Frequently Asked Questions about Claims, Billing and Service Authorization in Virginia Dual Eligible Special Needs Plans

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Many individuals who are eligible for both Medicare and Medicaid coverage are enrolled in special Medicare Advantage plans designed for Medicaid enrollees known as Dual Eligible Needs Plans (D-SNPs). Effective January 1, 2025, all enrollees in Virginia D-SNPs will be required to enroll with the Medicaid Managed Care Organization (MCO) operated by their D-SNP MCO. Medicare policy requires that the member have choice of Original Medicare/Medicare Advantage coverage, so the individual's Medicaid enrollment is determined by their choice of D-SNP. This means that if a member who is eligible for both Medicare and **full** Medicaid coverage elects to enroll in Company A's D-SNP, they must also be enrolled in Company A's Medicaid MCO plan.

This arrangement, which is referred to as Exclusively Aligned Enrollment (EAE), will provide for greater integration of the member's Medicare and Medicaid benefits and services. For providers, this will mean some processes, such as billing and service authorization, will be integrated. This document provides an explanation of how this integrated process will work.

For further information and assistance, please contact the DMAS D-SNP team at DSNP@dmas.virginia.gov. If you have health plan specific questions, please submit them to the appropriate health plan.

D-SNP Billing and Claims Processes

Effective January 1, 2025, a dual eligible member that is enrolled in an aligned D-SNP (i.e., enrolled with the same MCO for Medicare and Medicaid) will have one member ID card issued by the D-SNP. This card will be co-branded with the D-SNP logo and Cardinal Care logo, and will include the member's Medicare and Medicaid ID numbers. The card will also provide contact information for members and providers to use if they have questions.

Providers should use the information on this card to bill for **all** services. This includes those services that are only covered by Medicare, services that are only covered by Medicaid, and those services that are covered by both Medicare and Medicaid. This means that providers will be billing the D-SNP, a Medicare Advantage Plan, for services that are covered by Medicaid in most cases. (Technically, the Medicaid portion is being paid using Medicaid dollars. The D-SNP is coordinating the payment behind the scenes so the provider gets one payment).

Billing for Medicare-Only Services

- If the services being billed for are **Medicare-only** services, the D-SNP will adjudicate the claim using Medicare rules (medical necessity, amount, duration and scope, etc.).
    - If the claim is denied, in part or in full, the provider will receive a notice stating why the claim was rejected and how to appeal.
    - If the claim is paid in full, the D-SNP will pay for the Medicare potion of the service and the Medicaid cost sharing amount at the same time. This means the provider will not have to bill twice, i.e., once for the Medicare portion and once for the Medicaid coinsurance amount. (Technically, the Medicaid portion is being paid using Medicaid dollars. The D-SNP is coordinating the payment behind the scenes so the provider gets one payment).

Billing for Medicaid-Only Services

- If the service being billed for is a **Medicaid-only** service, providers can still bill the Medicaid MCO directly. However, providers may also bill the DSNP for a Medicaid-only service, the D-SNP will identify it as such and then will automatically "send" it to the Medicaid side of the house where it will be adjudicated using Medicaid rules (medical necessity, amount, duration and scope, etc.). **There are no changes to Medicaid rules as a result of the move to exclusively aligned enrollment.**
- If the claim is denied, in part or in full, the provider will receive a notice stating why the claim was rejected and how to appeal.
- If the claim is paid in full, the D-SNP will pay for the service. (Technically, Medicaid-only covered services are being paid using Medicaid dollars. As with Medicare cost sharing, the D-SNP is coordinating the payment behind the scenes).

Billing for Services Covered by Both Medicare and Medicaid

- If the service is covered by **both Medicare and Medicaid,** the D-SNP will identify it as such and adjudicate the claim using Medicare rules first as Medicare is the primary insurer and payer). Then, if necessary, the D-SNP will adjudicate the claim using Medicaid rules (see below).
- If the claim is denied, in part or in full, using Medicare rules, the D-SNP will automatically send the unpaid balance to the Medicaid side of the house where it will be adjudicated using Medicaid rules.
    - If the claim is denied in full using both the Medicare and Medicaid rules, the provider will receive a notice saying why it was rejected using Medicare rules, why it was rejected using Medicaid rules, and how to appeal both decisions.
    - If the claim is denied in part by Medicare but paid using Medicaid rules, the provider will receive a notice that it was rejected using Medicare rules but is being paid using Medicaid rules and how to appeal the Medicare decision.
- If the claim is paid in full, the D-SNP will pay for the Medicare portion of the service and the Medicaid cost sharing amount at the same time. This means the provider will not have to bill twice as you do today, i.e., once for the Medicare portion and once for the Medicaid coinsurance amount. (As stated above, technically, the Medicaid portion is being paid using Medicaid dollars, but the D-SNP is coordinating the payment behind the scenes so the provider gets one payment).

Service Authorizations

Throughout the explanation above we've described the process for claims processing. The same processes apply to service authorization requests: The provider submits all requests to the D-SNP and the plan coordinates the adjudication. There will be no change in the timeframe for approval/denial of service authorizations.

Frequently Asked Questions about DSNP Billing

Question 1: When will this billing policy apply? Will the billing requirement changes include all services billed after 1/1/25 regardless of service date?

Answer 1: It applies to services provided on and after 1/1/2025.

Question 2: Will the provider bill non-covered Medicare services (such as Waiver services) to the D-SNP Medicare plan even though this service is not covered by the D-SNP?

Answer 2: Providers can choose to bill either the Medicaid plan or the DSNP for Medicaid-only services. Please see explanation above of policies for Medicaid-only covered services and services that are covered by both Medicare and Medicaid.

Question 3: What happens when the provider bills the D-SNP for a service that is either covered by both Medicare and Medicaid, or is only covered by Medicaid but Medicare rules don't allow the provider to provide the service? This can happen where state licensure rules allow a certain provider type to provide a service but Medicare requires a different licensure type (for example, Medicare requires a service to be provided by a Nurse Practitioner but Medicaid allows the service to be provided by a Licensed Clinical Social Worker), or when Medicare doesn't allow a license-eligible staff to bill under the supervising licensed clinician's credential but Medicaid does.

Answer 3: The D-SNP will coordinate the adjudication of the claim/service auth request and apply Medicaid rules as necessary. Let's use the example of a service that is covered by both Medicare and Medicaid for which Medicare requires the services to be provided by a NP but Medicaid rules allow a LCSW to provide the service. If the LCSW provides the service, the D-SNP will reject the claim under Medicare rules but will automatically apply Medicaid rules and pay the claim (assuming everything else on the claim was correct). ***NOTE: UnitedHealthcare is the exception to this rule. UHC requires the provider to bill the Medicaid plan if the clinician is not credentialed with Medicare.***

Question 4: Should providers continue to obtain service authorizations from the Medicaid plans and not the D-SNP?

Answer 4: Providers can still obtain service authorizations from the Medicaid plans if they so desire, but the D-SNP will coordinate the service authorization process as well. All SA requests should be sent to the D-SNP and the D-SNP will coordinate the adjudication of the SA using both Medicare and Medicaid rules.

Question 5: If a member's current health plan doesn't require a service authorization for a specific service but the new health plan does, what is the timeframe to transition to a new authorization?

