CareSource

P.O. Box 8730
Dayton, OH 45401-8730

Return Service Requested

John Doe, M.D.
100 State St.
Dayton, OH 45458

EXPLANATION OF PAYMENT

If you have any questions, please visit our Provider Portal at www.caresource.com 24 hours per day, 7 days a week.

Name: John Doe, M.D.
Payee: 999999999
Check No: 0060875566
Date: 10/27/2007
Amount: 252.49

A B C D E F

Service Date	POS	No. of Units	Procedure Code	Tooth Number	Amount Billed	Amount Allowed	COB	Net Amount Processed	Explanation Code(s)
Account #: 12345				**Member Name:** Miller, Mark M.			**Prior Processed Amount:** 0.00		
Claim #: 072967262400				**Member ID:** 10285566100			**Provider:** Doe, John		
10/11/2007	11	1	99213		65.00	36.07	0.00	36.07	
				Claim Total:	65.00	36.07	0.00	36.07	
Account #: 23456				**Member Name:** Cane, Carol C.			**Prior Processed Amount:** 0.00		
Claim #: 072967286100				**Member ID:** 10285408200			**Provider:** Doe, John		
10/05/2007	11	1	99213		65.00	36.07	0.00	36.07	
				Claim Total:	65.00	36.07	0.00	36.07	
Account #: 34567				**Member Name:** Cane, Carol C.			**Prior Processed Amount:** 0.00		
Claim #: 072967286200				**Member ID:** 10285408200			**Provider:** Doe, John		
10/12/2007	11	1	99213		65.00	36.07	0.00	36.07	
				Claim Total:	65.00	36.07	0.00	36.07	
Account #: 45678				**Member Name:** Cane, David D.			**Prior Processed Amount:** 0.00		
Claim #: 072967282400				**Member ID:** 10285408100			**Provider:** Doe, John		
10/12/2007	11	1	99213		65.00	36.07	0.00	36.07	
				Claim Total:	65.00	36.07	0.00	36.07	
Account #: 56789				**Member Name:** Cane, Jessica L.			**Prior Processed Amount:** 0.00		
Claim #: 072967263500				**Member ID:** 10285602000			**Provider:** Doe, John		
10/12/2007	11	1	99213		65.00	36.07	0.00	36.07	
				Claim Total:	65.00	36.07	0.00	36.07	
Account #: 67891				**Member Name:** Ham, Suzie			**Prior Processed Amount:** 0.00		
Claim #: 072967263500				**Member ID:** 10285237400			**Provider:** Doe, John		
10/12/2007	11	1	99393		95.00	0.00	0.00	0.00	CBI
10/12/2007	11	1	90700		6.00	0.00	0.00	0.00	CBI
10/12/2007	11	1	90707	G	6.00	0.00	0.00	0.00	CBI
10/12/2007	11	1	90713		6.00	0.00	0.00	0.00	CBI
10/12/2007	11	1	90716		6.00	0.00	0.00	0.00	CBI
				Claim Total:	119.00	0.00	0.00	0.00	
Account #: 78910				**Member Name:** Ham, Suzie			**Prior Processed Amount:** 0.00		
Claim #: 072966935200				**Member ID:** 10285237400			**Provider:** Doe, John		
10/12/2007	11	1	92015		20.00	0.00	0.00	0.00	CBI
10/12/2007	11	1	99213		65.00	0.00	0.00	0.00	CBI
				Claim Total:	85.00	0.00	0.00	0.00	
Account #: 89101				**Member Name:** Kelly, Cheryl A.			**Prior Processed Amount:** 0.00		
Claim #: 072967262600				**Member ID:** 10285589500			**Provider:** Doe, John		
10/12/2007	11	1	99213		65.00	36.07	0.00	36.07	
				Claim Total:	65.00	36.07	0.00	36.07	
Account #: 91011				**Member Name:** Miller, Samantha B.			**Prior Processed Amount:** 0.00		
Claim #: 072967247100				**Member ID:** 10287848800			**Provider:** Doe, John		
10/09/2007	11	1	99213		65.00	36.07	0.00	36.07	
				Claim Total:	65.00	36.07	0.00	36.07	

Total Amount Billed	Total Amount Allowed	Total COB	Total Net Amount Processed
659.00	252.49	0.00	252.49

Overpayments recovered this period: 0.00

Remaining overpayment amount: 0.00

NET CHECK AMOUNT: 252.49

CareSource

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Dayton, OH 45401-8730

Name: John Doe, M.D.
Payee: 999999999
Check No: 0060875566
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H

Payment Summary

Description	Provider ID	Amount Billed	Amount Allowed	COB	Prior Processed Amount	Net Amount Processed
Doe, John	999999999999	659.00	252.49	0.00	0.00	252.49

Messages

CBI COB information not received

I

Explanation of Payment Notes

A – The Account Number refers to the patient account number.

B – POS stands for Place of Service. Standard CMS location codes are used.

C – No. of Units refers to the quantity of a specific service rendered.

D – COB stands for Coordination of Benefits and indicates a third party payment.

E – Net Amount Processed indicates the dollar amount paid. Unpaid claims will contain a "0.00" in this column.

F – Explanation Codes: This column contains codes that describe the reason for how claims were processed or payment denial.

G – Amount Billed: Total billed charges for individual claim; also a subtotal of billed charges for all claims listed on the EOP.

H – The Payment Summary includes totals grouped together by provider.

I – Messages: These descriptions define the meaning of each explanation code used in the Explanation of Payment (EOP).

Provider Remittance

Any provider refunds should be mailed to:

CareSource
P.O. Box 1920
Dayton, OH 45401-1920