Created 08/06/04

ST1

MEDICARE STATEMENT EXAMPLES

EXAMPLE 4

Medicare Summary Notice

December 10, 1998

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
Tele-Device for the Deaf: 1-800-XXX-XXXX

HELP STOP FRAUD: Beware of telemarketers offering free or discounted Medicare items or services

This is a summary of claims processed from 11/10/98 through 12/10/98.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 1234-5678-9101						
Paul Jones, M.D., 123 West Street, Jacksonville, FL 33231-0024						a
Referred by: Scott Wilson, M.D.						
10/19/98	1 Influenza immunization (90724)	$5.00	$3.88	$3.88	$0.00	b
10/19/98	1 Admin. Flu vac (G0008)	5.00	3.43	3.43	0.00	b
	Claim Total	**$10.00**	**$7.31**	**$7.31**	**$0.00**	
Claim number 1234-5678-9102						
ABC Ambulance, P.O. Box 2149 Jacksonville, FL 33231						a
10/25/98	1 Ambulance, base rate (A0020)	$289.00	$249.78	$199.82	$49.96	
10/25/98	1 Ambulance, per mile (A0021)	21.00	16.96	13.57	3.39	
	Claim Total	**$310.00**	**$266.74**	**$213.39**	**$53.35**	

PART B MEDICAL INSURANCE - UNASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid You	You May Be Billed	See Notes Section
Claim number 1234-5678-9103						
William Newman, M.D., 362 North Street, Jacksonville, FL 33231-0024						a
09/10/98	1 Office/Outpatient Visit, ES (99213)	$47.00	$33.93	$27.15	$39.02	c

THIS IS NOT A BILL - Keep this notice for your records.

EXAMPLE 5

Medicare Summary Notice

November 15, 1998

RUTH DOE
123 MAPLE AVENUE
DOW, TX 72151

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 123-45-6789D

If you have questions, write or call:
MEDICARE PART A
P.O. BOX 660155
DALLAS, TEXAS 75266-0155

Local: (800) 813-8868
Toll-free: 1-800-813-8868
Tele-Device for the Deaf: 1-800-516-6684

HELP STOP FRAUD: Protect your Medicare number as you would a credit card number.

This is a summary of claims processed on 10/16/98.

PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS

Dates of Service	Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Claim number 12345-84956-84556-45621						
Columbia Med Cntr 11 Gallagher Street Dow, TX 72151						
Referred by: Peter Howe						
10/03/98	Assay serum potassium (84132)	$25.00	$0.00	$0.00	$0.00	a
	Blood typing, ABO (86900)	5.00	0.00	0.00	0.00	a
	Office/outpatient visit, est (99212)	20.00	0.00	4.00	4.00	
	Influenza immunization (90724)	12.00	0.00	0.00	0.00	
	Claim Total	**$62.00**	$0.00	**$4.00**	**$4.00**	

Notes Section:

a This service is paid at 100% of the Medicare approved amount.

Deductible Information:

You have met the Part B deductible for 1998.

General Information:

If you change your address, please contact Medicare Part A by calling 1-800-813-8868 and the Social Security Administration by calling 1-800-772-1213.

THIS IS NOT A BILL - Keep this notice for your records.

Created 08/06/04

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MEDICARE STATEMENT EXAMPLES

EXAMPLE 6

Medicare Summary Notice

December 10, 1998

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
Tele-Device for the Deaf: 1-800-XXX-XXXX

HELP STOP FRAUD: Beware of telemarketers offering free or discounted Medicare items or services

OUR RECORDS SHOW THAT

Your enrollment in ABC Plan, a Medicare managed care plan, was effective mm/dd/yy.

Your disenrollment from XYZ Plan was effective mm/dd/yy.

You became Nursing Home Certified effective mm/dd/yy.

You became entitled to ESRD status effective mm/dd/yy.

Your new address is: 123 Security Boulevard, Baltimore, MD 21244.

PART A HOSPITAL INSURANCE - INPATIENT CLAIMS

Dates of Service	Benefit Days Used	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Claim number 12345-84956-84556-45622					a
Care Hospital, 123 Sick Lane, Dallas, TX 75555					
Referred by: Paul Jones, M.D.					
10/05/98-10/19/98	14 days	$0.00	$760.00	$760.00	

THIS IS NOT A BILL - Keep this notice for your records.