Answer 5: The new MCO must provide coverage at the Medicaid FFS rate for any previously scheduled medical appointments, surgeries, durable medical equipment, prosthetics, orthotics or other supplies determined to be medically necessary by the Department and/or the previous MCO. This includes any services that don't have existing SA's. DMAS provides the new MCO with 2 years of previous claims experience for each member. However, while DMAS provides the new MCO with a

transition report that includes the services the member is receiving (not just those with open SA's), it is possible the new MCO could misidentify what those services are. In light of that possibility, it may be safer to submit a new SA request to the new MCO. You may also want to discuss this with the new MCO.

Question 6: Will there be any change in the D-SNP/MCO response time for service authorization approvals, denials, etc.?

Answer 6: No. Per CMS regulations, plans must provide a decision on prior authorization requests within 72 hours for urgent situations and fourteen (14) calendar days for standard requests. This is the requirement for both Medicaid and D-SNP/Medicare Advantage service authorizations.

Question 7: When the DSNP MCO pays provider claims which include both Medicare and Medicaid reimbursement revenue, how can the provider discern from the remittance how much of the claim is paid by Medicare and how much is paid by Medicaid?

Answer 7: With the exception of Anthem Healthkeepers, each Virginia DSNP provides a breakdown of revenue source between Medicare and Medicaid on its Electronic Remittance Advice (ERA). DMAS has provided examples of these remittances as an attachment to this FAQ.

While Anthem Healthkeepers does not provide a revenue breakdown on its ERAs, providers have the option of receiving a paper remittance or electronic/835 file. The paper remit can be changed to display the Medicare and Medicaid payment information separately; however, Anthem states it would not be able to change the 835 (electronic remittance).

Virginia DSNP MCO Claims and Billing Portal Information and Instructions

Aetna Better Health of Virginia

Claims may be submitted to:
Aetna Virginia (HMO D-SNP)
Payor ID# 128VA
P.O. BOX 982980
El Paso, TX 79998
Phone number: 1-855-463-0933 (TTY: 711)

Portal links can be found at https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal.

Additional claims information can be found at https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/claims

Anthem Healthkeepers

Full instructions for submitting claims to Anthem DSNP are provided in the Anthem Provider Orientation document at https://providers.anthem.com/docs/gpp/VA_CAID_AnthemFullDualAdvantageHMODSNP.pdf?v=202502121502.

Paper Submissions	Electronic submission payers	EDI hotline
Anthem P.O. Box 6101 Virginia Beach, VA 23466	Availity Essentials: 800-282-4548 Website: Availity.com Payer ID: 00423	Phone: 800-590-5745

Humana Healthy Horizons in Virginia

Humana accepts electronic and paper claims. All claims may be submitted by one of the following ways:
Mail:
Humana Claims Office
P.O. Box 14359
Lexington, KY 40512-4359
Phone: 1-844-881-4482 (TTY:711)

Providers are encouraged to submit claims electronically via Availity Essentials.

When providers submit a claim for a FIDE SNP member (i.e., a plan in which members are eligible for full Medicaid benefits) the claim is first reviewed for Medicare coverage, then for Medicaid coverage. You do not have to bill both Medicare and Medicaid plans when submitting a claim for a FIDE SNP member, unless the member is receiving Medicaid services via fee-for-service Medicaid.

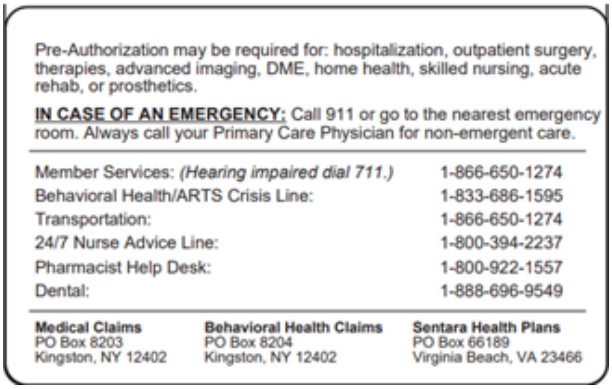
Additional claims information can be found at Humana.com/Provider.

Sentara Community Complete

All claims for our DSNP plan should be submitted to:
Medical Claims
P.O. Box 8203
Kingston NY, 12402

This address is located on each member's ID Card, shown at right.

The provider can also submit though the clearinghouse they currently use for Sentara Health Plans.


Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

Member Services: *(Hearing impaired dial 711.)*	1-866-650-1274
Behavioral Health/ARTS Crisis Line:	1-833-686-1595
Transportation:	1-866-650-1274
24/7 Nurse Advice Line:	1-800-394-2237
Pharmacist Help Desk:	1-800-922-1557
Dental:	1-888-696-9549

Medical Claims	Behavioral Health Claims	Sentara Health Plans
PO Box 8203 Kingston, NY 12402	PO Box 8204 Kingston, NY 12402	PO Box 66189 Virginia Beach, VA 23466

The claims will be processed under Medicare, then under Medicaid. Those services not covered under Medicare will be processed under the members Medicaid benefit.

Helpful links and contacts:

- Additional billing and claims information can be found at https://www.sentarahealthplans.com/en/providers/billing-and-claims
- Provider portal: https://www.sentarahealthplans.com/en/providers/provider-connection-registration
- Providers can call our Sentara Health Plans Provider Relations team at 1-844-512-3172 or email at ProviderRelations@sentara.com

UnitedHealthcare

For UHC DSNP claims, providers can submit via the UHC Provider Portal. More information can be found a https://www.uhcprovider.com/en/resource-library/provider-portal-resources.html .

Providers can also find additional resources related to claims submission via the portal at https://chameleon-4-prod.s3.amazonaws.com/clients/39-64ecae4085df9/courses/558-6528183db3513/prod/index.html#/en-US.

If additional assistance is needed, Provider Services can be reached at 844-368-7151.

Sample Remittances

As stated in the Frequently Asked Questions above, each Virginia DSNP except Anthem Healthkeepers provides a breakdown of revenue source between Medicare and Medicaid on its Electronic Remittance Advice (ERA). DMAS has provided examples of these remittances below.

Note about Anthem Healthkeepers: While Anthem Healthkeepers does not provide a revenue breakdown on its ERAs, providers have the option of receiving a paper remittance or electronic/835 file. The paper remit can be changed to display the Medicare and Medicaid payment information separately; however, Anthem states it would not be able to change the 835 (electronic remittance). Providers should contact Anthem Healthkeepers Provider Services' team for assistance and further information.

Note about Humana Healthy Horizons in Virginia: Humana provides an ERA or a paper Explanation of Remittance (EOR), in which both remittance options include a Medicare and Medicaid revenue source breakdown. If the provider is enrolled to receive the ERA (835 file), then they will receive the X12 data with claim details for Medicare and Medicaid processing. Similarly, the single EOR separately displays the Medicare and Medicaid revenue source for the single claim. In instances where there is only one revenue source, the remittance will only include the applicable line of business.

Providers will begin receiving remittances on 7/1/2025. Due to current system enhancements, Humana will provide a sample remittance to DMAS at a later date.

For additional questions regarding claims or remittances please contact Humana at 1-844-881-4482 (TTY:711) or visit us online at Humana.com/Provider.

