139

Remittance Advice Process Date: 2/19/2007

Patient: ANNE, ELIZABETH	Subscriber Name: ANNE, ELIZABETH	Encounter No: 07050000002
Member ID: HP1000074700	Subscriber SSN: 563627906	PCP: INTERFAITH COMMUNITY HEALTH CENTE
Patient Account No:	Program: Medicare Advantage	Primary Diag Code: V76.11

Dates of Service	Rev/Svc/Mod Code	# Units	Status	Charge Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Amount Paid	Reason Code
01/02/2007-01/02/2007	77057	1	PAID	\$110.00	\$80.04	\$29.96	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$80.04	
02/02/2007-02/02/2007	77057	1	DENIED	\$110.00	\$80.04	\$0.00	\$110.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	M0020
Totals for Encounter :				\$220.00	\$160.08	\$29.96	\$110.00	\$0.00	\$0.00	\$0.00	\$0.00	\$80.04	

Explanation of Reason Codes:

[M0020]M0020-Benefit Visit Limit Exceeded

Totals for Provider:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Amount Paid
\$220.00	\$160.08	\$29.96	\$110.00	\$0.00	\$0.00	\$0.00	\$80.04

Totals for Vendor:

Charged Amount	Allowed Amount	Provider Write Off	Patient Responsibility	CoPay	Co-Ins	Deduct	Interest Payment	Advance Amount	Amount Paid
\$220.00	\$160.08	\$29.96	\$110.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$80.04