EXAMPLE 7

Medicare Summary Notice

February 10, 1999

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
Tele-Device for the Deaf: 1800-XXX-XXXX

HELP STOP FRAUD: Beware of telemarketers offering free or discounted Medicare items or services.

This is a summary of claims processed from 1/1/99 through 1/31/99.

PART A – HOME HEALTH FACILITY CLAIMS

Dates of Service	Number of Services Provided	Amount Charged	Non-Covered Charges	Coinsurance	You May Be Billed	See Notes Section
Claim number 12435-84956-84556-45624						
Medicare Home Health, 123 Medicare Blvd., Medicare, TX 75602						
Referred by: Dr. Dan Visit, M.D.						
12/25/98	Med-Surg Supplies	$154.25	$0.00	$0.00	$0.00	
12/31/98-01/25/99	2 Physical Therapy Visits	125.00	125.00	0.00	125.00	a
	2 Skilled Nursing Visits	1,000.00	0.00	0.00	0.00	
Claim Total		**$1,279.25**	**$125.00**	**$0.00**	**$125.00**	
Claim number 12435-84956-84556-45626						
Medicare Home Health, 123 Medicare Blvd., Medicare, TX 75602						
Referred by: Dr. Dan Visit, M.D.						
01/25/99-02/24/99	Hospital Bed	$1,375.00	$0.00	$880.00	$880.00	

Notes Section:

a The information provided does not support the need for this many services or items.

THIS IS NOT A BILL - Keep this notice for your records.

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MEDICARE STATEMENT EXAMPLES

EXAMPLE 8

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice

March 3, 2000

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION
Your Medicare Number: 111-11-1111AB

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

LOCAL: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

HELP STOP FRAUD: Always review your Medicare Summary Notice for correct information about the items or services you received.

This is a summary of claims processed on 02/20/2000.

PART A – HOSPICE FACILITY CLAIMS

Dates of Service	Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Claim number 98765432112345 02						
Hospice Care, Inc.						
222 Hospice Ave.						
Hospice, TX XXXXX						
Referred by: John Doe, M.D.						
01/01/00-01/31/00	Hospice/Rtn Home	$2,329.37	$0.00	$0.00	$0.00	
	Hospice/IP Non-respite	4,210.50	0.00	0.00	0.00	
	Initial hospital care (99223)	275.77	0.00	0.00	0.00	
	Subsequent hospital care (99232)	210.26	0.00	0.00	0.00	
Claim Total		**$7,025.90**	**$0.00**	**$0.00**	**$0.00**	

General Information:

If you change your address, please contact the Social Security Administration by calling 1-800-772-1213.

Appeals Information – Part A (Hospice)

If you disagree with any claims decision on this notice, you can request an appeal by **May 2, 2000**.

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

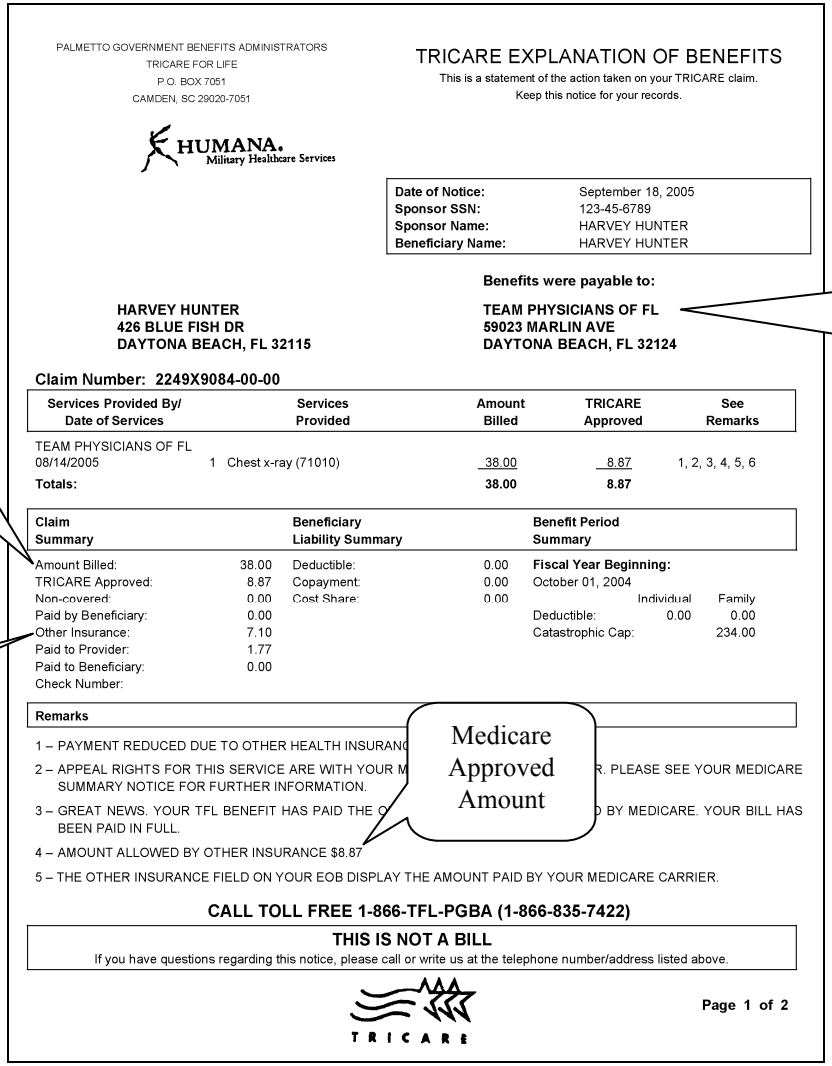
THIS IS NOT A BILL - Keep this notice for your records.