Aetna Better Health of Virginia
P.O. Box 982979
El Paso, TX 79998-2979

Aetna Better Health® of Virginia

MEMBER NAME
12345 STREET RD
CITY, STATE 54321

SAMPLE CLAIM REMITTANCE

Your name, **MEMBER,** and Tax ID have been verified by the IRS.

Claim Questions call: 1-800-279-1878

Federal regulation prohibits billing Medicaid members, unless noted as member responsibility on this remittance advice.

The patient is part of the Medicaid/Qualified Medicare Beneficiary program. The member does not owe a deductible, copay, or coinsurance at this time.
To identify the claims, look for the MA07 remark code.

Tax ID: 000000000 EPC Draft #: 0000000000 Payment Week: 6 Payment Date: 01/01/1990

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed / Base Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
									Co-Pay	Non-Cov	Deductible	Co-Ins	
Claim Number: 00000A000000				**Group ID:** CZ00044409					**Check Number:** 0000000				
Provider: PROVIDER NAME				**Patient Name:** FIRST NAME LAST NAME					**Subscriber Name:**				
Line of business: Virginia FIDE				**Patient Acct #:** A00000000000000					**Subscriber ID:** 000000000000				
02/05/25	36415	1	CO45 MA07 N781	$39.00	$2.55	$36.45	$0.00	$0.00	$0.00	$0.00	$2.55	$0.00	$0.00
02/05/25	82306	1	CO45 MA07 N781	$261.00	$27.96	$233.04	$0.00	$0.00	$0.00	$0.00	$27.96	$0.00	$0.00
02/05/25	80053	1	CO45 MA07 N781	$217.00	$9.98	$207.02	$0.00	$0.00	$0.00	$0.00	$9.98	$0.00	$0.00
02/05/25	80061	1	CO45 MA07 N781	$172.00	$12.65	$159.35	$0.00	$0.00	$0.00	$0.00	$12.65	$0.00	$0.00
02/05/25	83036	1	CO45 CO253 MA07	$90.00	$9.17	$81.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.99
02/05/25	G0472	1	CO45 CO253 MA07 N782 N781	$249.00	$39.40	$209.78	$0.00	$0.00	$0.00	$0.00	$28.06	$2.27	$8.89
02/05/25	86780	1	CO45 CO253 MA07 N782	$160.00	$12.50	$147.70	$0.00	$0.00	$0.00	$0.00	$0.00	$2.50	$9.80
02/05/25	85025	1	CO45 CO253 MA07 N782	$121.00	$7.34	$113.78	$0.00	$0.00	$0.00	$0.00	$0.00	$1.47	$5.75
		Claim Total:		$1,309.00	$121.55	$1,188.13	$0.00	$0.00	$0.00	$0.00	$81.20	$6.24	$33.43
Claim Number: 00000A000000				**Group ID:** CZ00044409					**Check Number:** 0000000				
Provider: PROVIDER NAME				**Patient Name:** FIRST NAME LAST NAME					**Subscriber Name:**				
Line of business: Virginia FIDE				**Patient Acct #:** A00000000000000					**Subscriber ID:** 000000000000				
01/15/25-01/31	97110 GP	3	CO45 CO253 MA07 N782	$813.00	$60.63	$753.34	$0.00	$0.00	$0.00	$0.00	$0.00	$12.13	$47.53
01/10/25-01/31	97530 GP	1	CO45 CO253 MA07 N782	$258.00	$26.21	$232.21	$0.00	$0.00	$0.00	$0.00	$0.00	$5.24	$20.55
01/10/25-01/31	97140 GP	1	CO45 CO253 MA07 N782	$245.00	$18.37	$226.92	$0.00	$0.00	$0.00	$0.00	$0.00	$3.67	$14.41
01/02/25-01/31	97113 GP	3	CO45 CO253 MA07 N782	$600.00	$76.59	$524.64	$0.00	$0.00	$0.00	$0.00	$0.00	$15.32	$60.04
01/03/25-01/31	97113 GP	3	CO45 CO253 MA07 N782	$600.00	$76.59	$524.64	$0.00	$0.00	$0.00	$0.00	$0.00	$15.32	$60.04
01/08/25-01/31	97113 GP	3	CO45 CO253 MA07 N782	$600.00	$76.59	$524.64	$0.00	$0.00	$0.00	$0.00	$0.00	$15.32	$60.04

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed / Base Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
									Co-Pay	Non-Cov	Deductible	Co-Ins	
01/17/25-01/31	97113 GP	3	CO45 CO253 MA07 N782	$600.00	$76.59	$524.64	$0.00	$0.00	$0.00	$0.00	$0.00	$15.32	$60.04
01/24/25-01/31	97113 GP	3	CO45 CO253 MA07 N782	$600.00	$76.59	$524.64	$0.00	$0.00	$0.00	$0.00	$0.00	$15.32	$60.04
01/31/25	97113 GP	3	CO45 CO253 MA07 N782	$600.00	$76.59	$524.64	$0.00	$0.00	$0.00	$0.00	$0.00	$15.32	$60.04
01/27/25-01/31	97113 GP	1	CO45 CO253 MA07 N782	$200.00	$25.53	$174.88	$0.00	$0.00	$0.00	$0.00	$0.00	$5.11	$20.01
	Claim Total:			$5,116.00	$590.28	$4,535.19	$0.00	$0.00	$0.00	$0.00	$0.00	$118.07	$462.74

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

02/04/25	36415	1	CO45 CO253 MA07 N782	$39.00	$2.55	$36.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.51	$2.00
02/04/25	82306	1	CO45 CO253 MA07 N782	$261.00	$27.96	$233.49	$0.00	$0.00	$0.00	$0.00	$0.00	$5.59	$21.92
02/04/25	80061	1	CO45 CO253 MA07 N782	$172.00	$12.65	$159.55	$0.00	$0.00	$0.00	$0.00	$0.00	$2.53	$9.92
02/04/25	82607	1	CO45 CO253 MA07 N782	$166.00	$14.24	$151.99	$0.00	$0.00	$0.00	$0.00	$0.00	$2.85	$11.16
02/04/25	83036	1	CO45 CO253 MA07	$90.00	$9.17	$81.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.99
	Claim Total:			$728.00	$66.57	$662.53	$0.00	$0.00	$0.00	$0.00	$0.00	$11.48	$53.99

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

01/17/25	71250	1	CO45 CO253 MA07	$2,842.00	$104.12	$2,739.55	$0.00	$0.00	$0.00	$0.00	$0.00	$20.82	$81.63
	Claim Total:			$2,842.00	$104.12	$2,739.55	$0.00	$0.00	$0.00	$0.00	$0.00	$20.82	$81.63

