



To contact Customer Service:
Medicare Advantage: 1-800-942-0247
All other Programs: 1-800-440-1561



XXXXXXXX XXXXXX
 XXX XXXX XX
 XXXXXXXXXXX, WA XXXXX

Payee: XXXXXXXX XXXXXXX
Vendor ID: 00000
Voucher Number: 000000
Vendor TIN: 000000000
Company Code: CHP

1 739

Payment Made Electronically

Print Date: 09/05/2017

Remittance Advice Process Dates: 09/01/2017 Through: 09/05/2017

Help CHPW reduce our paper footprint – Go GREEN and enroll in electronic Remittance Advice (RA) and Electronic Funds Transfer (EFT). Please refer to our EDI FAQ at <http://chpw.org/for-providers/bulletin-board/electronic-data-interface-faq> or email EDI.support@chpw.org.

Patient: XXXXXXXXXXXXXXXX		Subscriber Name: XXXXXXXXXXXXXXXX		Claim No: 0000000AV 0000000											
Member ID: 000000000000		Program: XXXXXXXXXXXXXXXX		Provider: XXXXXXXXXXXXXXXX											
Patient Acct No: 000000		PCP: XXXXXXXXXXXXXXXX		Primary Diag Code: 000.000											
Product: FHX															
Date(s) of Service	Rev/SVC/Mod	# Units	Status Date	Status	Billed Amount	Allowed Amount	Provider Write Off	CoPay	Co-Ins	Deduct	Other Patient Resp	Other Carrier	Withhold Amount	Interest Amount	Total Paid Amount
08/22/17-08/22/17	00400 QY 3.2		09/01/2017	PAID	308.00	65.72	242.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	65.72
Reason Codes: PCONV*CO*45															
08/22/17-08/22/17	99140 1		09/01/2017	DENIED	150.00	0.00	150.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Reason Codes: BUNDL*CO*97*M15															

Totals for Claim:	458.00	65.72	392.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	65.72
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Patient: XXXXXXXXXXXXXXXX		Subscriber Name: XXXXXXXXXXXXXXXX		Claim No: 0000000AV 0000000											
Member ID: 000000000000		Program: XXXXXXXXXXXXXXXX		Provider: XXXXXXXXXXXXXXXX											
Patient Acct No: 000000		PCP: XXXXXXXXXXXXXXXX		Primary Diag Code: 000.000											
Product: HEX															
Date(s) of Service	Rev/SVC/Mod	# Units	Status Date	Status	Billed Amount	Allowed Amount	Provider Write Off	CoPay	Co-Ins	Deduct	Other Patient Resp	Other Carrier	Withhold Amount	Interest Amount	Total Paid Amount
08/18/17-08/18/17	00541 AA 14.		09/01/2017	PAID	2640.00	633.17	2006.83	0.00	0.00	0.00	0.00	0.00	0.00	0.00	633.17
Reason Codes: PCONV*CO*45															
08/18/17-08/18/17	36620 XU 1		09/01/2017	PAID	133.00	30.28	102.72	0.00	0.00	0.00	0.00	0.00	0.00	0.00	30.28
Reason Codes: PFEES*CO*45															

Totals for Claim:	2773.00	663.45	2109.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	663.45
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Totals for Providers	Billed Amount	Allowed Amount	Provider Write Off	CoPay	Co-Ins	Deduct	Other Patient Resp	Other Carrier	Withhold Amount	Interest Amount	Total Paid Amount
	32889.00	5994.63	26193.91	0.00	0.00	0.00	704.00	0.00	3.54	0.00	5991.09

Reason Code: Descriptions:

Reason Code:	Descriptions:
BUNDL	INCLUSIVE IN PRIMARY PROCEDURE
CAM02	PAYMENT REVERSED. MEMBER WAS RETROACTIVELY DISENROLLED ON OR PRIOR TO THE DATE OF SERVICE. MEMBER RESPONSIBILITY. PLEASE SEE YOUR MEDICAL BENEFIT BOOK OR EVIDENCE OF COVERAGE FOR MORE INFORMATION.
CDDUP	CLAIM DENIED - DUPLICATE SERVICE
CDEOB	CLAIM IS INCOMPLETE WITHOUT THE PRIMARY PLAN PAYMENT INFORMATION. THE CLAIM WILL PROMPTLY BE PROCESSED AFTER IT HAS BEEN RESUBMITTED WITH THE EOB FROM THE PRIMARY PAYER.
CMSRD	CMS MANDATORY 2% PAYMENT REDUCTION PURSUANT TO THE BUDGET CONTROL ACT OF 2011 AKA SEQUESTRATION
MBRI2	CHARGES ARE PRIOR TO OR AFTER MEMBER ELIGIBILITY
PCONV	ALLOWED USING CONVERSION FACTOR
PFEES	FEE SCHEDULE
PMAMX	ALLOWED AMT/UNITS REDUCED TO STATE LIMIT