Community Health Plan of Washington
1111 Third Avenue, Ste. 400
Seattle, WA 98101

COMMUNITY HEALTH PLAN of Washington™

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

1 739

XXXXXXXX XXXXXX
XXX XXXX XX
XXXXXXXXX, WA XXXXX

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

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: XXXXXXXXXXXXXXX
Member ID: 000000000000
Patient Acct No: 000000

Subscriber Name: XXXXXXXXXXXXXXX
Program: XXXXXXXXXXXXXXXXX
PCP: XXXXXXXXXXXXXXXXXXXX
Product: FHX

Claim No: 0000000AV 0000000
Provider: XXXXXXXXXXXXXXXXXXXX
Primary Diag Code: 000.000

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	65.72

Patient: XXXXXXXXXXXXXXX
Member ID: 000000000000
Patient Acct No: 000000

Subscriber Name: XXXXXXXXXXXXXXX
Program: XXXXXXXXXXXXXXXXX
PCP: XXXXXXXXXXXXXXXXXXXX
Product: HEX

Claim No: 0000000AV 0000000
Provider: XXXXXXXXXXXXXXXXXXXX
Primary Diag Code: 000.000

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	663.45

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:
BDMNC	MEDICARE NON COVERED SERVICE PROVIDER WRITE OFF

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