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

01/23/25-01/24	0250	1	CO45 MA07	$101.05	$0.00	$101.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	0250	1	CO45 MA07	$101.05	$0.00	$101.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	Q9967	100	CO45 MA07	$252.25	$0.00	$252.25	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	J7030	2	CO45 MA07	$130.00	$0.00	$130.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	J7120	1	CO45 MA07	$65.00	$0.00	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	J7040	1	CO45 MA07	$64.00	$0.00	$64.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	96361	12	CO45 MA07	$2,820.00	$0.00	$2,820.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	96374 XU	1	CO45 MA07	$335.00	$0.00	$335.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	96375	1	CO45 MA07	$249.00	$0.00	$249.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	96376	1	CO45 MA07	$249.00	$0.00	$249.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	96376	1	CO45 MA07	$249.00	$0.00	$249.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	96361	1	CO45 MA07	$235.00	$0.00	$235.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	96372	1	CO45 MA07	$137.00	$0.00	$137.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	96372	1	CO45 MA07	$137.00	$0.00	$137.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	36415	1	CO45 MA07	$39.00	$0.00	$39.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	83880	1	CO45 MA07	$309.00	$0.00	$309.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	G0480	1	CO45 MA07	$246.00	$0.00	$246.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	80053	1	CO45 MA07	$217.00	$0.00	$217.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	80048	1	CO45 MA07	$197.00	$0.00	$197.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	82948 91	3	CO45 MA07	$174.00	$0.00	$174.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	84484	1	CO45 MA07	$158.00	$0.00	$158.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	83605	1	CO45 MA07	$123.00	$0.00	$123.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	82948 91	2	CO45 MA07	$116.00	$0.00	$116.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	82948 91	2	CO45 MA07	$116.00	$0.00	$116.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	83036	1	CO45 MA07	$90.00	$0.00	$90.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed / Base Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
									Co-Pay	Non-Cov	Deductible	Co-Ins	
01/22/25-01/24	83735	1	CO45 MA07	$59.00	$0.00	$59.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	85025	1	CO45 MA07	$121.00	$0.00	$121.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	85025	1	CO45 MA07	$121.00	$0.00	$121.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	87798	1	CO45 MA07	$1,222.00	$0.00	$1,222.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	87632	1	CO45 MA07	$773.00	$0.00	$773.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	87486	1	CO45 MA07	$222.00	$0.00	$222.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	87493	1	CO45 MA07	$197.00	$0.00	$197.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	87086	1	CO45 MA07	$177.00	$0.00	$177.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	87581	1	CO45 MA07	$164.00	$0.00	$164.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	81001 XU	1	CO45 MA07	$53.00	$0.00	$53.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	71045	1	CO45 MA07	$276.00	$0.00	$276.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	74177	1	CO45 MA07	$5,257.00	$0.00	$5,257.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	97530 GP	1	CO45 MA07	$258.00	$0.00	$258.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	97116 GP	1	CO45 MA07	$174.00	$0.00	$174.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	97161 GP	1	CO45 MA07 N783	$546.00	$55.74	$490.26	$0.00	$0.00	$55.74	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	97530 GO	1	CO45 MA07	$258.00	$0.00	$258.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	97165 GO	1	CO45 CO253 MA07 N783	$391.00	$59.89	$331.22	$0.00	$0.00	$54.26	$0.00	$0.00	$0.00	$5.52
01/22/25-01/24	99285 25	1	CO45 CO253 MA07 N783	$3,143.00	$2,592.22	$600.42	$0.00	$0.00	$110.00	$0.00	$0.00	$0.00	$2,432.58
01/23/25-01/24	J1650	4	CO45 MA07	$68.55	$0.00	$68.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	J1650	4	CO45 MA07	$68.55	$0.00	$68.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	J0696	4	CO45 MA07	$63.00	$0.00	$63.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/23/25-01/24	J0696	4	CO45 MA07	$63.00	$0.00	$63.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/24/25	J0696	4	CO45 MA07	$63.00	$0.00	$63.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	J1815	2	CO45 MA07	$0.05	$0.00	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	93005	1	CO45 MA07	$280.00	$0.00	$280.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/22/25-01/24	G0378	35	CO45 MA07	$2,478.00	$0.00	$2,478.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
		Claim Total:		$23,405.50	$2,707.85	$20,747.40	$0.00	$0.00	$220.00	$0.00	$0.00	$0.00	$2,438.10

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

02/04/25	36415	1	CO45 MA07 N781	$39.00	$2.55	$36.45	$0.00	$0.00	$0.00	$0.00	$2.55	$0.00	$0.00
02/04/25	82306	1	CO45 MA07 N781	$261.00	$27.96	$233.04	$0.00	$0.00	$0.00	$0.00	$27.96	$0.00	$0.00
02/04/25	80053	1	CO45 MA07 N781	$217.00	$9.98	$207.02	$0.00	$0.00	$0.00	$0.00	$9.98	$0.00	$0.00
02/04/25	80061	1	CO45 MA07 N781	$172.00	$12.65	$159.35	$0.00	$0.00	$0.00	$0.00	$12.65	$0.00	$0.00
02/04/25	83036	1	CO45 CO253 MA07	$90.00	$9.17	$81.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.99
02/04/25	86780	1	CO45 MA07 N781	$160.00	$12.50	$147.50	$0.00	$0.00	$0.00	$0.00	$12.50	$0.00	$0.00
02/04/25	86592	1	CO45 MA07 N781	$85.00	$4.04	$80.96	$0.00	$0.00	$0.00	$0.00	$4.04	$0.00	$0.00
02/04/25	85025	1	CO45 MA07 N781	$121.00	$7.34	$113.66	$0.00	$0.00	$0.00	$0.00	$7.34	$0.00	$0.00
02/04/25	87536	1	CO45 MA07 N781	$821.00	$80.37	$740.63	$0.00	$0.00	$0.00	$0.00	$80.37	$0.00	$0.00
		Claim Total:		$1,966.00	$166.56	$1,799.62	$0.00	$0.00	$0.00	$0.00	$157.39	$0.00	$8.99

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

01/17/25	36415	1	CO45 MA07	$39.00	$0.00	$39.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/17/25	80053	1	CO45 MA07	$217.00	$0.00	$217.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/17/25	80061	1	CO45 MA07 N781	$172.00	$12.65	$159.35	$0.00	$0.00	$0.00	$0.00	$12.65	$0.00	$0.00

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed / Base Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
									Co-Pay	Non-Cov	Deductible	Co-Ins	
01/17/25	73100 LT	1	CO45 MA07 N781	$405.00	$86.06	$318.94	$0.00	$0.00	$0.00	$0.00	$86.06	$0.00	$0.00
		Claim Total:		$833.00	$98.71	$734.29	$0.00	$0.00	$0.00	$0.00	$98.71	$0.00	$0.00

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

02/05/25	36415	1	CO45 MA07	$39.00	$2.55	$36.45	$0.00	$0.00	$0.00	$0.00	$2.55	$0.00	$0.00
02/05/25	83036	1	CO45 CO253 MA07	$90.00	$9.17	$81.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.99
02/05/25	80053	1	CO45 MA07	$217.00	$9.98	$207.02	$0.00	$0.00	$0.00	$0.00	$9.98	$0.00	$0.00
02/05/25	80061	1	CO45 MA07	$172.00	$12.65	$159.35	$0.00	$0.00	$0.00	$0.00	$12.65	$0.00	$0.00
02/05/25	84443	1	CO45 MA07	$162.00	$15.87	$146.13	$0.00	$0.00	$0.00	$0.00	$15.87	$0.00	$0.00
02/05/25	85027	1	CO45 MA07	$140.00	$6.10	$133.90	$0.00	$0.00	$0.00	$0.00	$6.10	$0.00	$0.00
		Claim Total:		$820.00	$56.32	$763.86	$0.00	$0.00	$0.00	$0.00	$47.15	$0.00	$8.99