Created 06/17/08

ST2

TRICARE STATEMENT EXAMPLES

Example 1: Palmetto Government Benefits Administrators



PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
TRICARE FOR LIFE
P.O. BOX 7051
CAMDEN, SC 29020-7051

HUMANA. Military Healthcare Services

TRICARE EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

Date of Notice:	September 18, 2005
Sponsor SSN:	123-45-6789
Sponsor Name:	HARVEY HUNTER
Beneficiary Name:	HARVEY HUNTER

HARVEY HUNTER
426 BLUE FISH DR
DAYTONA BEACH, FL 32115

Benefits were payable to:
TEAM PHYSICIANS OF FL
59023 MARLIN AVE
DAYTONA BEACH, FL 32124

If information appears here the "Provider Accepted Assignment".

Claim Number: 2249X9084-00-00

Services Provided By/ Date of Services	Services Provided	Amount Billed	TRICARE Approved	See Remarks
TEAM PHYSICIANS OF FL				
08/14/2005	1 Chest x-ray (71010)	38.00	8.87	1, 2, 3, 4, 5, 6
Totals:		**38.00**	**8.87**	

Total Charge

Claim Summary		Beneficiary Liability Summary		Benefit Period Summary		
Amount Billed:	38.00	Deductible:	0.00	**Fiscal Year Beginning:**		
TRICARE Approved:	8.87	Copayment:	0.00	October 01, 2004		
Non-covered:	0.00	Cost Share:	0.00		Individual	Family
Paid by Beneficiary:	0.00			Deductible:	0.00	0.00
Other Insurance:	7.10			Catastrophic Cap:		234.00
Paid to Provider:	1.77					
Paid to Beneficiary:	0.00					
Check Number:						

Medicare Payment

Remarks

1 – PAYMENT REDUCED DUE TO OTHER HEALTH INSURANC

2 – APPEAL RIGHTS FOR THIS SERVICE ARE WITH YOUR M R. PLEASE SEE YOUR MEDICARE SUMMARY NOTICE FOR FURTHER INFORMATION.

3 – GREAT NEWS. YOUR TFL BENEFIT HAS PAID THE C D BY MEDICARE. YOUR BILL HAS BEEN PAID IN FULL.

4 – AMOUNT ALLOWED BY OTHER INSURANCE $8.87

5 – THE OTHER INSURANCE FIELD ON YOUR EOB DISPLAY THE AMOUNT PAID BY YOUR MEDICARE CARRIER.

Medicare Approved Amount

CALL TOLL FREE 1-866-TFL-PGBA (1-866-835-7422)

THIS IS NOT A BILL
If you have questions regarding this notice, please call or write us at the telephone number/address listed above.

TRICARE

Page 1 of 2

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TRICARE STATEMENT EXAMPLES
(continued)

Example 2: TRICARE Southwest

TRICARE Southwest

P.O. BOX 8997
MADISON, WI 53707-8997

TRICARE SUMMARY
PAYMENT VOUCHER
B119602845 C5

TRICARE EXPLANATION OF BENEFITS
Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice for your records. If you have any questions regarding your claim payment please call the appropriate number:

Beneficiaries: 1-800-406-2832
Providers: 1-800-406-2833
PAGE 1 OF 1

BETTY SMITH
3249 E. COURT ST
DALLAS, TX 75001

BAPTIST HEALTH MED CTR – HE
07/26/05

All communications regarding these claims must reference the above check number.

