



**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**

**Forwarding Service Requested**

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

<b>Remit Date:</b>	05/24/2009
<b>Beginning Balance:</b>	0.00
<b>Processed Amount:</b>	122.54
<b>Discount/Penalty:</b>	-2.40
<b>Net Amount:</b>	120.14
<b>Refund Amount:</b>	116.50
<b>Amount Recouped:</b>	0.00
<b>Amount Paid:</b>	236.64
<b>Ending Balance:</b>	0.00
<b>EFT Reference #:</b>	EFT1234567
<b>EFT Amount:</b>	236.64
<b>Bank Account:</b>	XXXXX1234

**EXAMPLE # 2**

HOSPITAL CENTER

**TIN:** 123456789  
**Benefit Plan:** AHCCCS Acute

<b>Patient:</b> DOE, JANE							<b>Patient Acct #:</b> 333333333333					<b>Claim Status:</b> PAID			
<b>Member ID:</b> 999999999							<b>Authorization ID:</b>					<b>Claim #:</b> 050328888888			
<b>Date of Birth:</b> 12/24/1950							<b>Provider:</b> HOSPITAL CENTER					<b>Refund Amount:</b>			
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	
<b>Claim Totals</b>							249.00	0.00	239.04	0.00	0.00	239.04	-2.40	236.64	

<b>Patient:</b> DOE, JOHN							<b>Patient Acct #:</b> 444444444444					<b>Claim Status:</b> REVERSED			
<b>Member ID:</b> 88888888888							<b>Authorization ID:</b>					<b>Claim #:</b> 050229999999			
<b>Date of Birth:</b> 06/30/1992							<b>Provider:</b> HOSPITAL CENTER					<b>Refund Amount:</b> 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	
<b>Claim Totals</b>							-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



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**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](http://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**