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

01/14/25	A9552	1	CO45 MA07	$555.00	$0.00	$555.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/14/25	78816 PS	1	CO45 CO253 MA07 N782 N781	$12,562.00	$1,481.58	$11,101.75	$0.00	$0.00	$0.00	$0.00	$148.38	$266.64	$1,045.23
		Claim Total:		$13,117.00	$1,481.58	$11,656.75	$0.00	$0.00	$0.00	$0.00	$148.38	$266.64	$1,045.23

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

01/17/25	71250	1	CO45 CO253 MA07 N782 N781	$2,842.00	$104.12	$2,738.46	$0.00	$0.00	$0.00	$0.00	$68.02	$7.22	$28.30
		Claim Total:		$2,842.00	$104.12	$2,738.46	$0.00	$0.00	$0.00	$0.00	$68.02	$7.22	$28.30

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

01/17/25	77066	1	CO45 MA07 N781	$977.00	$105.60	$871.40	$0.00	$0.00	$0.00	$0.00	$105.60	$0.00	$0.00
01/17/25	G0279	1	CO45 MA07 N781	$240.00	$27.36	$212.64	$0.00	$0.00	$0.00	$0.00	$27.36	$0.00	$0.00
01/17/25	76642 LT	1	CO45 MA07 N781	$848.00	$86.06	$761.94	$0.00	$0.00	$0.00	$0.00	$86.06	$0.00	$0.00
		Claim Total:		$2,065.00	$219.02	$1,845.98	$0.00	$0.00	$0.00	$0.00	$219.02	$0.00	$0.00

Claim Number: 00000A000000
Provider: PROVIDER NAME
Line of business: Virginia FIDE

Group ID: CZ00044409
Patient Name: FIRST NAME LAST NAME
Patient Acct #: A00000000000000

Check Number: 0000000
Subscriber Name:
Subscriber ID: 000000000000

03/08/22	36415	1	OA18 MA07	$27.00	$0.00	$0.00	$0.00	$27.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	80053	1	OA18 MA07	$279.00	$0.00	$0.00	$0.00	$279.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	84156	1	OA18 MA07	$270.00	$0.00	$0.00	$0.00	$270.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	82248	1	OA18 MA07	$143.00	$0.00	$0.00	$0.00	$143.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	82550	1	OA18 MA07	$137.00	$0.00	$0.00	$0.00	$137.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	85025	1	OA18 MA07	$152.00	$0.00	$0.00	$0.00	$152.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	85652	1	OA18 MA07	$111.00	$0.00	$0.00	$0.00	$111.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	81001	1	OA18 MA07	$33.00	$0.00	$0.00	$0.00	$33.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	73521	1	OA18 MA07	$595.00	$0.00	$0.00	$0.00	$595.00	$0.00	$0.00	$0.00	$0.00	$0.00
03/08/22	72100	1	OA18 MA07	$534.00	$0.00	$0.00	$0.00	$534.00	$0.00	$0.00	$0.00	$0.00	$0.00
		Claim Total:		$2,281.00	$0.00	$0.00	$0.00	$2,281.00	$0.00	$0.00	$0.00	$0.00	$0.00

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed / Base Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
									Co-Pay	Non-Cov	Deductible	Co-Ins	
Claim Number: 00000A000000 **Provider:** PROVIDER NAME **Line of business:** Virginia FIDE					**Group ID:** CZ00044409 **Patient Name:** FIRST NAME LAST NAME **Patient Acct #:** A00000000000000				**Check Number:** 0000000 **Subscriber Name:** **Subscriber ID:** 000000000000				
02/04/25	0250	1	CO45 MA07	$60.65	$0.00	$60.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
02/04/25	80053	1	CO45 MA07	$217.00	$0.00	$217.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
02/04/25	82550	1	CO45 MA07	$128.00	$0.00	$128.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
02/04/25	82248	1	CO45 MA07	$122.00	$0.00	$122.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
02/04/25	83735	1	CO45 MA07	$59.00	$0.00	$59.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
02/04/25	85025	1	CO45 MA07	$121.00	$0.00	$121.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
02/04/25	71046	1	CO45 MA07 N781	$312.00	$86.06	$225.94	$0.00	$0.00	$0.00	$0.00	$86.06	$0.00	$0.00
02/04/25	36591	1	CO45 MA07	$226.00	$0.00	$226.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
		Claim Total:		$1,245.65	$86.06	$1,159.59	$0.00	$0.00	$0.00	$0.00	$86.06	$0.00	$0.00

Statement Summary	Total Charge	Allowed / Base Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
						Co -Pay	Non-Cov	Deductible	Co -Ins	
	$58,570.15	$5,802.74	$50,571.35	$0.00	$2,281.00	$220.00	$0.00	$905.93	$430.47	$4,161.40

Aetna Payment ID	Aetna Check	Aetna Check Amount
000000000000000	**Number** 0000000	$4,161.40

Explanations

Administered by	Codes	Description
AetnaBetterHealth	CO253	Sequestration - reduction in federal payment
	CO45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
	MA07	Alert: The claim information has also been forwarded to Medicaid for review.
	N781	Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
	N782	Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.
	N783	Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected copayment. This amount may be billed to a subsequent payer.
	OA18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

Messages

Aetna Medicare Better Health (HMO D-SNP) offers the following resources for additional information and assistance:

(1) **For Claims Inquiry:** please call 1-855-463-0933 Monday -Friday 8:00am to 5:00pm EST to verify that your claim processed correctly, or for clarification of information. You may also contact this number for more information on the claims inquiry process. Be prepared to provide the Provider Experience Representative with the Provider name and Provider ID, Member name and ID, date of service, and claim number from the remit notice.

(2) **Revised Claims Resubmission and Reprocessing:** A "resubmission" is defined as a claim originally denied because of missing information or incorrect coding that prevents Aetna Medicare Better Health (HMO D-SNP) from processing the claim. Health care providers must submit a corrected claim within 365 days from the claim date of service.

Mark at the top of the claim "RESUBMISSION" and include the following:

- Statement indicating the correction or request.
- Copy of the original claim.
- Copy of the remit notice showing the claim denial;
- Documentation supporting request.
- Any additional information required to process the claim

Mail to:

Aetna Medicare Better Health (HMO D-SNP)
P.O. Box 982974
El Paso, TX 79998

3) **Reconsiderations**

Please note that Reconsiderations (Disputes and Appeals), unless otherwise stated in your contract, must be filed within 180 days from the remittance advice, not to exceed 365 days from the date of service. Issues related but not limited to incomplete, incorrect or lost claim forms, electronic submissions, inappropriate or unapproved referrals, and any other billing disputes. Please review #4 below if you are Participating or Non Participating with the plan and follow these steps accordingly.

4) PAR Provider Dispute process:

If you are a PAR (Contracted) Provider, you may submit a Dispute Form to have your claim reconsidered. The form is located on our website. Please be sure to fill this form out completely and accurately to ensure proper handling of your Dispute. NOTE: For faster processing, you may also submit your Dispute thru our Secure Provider Web Portal. Instructions can be found on our website. Disputes will be settled according to terms of our contractual agreement and there will be no disruption or interference with the provision of services to enrollees as a result of the dispute.

Mail to:

Aetna Medicare Better Health (HMO D-SNP)
P.O. Box 982974
El Paso, TX 79998

OR

Non-PAR Provider Appeal process:

If you are a Non-PAR (not contracted) Provider, you have the right to appeal the claim decision. You may submit an appeal using the non-PAR Appeal form on our website for a claim denied or not paid as expected based on error or absence of fact, except for timely filing. Federal regulations 42 CFR 42 § 422.504(g) requires us to protect Aetna members from financial liability, therefore, appeals must include a signed Waiver of Liability (WOL) form for any denied claims, also available on our website.