THIS IS NOT A BILL

SPONSOR NO 123456789
PATIENT ACC # 0000000
SPONSOR CHARLES S

PATIENT NAME
BETTY SMITH

CLAIM NO
2453967 19 32

Medicare Approved Amount

Total Charge

PROVIDER		PROC	MOD	NO	TYP	BILLED	OWED	CODE
BAPTIST HEALTH M		250		01	O1	22.50	10.80	003
BAPTIST HEALTH M	09/05-05/09/05	66821	LT	01	OC	950.00	456.00	003
					TOTAL	972.50	466.80	

OTHER INS. ALLOWED	OTHER INS. PAID	REDUCTION DAYS	REDUCTION AMOUNT	PAID BY PATIENT
** 0.00	272.30	0	0.00	0.00

DEDUCT	CO SHARE/ YMENT	TOTAL PAYABLE	INTEREST PAID	NET PAYMENT
**	0.00	194.50	0.00	194.50

Medicare Payment

REMA
PA E TO THE PROVIDER OF CARE.
$9 LATED TOWARD THE CHAMPUS FISCAL YEAR
CA 3,000.00 FOR THE FISCAL YEAR '04.
ACC AL DEDUCTIBLE FOR FISCAL YEAR '04 IS $0.00.
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '04 IS $0.00.
CODE 003
IF YOU ARE NOT SATISFIED WITH OUR DETERMINATION. YOU HAVE THE RIGHT TO REQUEST A REVIEW WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.
SEE ITEM FIVE ON REVERSE OF PAGE 1

********** VOUCHER SUMMARY **********

TOTAL PAYABLE	NET PAYMENT
194.50	194.50

Health Net Federal Services

Example 3: WPS TRICARE Administration

TRICARE

TRICARE EXPLANATION OF BENEFITS
Administered by: WPS TRICARE Administration
This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

Page 1 of 1

ROBERT JONES
1278 S. OAK ST
BURKE, VA 22015

Date of Notice	7/15/2005
Sponsor SSN	XXX-XX-8778
Sponsor Name	Robert M Jones
Patient Name	Robert Jones
Claim Number	2005098 7784916
Provider #	100708507 94045 A001
Provider Name	Baptist Health Med Ctr

If you have questions about this notice, Please call toll free at **1-866-773-0404.** For TDD, call **1-866-773-0405.** You can also visit us online at **www.tricare4u.com**

THIS IS NOT A BILL

SERVICES PROVIDED BY	DATE OF SERVICE	AMOUNT BILLED	TRICARE ALLOWED	REMARKS
Baptist Health M	5/12/05 – 05/12/05	$800.00		003
14040 – 1 service				
Baptist Health M	5/12/05 – 05/12/05	$670.00		003
17304 – 1 service				
Baptist Health M		$205.00	$158.08	003
17305 – 1 service				
Total		$1,680.00	$1,480.98	

Total Charge

Approved Amount

CLAIM SUMMA **BENEFICIARY SHARE**

TRICARE Amount Billed			
TRICARE Allowed	$1,480.98	Cost Share/Copay	$0.00
TRICARE Paid	$300.80	Deductible	$0.00
Medicare/Other Ins. Allowed	$1,445.00	Beneficiary Responsibility	$0.00
Medicare/Other Ins. Paid	$1,379.20		
Medicare/Other Ins. Patient Re	$300.80		

OUT OF POCKET EXPENSE:

	Beginning Limit	ning October 1, 2003 nit Met to Date	Beginning October 1, 2002 Limit	Met to Date
Catastrophic Cap	$3,000.	000.00 $6.00	$3,000.00	$0.00
Individual Deductible	$150.	150.00 $0.00	$150.00	$0.00
Family Deductible	$300.	300.00 $0.00	$300.00	$0.00

Medicare Payment

Remark Codes:
Payment has been made to the provider of care.
03: If you are not satisfied with our determination, you have the right to request a review within 90 days of the date of this notice. See item five on important notice page.

PAID TO	AMOUNT PAID	BENEFICIARY RESPONSIBILITY
Baptist Health Med-Ctr	$300.80	$0.00

WPS TRICARE FOR LIFE