UNDERSTANDING YOUR EXPLANATATION OF BENEFITS (EOB)

Your Explanation of Benefits, or EOB, is a form your Insurance will send that gives you details about your claim status for Date of Service and Procedure.

The EOB explains how much you may owe your provider, why it was denied, and your deductible and co-ins responsibility.

Details about your claim will be displayed in column format, so you can easily track the information about each service you received.

EXPLANATION OF BENEFITS
This is not a bill

1	2	3	4	5	6	7	8	9	10	11	12
PROV ID	DOS	POS	NOS	BILLED	ALLOWED	PRO ADJ	DEDUCT	COINS/COPAY AMOUNT NOT COVERED	PROV PD	REMARK	PT RESP
SUBSCRIBER 13 NAME 14	HID 15		ACNT 16		CLAIM # 17						
4984948	12/12/06	11	1	1350.00	782.69	567.31	250.00	78.26	454.43	PR4	**328.26**
MAY BLOGGS JO BLOGGS	JBXH33333301 JBXH33333302		BLOJO000		02021465416						
PT RESP 328.26 18		**CLAIMS TOTAL 1350.00** 19								**454.43 NET** 22	
Date Received	12/15/06 20		**Date Processed**		12/22/06 21						

Your 2006/Plan Year Medical Deductible: $250.00
Your 2006/Family Plan Year Medical Deductible: $500.00

Your 2006/Plan Year Medical Deductible satisfied so far: $0.00
Your 2006/Plan Year Family Medical Deductible satisfied so far: $0.00

REMARK/EXPLANATION CODES
PR4 Patient Responsibility. Amount applied to Deductible and Co-ins

APPEAL /REVIEW

You may ask us to review a denied claim by sending a written request within 90 days to:

HEALTH ADVANTAGE
PO BOX 5858
LITTLE EATON, AR 45845
TEL: 800-548-8869

EOB Description

The following is a description of the items listed on the EOB. The field numbers referenced within the sample EOB correspond with the field names and descriptions provided below. Field 18 is probably the most important to you. It shows the total amount you, as the patient, are responsible for paying.

FIELD NUMBER	FIELD NAME	FIELD DESCRIPTION
1	PROVIDER NUMBER	The number assigned to the provider.
2	DATE OF SERVICE	The date the patient received services.
3	PLACE OF SERVICE	A description of the place/type of service provided.
4	NUMBER OF SERVICES	The amount of services
5	BILLED AMOUNT	The amount the provider charged for the service.
6	ALLOWED AMOUNT	The customary amount for a service from which your coinsurance, if applicable, will be determined.
7	PROVIDER ADJUSTMENT AMOUNT	The amount the provider must write off and/or the amount that has been withheld from the provider payment subject to the terms and conditions of the contractual agreement with the provider. The provider cannot bill you for this amount.
8	DEDUCTIBLE AMOUNT	The amount, if applicable, **you pay to providers** for services each benefit period before your health plan starts paying its share.
9	COINSURANCE AMOUNT COPAYMENT AMOUNT NON- COVERED SERVICES	The percentage of the Allowed Amount **you pay to the provider** for covered services for which the member is responsible. The Allowed Amount includes amounts withheld from provider payment, which are subject to the terms and conditions of the contractual agreement with the provider. The amount you pay to the provider each time you receive a certain service. The amount, if any, for non-covered services or the amount that is above the allowed charge when seeing an out-of-network provider.
10	PROVIDER PAYMENT	The amount your health plan paid based on your coverage and the contractual agreement with the provider.
11	EXPLANATION CODES	This is an explanation of activity that occurred on this claim/service, describing the disposition of the claim.
12	YOUR MINIMUM RESPONSIBILITY	The amount you pay to the provider for this claim. This includes any copayment, coinsurance, deductible, non-covered services, or the amount above the allowable.
13	SUBSCRIBER NAME	The name of the contract holder who meets all applicable eligibility requirements.
14	PATIENT NAME	The name of the person who received the service. This could be you, your spouse, or a dependent child who has coverage under your health plan.
15	ID NUMBER	The member number of the person receiving the service.
16	ACC NUMBER	Provider Account number.
17	CLAIM NUMBER	The number assigned to this claim for tracking purposes.
18	YOUR TOTAL RESPONSIBILITY	Total amount you pay to the provider for this claim. This includes any copayment, coinsurance, deductible, non-covered services, or the amount above the allowable.
19	CLAIMS AMOUNT	Total amount the provider charged for the service.
20	DATE RECEIVED	The date the claim was received by Health Advantage.
21	DATE PROCESSED	The date the claim was paid or denied by Health Advantage.
22	NET AMOUNT	Total amount paid to the provider of service.
23	GROUP NUMBER	The number assigned to your employer for tracking purposes.

NOTE:

Q&A with regards to Referrals/authorizations/deductibles etc should be direction to your insurance plan.
We do advise however to always call your insurance to ensure that we are an in-network participate with your insurance.
We are recognized as Outpatient diagnostic Facility in Office settings/ Independent Diagnostic Services