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

Forwarding Service Requested

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

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

1

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
EFT Reference #:	EFT1234567
EFT Amount:	183.03
Bank Account:	XXXXX1234

EXAMPLE # 2

IDEAL PROVIDER, MD

TIN: 123456789
Benefit Plan: Healthcare Group

2

3

Patient: DOE, JANE **Patient Acct #:** 3333333333333 **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 Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
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
2	12/11/08	20605			1	82.60	2.62	79.98	0.00	0.00	0.00	0.00	79.98	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	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
5	12/11/08	73100			1	74.00	30.52	43.48	0.00	0.00	0.00	0.00	43.48	0.00	43.48
					Claim Totals	185.10	40.65	144.45	15.00	0.00	0.00	0.00	129.45	0.00	129.45

4

Code/Description

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

5

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 Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	12/15/08	36415			1	18.00	8.22	9.78	0.00	0.00	0.00	0.00	9.78	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	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	34.93
					Claim Totals	134.00	65.42	68.58	15.00	0.00	0.00	0.00	53.58	0.00	53.58

6

Remit Totals

Billed Amount	Disallow	Allowable Amount	Patient Responsibility 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

SAMPLE

EXAMPLE # 2

Mercy Healthcare Group

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

Forwarding Service Requested

IDEAL PROVIDER, MD
TIN: 123456789

EXAMPLE # 2

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

7

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.

SAMPLE

EXAMPLE # 2