20170209140?

Health Choice Arizona, Inc.
410 N. 44th Street
Suite 500
Phoenix, AZ 85008

[redacted]

58 OF 58 F

ENV 1221

Invoice #: [redacted]
Check No: [redacted]
Provider TIN: [redacted]
Provider ID #: [redacted]
Payee NPI #: [redacted]
Date: 2/10/17

Service Date	Service Code	Tooth No.	# Units	Amount Billed	Excluded/ Deductible	Not Allowed	Allowed Amount	C.O.B. Insurance	Co-pay Amount	Paid Amount	Adjustment-Reason/code
Claim Totals:				201.00	0.00	122.89	78.11	0.00	0.00	78.11	

Member: [redacted] **Member #:** [redacted] **Claim #:** [redacted]
Provider: [redacted] **Account No:** [redacted] **Plan:** [redacted]
Attending NPI #: [redacted] **Paid DRG:**

1/14/17	D0120		1	52.00	0.00	29.88	22.12	0.00	0.00	22.12	
1/14/17	D1120		1	70.00	0.00	36.95	33.05	0.00	0.00	33.05	
1/14/17	D1208		1	55.00	0.00	39.44	15.56	0.00	0.00	15.56	
Claim Totals:				177.00	0.00	106.27	70.73	0.00	0.00	70.73	

Member: [redacted] **Member #:** [redacted] **Claim #:** [redacted]
Provider: [redacted] **Account No:** [redacted] **Plan:** [redacted]
Attending NPI #: [redacted] **Paid DRG:**

1/11/17	D0120		1	52.00	0.00	29.88	22.12	0.00	0.00	22.12	
1/11/17	D0274		1	67.00	0.00	41.51	25.49	0.00	0.00	25.49	
1/11/17	D1110		1	94.00	0.00	53.57	40.43	0.00	0.00	40.43	
1/11/17	D1208		1	55.00	0.00	39.44	15.56	0.00	0.00	15.56	
Claim Totals:				268.00	0.00	164.40	103.60	0.00	0.00	103.60	

Member: [redacted] **Member #:** [redacted] **Claim #:** [redacted]
Provider: [redacted] **Account No:** [redacted] **Plan:** [redacted]
Attending NPI #: [redacted] **Paid DRG:**

12/22/16	D2392	30	1	243.00	0.00	170.33	72.67	0.00	0.00	72.67	
12/22/16	D2393	T	1	299.00	0.00	211.14	87.86	0.00	0.00	87.86	
12/22/16	D2930	S	1	283.00	0.00	179.35	103.65	0.00	0.00	103.65	
12/22/16	D9230		1	80.00	0.00	58.96	21.04	0.00	0.00	21.04	
Claim Totals:				905.00	0.00	619.78	285.22	0.00	0.00	285.22	

	Amount Billed	Excluded/ Deductible	Not Allowed	Allowed Amount	C.O.B. Insurance	Co-pay Amount	Total Paid Amount
Statement Totals:	70,980.00	0.00	48,144.43	22,852.48	0.00	0.00	22,852.48

Adjustment-Reason/code Descriptions

R3	REDUCED REIMBURSEMENT BY DENTAL REVIEW
XM	MAXIMUM PAYABLE FOR INTRAORAL FILMS HASBEEN PAID FOR THIS MEMBER ON THIS DOS
ZZ	OVERRIDE DENTAL FREQUENCY FOR OFFICE VISIT
T9	NOT ALLOWED - AGE RESTRICTION
AJ	ADJUSTMENT TO PREVIOUS CLAIM
ED	DENIED-EXACT DUPLICATE OF ANOTHER CLAIMON FILE
T8	EXCEEDS FREQUENCY LIMITS
H5	AUTHORIZATION IN DENIED STATUS
14	DENIED-THIS SERVICE REQUIRES PRIOR AUTHORIZATION
I%	INTEREST PAID
VC	VERIFIED COB
36	RESUBMIT WITH PHYSICIANS PROGRESS NOTESAND ORDERS, PLEASE INCLUDE THE CLAIM
N3	RESUBMIT CLAIM AND INCLUDE THE CORRECT XRAY (S)
AA	MEMBER AGE INAPPROPRIATE FOR PROCEDURE/DIAGNOSIS CODE
T4	RESUBMIT CLAIM WITH DENTAL XRAY THAT SUPPORTS CHARGES
***	Health Choice Arizona adjudicates claims that contain all information necessary for processing (i.e. "clean claims") within thirty (30) days of receipt. In accordance with A.R.S. § 36-2904 (G) and A.A.C. R9-22-705 (B), re-submission of a claim denied for any reason other than timeliness of submission must be received within twelve (12) months from the last date of service, or the date of eligibility posting, whichever is later, with the appropriate corrections or documentation. Claims that do not achieve a clean claim status within 12 months from the date of service or date of eligibility posting, whichever is later, will be denied. Mail Claim Re-submissions to: Health Choice Arizona; Attn: Claims Department; 410 N. 44th Street, #900; Phoenix, AZ 85008.

Additional details on claims re-submissions can be located in Chapter 7 of the Provider Manual, and on our website at: http://www.healthchoiceaz.com/docs/providers/ProviderManual/HCA_CH-07_GeneralBillingRules.pdf Or, you may contact the Health Choice Claims Department at 1 (866)322-8670.

If you disagree with a decision made on your claim, you can file a Claim Dispute. In accordance with A.R.S. § 36-2903.01 (B)(4) and A.A.C. R9-34-405 (A), claim disputes challenging claim denials must be filed in writing no later than twelve (12) months from the date of service, twelve (12) months from the date of eligibility posting or within sixty (60) days after the date of denial of a timely claim submission, whichever is later. Untimely disputes will be denied as untimely and Health Choice Arizona will not address the merits of the dispute. Mail Claim Disputes to: Health Choice Arizona; Attn: Claim Dispute Department; 410 N. 44th Street, #900; Phoenix, AZ 85008.

Additional information regarding Claim Re-submissions and Claim Disputes can be located on our website at: http://www.healthchoiceaz.com/docs/providers/providermanual/hca_ch15_claimdisputesandmemberappeals.pdf Or, you may contact the Health Choice Claim Dispute Department at 1 (866)322-8670.