

Mercy Healthcare Group
 4350 E. Cotton Center Blvd
 Building D
 Phoenix, AZ 85040

**If you have any questions
 Please contact the Claims Department at
 (602) 798-2800 or (800) 780-2300**

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Remit Date:	05/24/2009
Beginning Balance:	0.00
Processed Amount:	183.03
Discount/Penalty:	0.00
Net Amount:	183.03
Refund Amount:	0.00
Amount Recouped:	0.00
Amount Paid:	183.03
Ending Balance:	0.00
Check #:	123456
Check Amount:	183.03

Forwarding Service Requested

IDEAL PROVIDER, MD
 321 E. MAIN ST
 P.O. BOX 1234
 PHOENIX, AZ 85004

EXAMPLE # 2

TIN: 123456789

Benefit Plan: Healthcare Group

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IDEAL PROVIDER, MD

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Patient: DOE, JANE		Patient Acct #: 333333333333				Claim Status: PAID										
Member ID: 99999999999		Authorization ID:				Claim #: 050129999999										
Date of Birth: 12/25/1950		Provider: IDEAL PROVIDER, MD (C)				Refund Amount:										
#	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	Unit	Billed Amount	Disallow	Allowable Amount	Patient Responsibility			COB Paid	Processed Amount	Discount/Penalty	Net Amount	
									Co-Pay	Ded.	Co-Ins					
1	12/11/08	99202	25		1	15.00	0.00	15.00	15.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	12/11/08	20605			1	82.60	2.62	79.98	0.00	0.00	0.00	0.00	79.98	0.00	0.00	79.98
3	12/11/08	J1030			1	10.00	4.01	5.99	0.00	0.00	0.00	0.00	5.99	0.00	0.00	5.99
4	12/11/08	J2000			1	3.50	3.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	12/11/08	73100			1	74.00	30.52	43.48	0.00	0.00	0.00	0.00	43.48	0.00	0.00	43.48
Claim Totals						185.10	40.65	144.45	15.00	0.00	0.00	0.00	129.45	0.00	0.00	129.45

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Code/Description

Line 4 - 97 - Payment is included in the allowance for another service/procedure

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Patient: DOE, JOHN		Patient Acct #: 44444444444444				Claim Status: PAID										
Member ID: 8888888888888		Authorization ID:				Claim #: 0504288888888										
Date of Birth: 5/20/1992		Provider: IDEAL PROVIDER, MD (C)				Refund Amount:										
#	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	Unit	Billed Amount	Disallow	Allowable Amount	Patient Responsibility			COB Paid	Processed Amount	Discount/Penalty	Net Amount	
									Co-Pay	Ded.	Co-Ins					
1	12/15/08	36415			1	18.00	8.22	9.78	0.00	0.00	0.00	0.00	9.78	0.00	0.00	9.78
2	12/15/08	85025			1	34.00	25.13	8.87	0.00	0.00	0.00	0.00	8.87	0.00	0.00	8.87
3	12/15/08	99213			1	82.00	32.07	49.93	15.00	0.00	0.00	0.00	34.93	0.00	0.00	34.93
Claim Totals						134.00	65.42	68.58	15.00	0.00	0.00	0.00	53.58	0.00	0.00	53.58

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 Remit Totals

			Patient Responsibility						
Billed Amount	Disallow	Allowable Amount	Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/Penalty	Net Amount
319.10	106.07	213.03	30.00	0.00	0.00	0.00	183.03	0.00	183.03

EXAMPLE # 2

**If you have any questions
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Forwarding Service Requested

IDEAL PROVIDER, MD
TIN: 123456789

EXAMPLE # 2

Remit Date: 05/24/2009
EFT Reference #: EFT1234567
Benefit Plan: Healthcare Group

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Messages

Mercy Healthcare Group offers the following resources for additional information and assistance:

- (1) In accordance with Arizona Administrative Codes (AAC) R9-27-702, "An HCG Plan, subcontractor, or noncontracting provider reimbursed by an HCG Plan shall not charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that a member willfully withheld information pertaining to the member's enrollment in an HCG Plan. An HCG Plan shall have the right to recover from a member that portion of payment made by a third party to a member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan."

- (2) For Claims Inquiry please go to our website at www.mercyhealthcaregroup.com or call (602) 798-2800 or (800) 780-2300 to verify that your claim was processed correctly or for clarification of information before initiating a claims dispute.

- (3) For Claims Resubmission and Reconsideration: Mark at the top of the claim "resubmission" or "reconsideration" and submit:

- Nature of request;
- Member's name, date of birth, member ID number;
- Service/admission date;
- Location of treatment, service, or procedure;
- Documentation supporting request;
- Copy of claim; and
- Copy of the remittance advice on which the claim was denied or incorrectly paid.

Request for Resubmission and Reconsideration
MUST be sent to:
Mercy Healthcare Group
Attn: Claims R & R
P.O. Box 52089
Phoenix, AZ 85072-2089

Please note: You have 12 months from date of service to file a resubmission or request for reconsideration of a claim. If you have any questions please contact Claims Inquiry at (602) 263-3000 or (800) 624-3879

- (4) To file a formal written claims dispute submit:
 - Nature of request (legal and factual basis for appeal);
 - Member's name, date of birth, member ID number;
 - Service/admission date;
 - Location of treatment, service, or procedure;
 - Clinical information and/or medical records/documentation supporting request;
 - Copy of claim; and
 - Copy of the remittance advice on which the claim denied or incorrectly paid.

Claims disputes MUST be sent to:
Mercy Healthcare Group
Attn: Claims Disputes
4350 E. Cotton Center Blvd
Bldg. D
Phoenix, AZ 85040

Please note: Claims disputes must be filed within 12 months from date of service, 12 months after the date of eligibility posting or within 60 days after the date of a timely claim submission, whichever is less. Claims disputes challenging an adverse decision must be filed within 60 days.

EXAMPLE # 2