Mail to:

Aetna Medicare Better Health (HMO D-SNP)
Attn: Appeals
P.O. Box 818070
Cleveland, OH 44181

5) To return this check please mail to:

Aetna Medicare Better Health (HMO D-SNP)
Attn: Finance
P.O. Box 982979
El Paso, TX 79998-2979

Please mail a refund check for any overpayments or claim processing errors within 60 days to:
Aetna Medicare Better Health (HMO D-SNP)
Attn: Finance
P.O. BOX 842635
Dallas, TX 75284-2635

Providers are encouraged to review our website: www.AetnaBetterHealth.com/Virginia-hmosnp for updates to our Provider Manual and provider notifications

If you would like to report healthcare fraud related issues please call the toll-free hotline at 1-855-463-0933 or contact us by e-mail at aetnasiu@aetna.com.

If you have any questions, please contact the Claims Department at 1-855-463-0933 visit our website at www.AetnaBetterHealth.com/Virginia-hmosnp

HUMANA CLAIMS
PO BOX 14359
LEXINGTON, KY 40512-4359

Humana. | CardinalCare Virginia's Medicaid Program

DATE [10/11/2022]

[TEORQTEOR127W1014202214480000001 - CAS]
[SMITH MEDICAL ASSOCIATES]
[123 STATE STR]
[LOUISVILLE, KY 40202-1049]

PROVIDER ID: [SMIMEDIC001]
FEDERAL TAX ID: [XXXXX1234]
REMITTANCE ID: [999999999999999]
[CHECK NUMBER: 0001234]
[BANK CODE: 13]
[CLIENT: 01]

[This payment was reduced for claim overpayments. Please see overpayment section for details.]

DATE OF SERVICE FROM	DATE OF SERVICE TO	SERVICE CODE	SERVICE CODE MODIFIERS	SERVICE UNITS	CHARGE	ALLOWED AMOUNT	PATIENT RESPONSIBILITY	FEE REDUCTION/ EXCLUDED	EXPLANATION/ HIPAA CODE	AMOUNT PAID
BILLING NPI NUMBER: [1234567890] PROVIDER NAME: [JOHN A SMITH XXXXX (35)] MEMBER NAME: [DOE, JOHN A]					RENDERING NPI NUMBER: [1234567899] MEMBER ID: [0000012345 00] MEMBER DOB: [06/30/1995]			CLAIM NUMBER: [123456789] PATIENT ACCOUNT: [1234567890] GROUP: [123456]		
[11/03/2021]	[11/03/2021]	[T2030]	[01/02/03/04/05]	[10]	[300.00]	[200.00]	[0.00]	[0.00]	[0PC/45]	[200.00]
[11/03/2021]	[11/03/2021]	[T2030]	[01/02/03/04/05]	[10]	[295.00]	[195.00]	[0.00]	[0.00]	[0PC/45]	[195.00]
CLAIM TOTALS					[595.00]	[395.00]	[0.00]	[0.00]		[395.00]

[OTHER INSURANCE 0.00] [MEDICAID RESPONSIBILITY 0.00] TOTAL PAID [395.00]
[COB RESERVE PAID 0.00] [INTEREST PAID 0.00] [TOTAL PAID WITH INTEREST 395.00]
[WITHHOLD AMOUNT 0.00] [NET PAID AFTER WITHHOLD 0.00]

INSURANCE COMPANY NAME: [INSERT COMPANY NAME HERE]
INSURANCE COMPANY BILLING ADDRESS FOR CLAIMS: [INSERT COMPANY BILLING ADDRESS]
MEMBER'S GROUP NUMBER: [123456789]
MEMBER'S POLICY NUMBER: [123456789101112131415]
POLICYHOLDER'S NAME: [INSERT POLICYHOLDER'S NAME HERE]

[Ancillary lines have been consolidated into an all-inclusive line.]
[This is an adjustment of a previously processed claim.]
[*This patient is on a Dual Special Needs Plan. Medicaid may be responsible for a portion of this amount.]
[This patient has an Aligned Dual Special Needs Plan and Medicaid plan. This member is cost-share protected and should not be billed.]

DATE OF SERVICE FROM	DATE OF SERVICE TO	SERVICE CODE	SERVICE CODE MODIFIERS	SERVICE UNITS	CHARGE	ALLOWED AMOUNT	PATIENT RESPONSIBILITY	FEE REDUCTION/ EXCLUDED	EXPLANATION/ HIPAA CODE	AMOUNT PAID
BILLING NPI NUMBER: [1234567890] PROVIDER NAME: [JOHN A SMITH XXXXX (35)] MEMBER NAME: [DOE, JOHN A]					RENDERING NPI NUMBER: [1234567899] MEMBER ID: [0000012345 00] STATE MEDICAID ID: [0000012345 00] MEMBER DOB: [06/30/1995]			CLAIM NUMBER: [123456789] PATIENT ACCOUNT: [1234567890] GROUP: [123456]		
[11/03/2021]	[11/03/2021]	[T2030]	[01/02/03/04/05]	[10]	[300.00]	[200.00]	[0.00]	[0.00]	[0PC/45]	[200.00]
[11/03/2021]	[11/03/2021]	[T2030]	[01/02/03/04/05]	[10]	[295.00]	[195.00]	[0.00]	[0.00]	[0PC/45]	[195.00]
CLAIM TOTALS					[595.00]	[395.00]	[0.00]	[0.00]		[395.00]

[OTHER INSURANCE 0.00] [PATIENT RESPONSIBILITY 0.00] TOTAL PAID [395.00]
[COB RESERVE PAID 0.00] [INTEREST PAID 0.00] [TOTAL PAID WITH INTEREST 395.00]
[WITHHOLD AMOUNT 0.00] [NET PAID AFTER WITHHOLD 0.00]

INSURANCE COMPANY NAME: [INSERT COMPANY NAME HERE]
INSURANCE COMPANY BILLING ADDRESS FOR CLAIMS: [INSERT COMPANY BILLING ADDRESS]
MEMBER'S GROUP NUMBER: [123456789]
MEMBER'S POLICY NUMBER: [123456789101112131415]
POLICYHOLDER'S NAME: [INSERT POLICYHOLDER'S NAME HERE]

[This is an adjustment of a previously processed claim.]

For questions about claims, please call **[844-881-4482]** or visit **[HUMANA.COM/DUALS-PROVIDER-RESOURCES.]**

Humana Healthy Horizons in Virginia is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation.

