



Mercy Care Plan
 4350 E. Cotton Center Blvd.
 Building D
 Phoenix, AZ 85020

**If you have any questions
 Please contact the Claims Department at
 (602) 263-3000 or (800) 624-3879**

Remit Date:	05/24/2009
Beginning Balance:	0.00
Processed Amount:	122.54
Discount/Penalty:	-2.40
Net Amount:	120.14
Refund Amount:	116.50
Amount Recouped:	0.00
Amount Paid:	236.64
Ending Balance:	0.00
Check #:	123456
Check Amount:	236.64

Forwarding Service Requested

HOSPITAL CENTER
 987 E. RIVER STREET
 P O BOX 1234
 PHOENIX, AZ 85004

EXAMPLE # 2

TIN: 123456789
Benefit Plan: AHCCCS Acute

HOSPITAL CENTER

Patient: DOE, JANE							Patient Acct #: 333333333333				Claim Status: PAID			
Member ID: 999999999							Authorization ID:				Claim #: 050328888888			
Date of Birth: 12/24/1950							Provider: HOSPITAL CENTER				Refund Amount:			
Line #	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/Penalty	Net Amount
1	02/06/09	73130	RT	320	FFS	1	34.00	0.00	32.64	0.00	0.00	32.64	-0.33	32.31
2	02/06/09	99281		451	FFS	1	60.00	0.00	57.60	0.00	0.00	57.60	-0.58	57.02
3	02/06/09	99283		452	FFS	1	155.00	0.00	148.80	0.00	0.00	148.80	-1.49	147.31
Claim Totals							249.00	0.00	239.04	0.00	0.00	239.04	-2.40	236.64

Patient: DOE, JOHN							Patient Acct #: 444444444444				Claim Status: REVERSED			
Member ID: 88888888888							Authorization ID:				Claim #: 050229999999			
Date of Birth: 06/30/1992							Provider: HOSPITAL CENTER				Refund Amount: 116.50			
Line #	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/Penalty	Net Amount
1	10/10/09	99285			FFS	-1	-388.00	0.00	-116.50	0.00	0.00	-116.50	0.00	-116.50
Claim Totals							-388.00	0.00	-116.50	0.00	0.00	-116.50	0.00	-116.50

Code/Description
 Reversal of Claim # 033012345678
 123 - Payer refund due to overpayment

Remit Totals

Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/Penalty	Net Amount
-139.00	0.00	122.54	0.00	0.00	122.54	-2.40	120.14

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HOSPITAL CENTER
 TIN: 123456789



EXAMPLE # 2

Remit Date: 05/24/2009
EFT Reference #: EFT1234567
Benefit Plan: AHCCCS Acute

Messages

Mercy Care Plan offers the following resources for additional information and assistance:

- (1) In accordance with Arizona Administrative Codes (AAC) R9-22-702, R9-28-702 and R9-31-702, "A contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or eligible person, or a person acting on behalf of a member or eligible person, for any covered service except to collect an authorized co-payment or payment for additional services." This means that eligible members cannot be billed for covered services. Members must not be billed for services that are not paid due to the failure of the provider to comply with Mercy Care Plan authorization or billing requirements.
- (2) For Claims Inquiry please go to our website at www.mercycareplan.com or call (602) 263-3000 or (800) 624-3879 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 Care Plan
 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 Care Plan
 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