HUMANA CLAIMS
PO BOX 14359
LEXINGTON, KY 40512-4359

PROVIDER ID: [SMIMEDIC001]
FEDERAL TAX ID: [XXXXX1234]
REMITTANCE ID: [999999999999999]
[CHECK NUMBER: 0001234]
[BANK CODE: 13]
[CLIENT: 01]

[SMITH MEDICAL ASSOCIATES]
[123 STATE STR]
[LOUISVILLE, KY 40202-1049]

DATE OF SERVICE FROM	TO	SERVICE CODE	SERVICE CODE MODIFIERS	SERVICE UNITS	CHARGE	ALLOWED AMOUNT	PATIENT RESPONSIBILITY	FEE REDUCTION/ EXCLUDED	EXPLANATION/ HIPAA CODE	AMOUNT PAID
OVERPAYMENTS: THE FOLLOWING IS A DETAILED LIST OF OVERPAYMENTS USED TO REDUCE THE PAID AMOUNT FOR THIS CHECK.										
MEMBER NAME: [SALLY A DOE] MEMBER ID: [0000012345 00] MEMBER DOB: [05/22/1990] OVERPAID REASON CODE: [022] OVERPAID CLAIM NUMBER: [123456789] PATIENT ACCOUNT: [1234567890] CHECK/REMIT NUMBER: [0001234] FINANCIAL RECOVERY NUMBER: [12345] [THIS REDUCED PAYMENT OF CLAIM ID: 123456789012345]										
[11/03/2021]	[11/03/2021]	[T2030]	[01/02/03/04/05]		[-165.00]	[-165.00]				[-165.00]
OVERPAID CLAIM TOTALS					[-165.00]	[-165.00]				[-165.00]
REMITTANCE TOTALS										
SERVICING PROVIDER NAME/ID: [JUSTIN C SMITH/XXXXX6789A]										
TOTALS					[9,930.00]	[6,670.00]	[0.00]	[0.00]		[6,670.00]
[OTHER INSURANCE 0.00] [PATIENT RESPONSIBILITY 0.00] TOTAL PAID [0.00] [COB RESERVE PAID 0.00] [INTEREST PAID 0.00] [TOTAL PAID WITH INTEREST 0.00]										
ROLLUP TOTALS FOR REMITTANCE										
TOTALS					[9,930.00]	[6,670.00]	[0.00]	[0.00]		[6,670.00]
[OTHER INSURANCE 0.00] [PATIENT RESPONSIBILITY 0.00] TOTAL PAID [6,670.00] [COB RESERVE PAID 0.00] [INTEREST PAID 0.00] [TOTAL PAID WITH INTEREST 6,670.00] [TOTAL RECOVERIES 0.00] [TOTAL PAID AFTER RECOVERIES 6,670.00] [TOTAL WITHHOLD AMOUNT 0.00] [TOTAL NET PAID AFTER WITHHOLD 6,670.00]										

EXPLANATION CODES/DESCRIPTIONS

[0PC] [THIS PROVIDER IS A MEMBER OF YOUR PARTICIPATING PROVIDER ORGANIZATION NETWORK. SERVICES ARE DISCOUNTED ACCORDING TO THE NEGOTIATED RATE.]

HIPAA CODES/DESCRIPTIONS

[45] [CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.]

[OVERPAID REASON CODES/DESCRIPTIONS]

[022] [MEMBER NOT COVERED AT TIME OF SERVICE]

[960] [INCORRECT CONTRACTED RATE APPLIED]

SERVICE CODES/TREATMENT TYPES/DESCRIPTIONS

[T2030] [ASSISTED LIVING, WAIVER; PER MONTH]

HUMANA CLAIMS
PO BOX 14359
LEXINGTON, KY 40512-4359

PROVIDER ID: [SMIMEDIC001]
FEDERAL TAX ID: [XXXXX1234]
REMITTANCE ID: [999999999999999]
[CHECK NUMBER: 0001234]
[BANK CODE: 13]
[CLIENT: 01]

DATE [10/11/2022]

[SMITH MEDICAL ASSOCIATES]
[123 STATE STR]
[LOUISVILLE, KY 40202-1049]

SPECIAL MESSAGES

[To receive electronic funds transfer (EFT) and electronic remittance advice (ERA), sign in to www.availity.com. Select "Payer Spaces," then "Humana," then "Resources." From the Resources links, select "ERA/EFT Setup Change Request." If you have questions, call us at **877-845-3480**.]

In accordance with 42 C.F.R. §455.18, the following statement shall be included on each remittance: "This is to certify that the foregoing information is true, accurate and complete."

In accordance with 42 C.F.R. §455.18, the following statement shall be included on each remittance: "I understand that payment of this claim will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws."

[RIGHT OF RECONSIDERATION - IF YOU BELIEVE THE DETERMINATION OF THIS CLAIM IS INCORRECT, YOU HAVE THE RIGHT TO REQUEST A RECONSIDERATION. THE RECONSIDERATION WILL BE REVIEWED BY PARTIES NOT INVOLVED IN THE INITIAL DETERMINATION. IN ORDER TO REQUEST RECONSIDERATION, YOU MUST SUBMIT YOUR REQUEST IN WRITING WITHIN 65 DAYS OF THIS NOTICE. THIS REQUEST SHOULD INCLUDE DOCUMENTATION AS A COPY OF THE ORIGINAL CLAIM, REMITTANCE NOTIFICATION SHOWING THE DENIAL AND ANY CLINICAL RECORDS AND OTHER DOCUMENTATION THAT SUPPORTS YOUR ARGUMENT FOR REIMBURSEMENT. YOU MUST INCLUDE A SIGNED WAIVER OF LIABILITY FORM HOLDING THE MEMBER HARMLESS REGARDLESS OF THE OUTCOME OF THE APPEAL. ONCE YOU HAVE COMPLETED THE REQUEST, YOU SHOULD MAIL IT: P.O. BOX 14163 LEXINGTON, KY 40512-4163. THE WAIVER OF LIABILITY FORM IS AVAILABLE AT HUMANA.COM/RESOURCES/SUPPORT_CENTER/FORMS.]

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SENTARA
Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466

Payment Date: 01/17/2025
Payment Number: 1309738
Payment Amount: $9,305.71

[redacted]

SAMPLE CLAIM REMITTANCE

SENTARA
Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466

Wells Fargo
420 Montgomery Street
San Francisco, CA, 94104
11-24/1210

Payment Date	Number
01/17/2025	1309738

Amount
$********9305.71

PAY *ACH PAYMENT*

PAY TO THE ORDER OF [redacted]

SENTARA

Sentara Health Plans

[redacted]

EXPLANATION OF PAYMENT

[redacted]

Payment Date:	01/17/2025
Payment#:	1309738
Total Claim Pymt:	$9,305.71
Interest Paid:	$0.00
Refunds Received:	$0.00
Advances Applied:	$0.00
Payment Amt:	$9,305.71
Future Advance Outstanding:	$0.00

Insured Name: [redacted] **Patient ID:** T103960827O6C6D **Interest:** $0.00
Insured Policy#: [redacted] **Servicing Provider:**
Claim Number: 25013S00962 **NPI/API:**
Line of Business: MCAID

Dates From/To	Diag#	Proc#	Mod	Qty	Charged	Eligible	Deduct	CoIns	CoPay	Disallow	COB	Denied	Payment	Explain Codes
01/01/25-01/01/25	R53.1	T1019		7.75	$153.68	$153.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$153.68	
01/02/25-01/02/25	R53.1	T1019		9.50	$188.39	$188.39	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$188.39	
01/03/25-01/03/25	R53.1	T1019		9.75	$193.34	$193.34	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$193.34	
Sub-total					$535.41	$535.41	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$535.41	

Insured Name: [redacted] **Patient ID:** T103960827O6C9D **Interest:** $0.00
Insured Policy#: [redacted] **Servicing Provider:**
Claim Number: 25013S02267 **NPI/API:**
Line of Business: MCAID

Dates From/To	Diag#	Proc#	Mod	Qty	Charged	Eligible	Deduct	CoIns	CoPay	Disallow	COB	Denied	Payment	Explain Codes
01/01/25-01/01/25	R53.1	T1019		7	$138.81	$138.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$138.81	
01/02/25-01/02/25	R53.1	T1019		7	$138.81	$138.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$138.81	
01/03/25-01/03/25	R53.1	T1019		7	$138.81	$138.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$138.81	
Sub-total					$416.43	$416.43	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$416.43	

Insured Name: [redacted] **Patient ID:** T103960827O4C11D **Interest:** $0.00
Insured Policy#: [redacted] **Servicing Provider:**
Claim Number: 25008E034152 **NPI/API:**
Line of Business: DSNP

Dates From/To	Diag#	Proc#	Mod	Qty	Charged	Eligible	Deduct	CoIns	CoPay	Disallow	COB	Denied	Payment	Explain Codes
01/01/25-01/01/25	R53.1	T1019		3	$59.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.49	$0.00	D05
01/01/25-01/01/25	R53.1	T1019	76	5	$99.15	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$99.15	$0.00	D05
01/02/25-01/02/25	R53.1	T1019		3	$59.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.49	$0.00	D05
01/02/25-01/02/25	R53.1	T1019	76	5	$99.15	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$99.15	$0.00	D05
01/03/25-01/03/25	R53.1	T1019		3	$59.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.49	$0.00	D05
01/03/25-01/03/25	R53.1	T1019	76	5	$99.15	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$99.15	$0.00	D05
01/04/25-01/04/25	R53.1	T1019		3	$59.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.49	$0.00	D05

SENTARA

Sentara Health Plans

[redacted]

EXPLANATION OF PAYMENT

Prov ID: [redacted]

Payment Date:	01/17/2025
Payment#:	1309738
Total Claim Pymt:	$9,305.71
Interest Paid:	$0.00
Refunds Received:	$0.00
Advances Applied:	$0.00
Payment Amt:	$9,305.71
Future Advance Outstanding:	$0.00

Dates From/To	Diag#	Proc#	Mod	Qty	Charged	Eligible	Deduct	CoIns	CoPay	Disallow	COB	Denied	Payment	Explain Codes
01/04/25-01/04/25	R53.1	T1019	76	5	$99.15	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$99.15	$0.00	D05
Sub-total					$634.56	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$634.56	$0.00	

Insured Name: [redacted] **Patient ID:** T103960827O4C10D **Interest:** $0.00
Insured Policy#: [redacted] **Servicing Provider:**
Claim Number: 25013S08400 **NPI/API:** **Patient Pay:** $79.32
Line of Business: MCAID

Dates From/To	Diag#	Proc#	Mod	Qty	Charged	Eligible	Deduct	CoIns	CoPay	Disallow	COB	Denied	Payment	Explain Codes
01/04/25-01/04/25	R53.1	T1005		4	$79.32	$79.32	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
Sub-total					$79.32	$79.32	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	

Insured Name: [redacted] **Patient ID:** T103960827O4C18D **Interest:** $0.00
Insured Policy#: [redacted] **Servicing Provider:**
Claim Number: 25013S03681 **NPI/API:**
Line of Business: MCAID

Dates From/To	Diag#	Proc#	Mod	Qty	Charged	Eligible	Deduct	CoIns	CoPay	Disallow	COB	Denied	Payment	Explain Codes
01/01/25-01/01/25	R53.1	T1019		9	$178.47	$178.47	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$178.47	
01/02/25-01/02/25	R53.1	T1019		9	$178.47	$178.47	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$178.47	
01/03/25-01/03/25	R53.1	T1019		9	$178.47	$178.47	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$178.47	
Sub-total					$535.41	$535.41	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$535.41	

Insured Name: [redacted] **Patient ID:** T103960827O4C36D **Interest:** $0.00
Insured Policy#: [redacted] **Servicing Provider:**
Claim Number: 25013S10447 **NPI/API:**
Line of Business: MCAID

Dates From/To	Diag#	Proc#	Mod	Qty	Charged	Eligible	Deduct	CoIns	CoPay	Disallow	COB	Denied	Payment	Explain Codes
01/01/25-01/01/25	R53.1	T1019		8	$158.64	$158.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$158.64	
01/02/25-01/02/25	R53.1	T1019		8	$158.64	$158.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$158.64	
01/03/25-01/03/25	R53.1	T1019		8.25	$163.60	$163.60	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$163.60	
01/04/25-01/04/25	R53.1	T1019		8	$158.64	$158.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$158.64	
Sub-total					$639.52	$639.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$639.52	

DSNP Remit Example:

STD-PRA

PROVIDER REMITTANCE ADVICE

UnitedHealthcare®
Community Plan

Virginia

PAYMENT DATE: 03/08/24
PAYEE TAX NUMBER: 540787833
PAYEE ID: 007058692501
PAYEE NAME: FAIRFAX FALLS CHURCH CSB
PAYMENT NUMBER: 24068B1000666556
PAYMENT AMOUNT: $1,023.57
GRP ID: VADS
RA REFERENCE ID: 24068B1000666556

SAMPLE CLAIM REMITTANCE

PATIENT ACCOUNT: 1447664
PRODUCT DESC.: VA UnitedHealthcare Dual Complete HMOPOS FIDE H7464-007-000
BILLING NPI: 1154356244
CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE SUBMITTED/ADJUDICATED	UNITS	BILLED AMT	DISALLOW AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
02/27/24 - 02/27/24	99214 POS/ Bill Type 53	1	$190.00	$137.00	$53.00		$10.60	$0.00	$0.00	$42.40	$10.60			PR2, CO45
	CLAIM NUMBER: 24D259740600 SUBTOTAL:		$190.00	$137.00	$53.00		$10.60	$0.00	$0.00	$42.40	$10.60			
									TOTAL PAYABLE TO PROVIDER	$1,023.57				

Cardinal Care LTSS Remit Example:

STD-PRA

PROVIDER REMITTANCE ADVICE

UnitedHealthcare®
Community Plan

Virginia

PAYMENT DATE: 03/13/24
PAYEE TAX NUMBER: 540787833
PAYEE ID: 007058692501
PAYEE NAME: FAIRFAX FALLS CHURCH CSB
PAYMENT NUMBER: 24073B1001539056
PAYMENT AMOUNT: $368.75
GRP ID: VACC
RA REFERENCE ID: 24073B1001539056

CLAIM NUMBER: 24D462334100
REMIT DETAIL: Professional Claim
PCP NAME: TYLENDA, CARLEEN

PATIENT ACCOUNT: 1447664
PRODUCT DESC.: VA Cardinal Care LTSS
BILLING NPI: 1154356244
CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE SUBMITTED/ADJUDICATED	UNITS	BILLED AMT	DISALLOW AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
02/27/24 - 02/27/24	99214 POS/ Bill Type 53	1	$190.00	$95.99	$94.01			$83.41	$0.00	$10.60	$0.00			OA23, CO45
	CLAIM NUMBER: 24D462334100 SUBTOTAL:		$190.00	$95.99	$94.01			$83.41	$0.00	$10.60	$0.00			
								TOTAL PAYABLE TO PROVIDER		$368.75				