HAC Payment Processing - Document Identification Screen

**[DOCUMENT IDENTIFICATION SCREEN]**

Batch Number: 0

PDI Number: 201807191000013

Total Pages: UNK

Page Number: 1 of UNK

Type of Image: BILL/INVOICE

Image Available: No

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**1)** Cont Edt 2) Next Scr  **3)** Sort PDI  **4)** Kill PDI  **5)** Not Aval  **6)** Unrd Img

**7)** PDI Revw 8) Pause  **9)** Comments **10)** Btch Cmp **11)** PPR  **12)** PPRs-PDI

**PDI:** 201807191000013 **Page #:** 1  **Img #:** 1  **Assignment:**

**Vendor:**  **Beneficiary:** DURHAM,NELLIE E

**[BENEFICIARY ID SCREEN - BILL/INVOICE]**

**Beneficiary ID:** DURHAM,NELLIE E  **Sponsor ID:**

--------------------------------------------------------------------------------

**Name:** DURHAM,NELLIE E

**SSN:** 458-28-3090  **OHI Cov Code:** 6 - MEDICARE A&B

**ID #:** 458283090  **Start Date:** NOV 1, 2003

**Add 1:** 201 MCDERMOTT STREET  **Stop Date:**

**Add 2:** APT 132  **OHI Name:** MED A&B

**City:** DEER PARK

**State:** TEXAS  **Comments:** Yes

**Zip:** 775366094

**Phone: 2819280395**

**DOB:** FEB 11, 1923

**Rel:** Spouse

**1)** Cont Edt 2) Next Scr  **3)** Prv Scrn  **4)** Kill  **5)** Dis Data  **6)** Psd Bene

**7)** OHI Hist 8) OHI Comm  **9)** OHI Edit **10)** Ch Ad Fg

**PDI:** 201807191000013 **Page #:** 1  **Img #:** 1  **Assignment:**

**Vendor:** SMITHFIELD PEDS  **Beneficiary:** DURHAM,NELLIE E

**TAX ID: | TOS:** OUTPATIENT

**NPI: | PAYP:** Yes

**RT NAME: | MCCR:** Yes

**RT ZIP: | PCN:**

**| TOB:**

**| PL ZIP:** 77536

**------------------------------------ || Billing/Remit-to Information |---------**

SMITHFIELD PEDS

A/V=Y 043431959- -

FAC TYPE=PHYSICIANS 6 BLACKSTONE VALLEY PL STE 706

DRG= LINCOLN

CMAC=1 RHODE ISLAND

EDI= 028651170

**1)** Cont Edt 2) Next Scr  **3)** Prev Scr  **4)** Kill  **5)** Dis Data  **6)** Psd Ven

**7)** Med Ven

**PDI:** 201807191000013 **Page #:** 1  **Img #:** 1  **Assignment:**

**Vendor:** SMITHFIELD PEDS  **Beneficiary:** DURHAM,NELLIE E

**[OUTPATIENT E/E SCREEN - BILL/INVOICE]**

**OHI** TOC: 6 - MEDICARE A&B  **OHI Edit TOC:**

DOS POS ICD REV SVCS/NDC MODS UNT/QTY AMOUNT P/R BAL

1 03/06/18 DO R50.9

2 03/06/18 DO 99204 AN 1 1000.00

3 03/06/18 DO 99204 PA 1 1000.00

4 03/06/18 DO 99204 AS 1 1000.00

5 03/06/18 DO 99204 NP 1 1000.00

6 03/06/18 DO 1

**TOTALS 4,000.00**

--------------------------------------------------------------------------------

**1)** Cont Edt 2) Next Scr  **3)** Prev Scr  **4)** Kill  **5)** Payments  **6)** Ben Pymt

**7)** TPL Pymt 8) Del Data  **9)** OHI Edit **10)** Restore

**PDI:** 201807191000013 **Page #:** 1  **Img #:** 1  **Assignment:**

**Vendor:** SMITHFIELD PEDS  **Beneficiary:** DURHAM,NELLIE E

**[OHI PAYMENTS E/E SCREEN]**

OHI TOC: 6 - MEDICARE A&B OHI Edit TOC:

**--- Primary OHI --- Add'l OHIs**

**DOS SVCS/NDC Billed Amt Paid P/R Paid P/R Bal**

2 03/06/18 99204-AN 1000.00 900.00 900.00

3 03/06/18 99204-PA 1000.00 900.00 900.00

4 03/06/18 99204-AS 1000.00 900.00 900.00

5 03/06/18 99204-NP 1000.00 900.00 900.00

**TOTALS 4,000.00 0.00 3,600.00 0.00 3,600.00**

--------------------------------------------------------------------------------

**\*\* WARNING - OHI was not entered on Beneficiary ID screen. \*\***

**1)** Cont Edt 2) Next Scr  **3)** Ent Ttls  **4)** OHI Edit  **5)** OHI Hist  **6)** ET DOS

**PDI:** 201807191000013 **Page #:** 1  **Img #:** 1  **Assignment:**

**Vendor:** SMITHFIELD PEDS  **Beneficiary:** DURHAM,NELLIE E

**[OUTPATIENT E/E SCREEN - BILL/INVOICE]**

**OHI** TOC: 6 - MEDICARE A&B  **OHI Edit TOC:**

DOS POS ICD REV SVCS/NDC MODS UNT/QTY AMOUNT P/R BAL

1 03/06/18 DO R50.9

2 03/06/18 DO 99204 AN 1 1000.00 900.00

3 03/06/18 DO 99204 PA 1 1000.00 900.00

4 03/06/18 DO 99204 AS 1 1000.00 900.00

5 03/06/18 DO 99204 NP 1 1000.00 900.00

6 03/06/18 DO 1

**TOTALS 4,000.00 3,600.00**

--------------------------------------------------------------------------------

**1)** Cont Edt 2) Next Scr  **3)** Prev Scr  **4)** Kill  **5)** Payments  **6)** Ben Pymt

**7)** TPL Pymt 8) Del Data  **9)** OHI Edit **10)** Restore

**PDI:** 201807191000013 **Page #:** 1  **Img #:** 1  **Assignment:**

**Vendor:** SMITHFIELD PEDS  **Beneficiary:** DURHAM,NELLIE E

**[DOCUMENT IDENTIFICATION SCREEN]**

Batch Number: 0

PDI Number: 201807191000013

Total Pages: UNK

Page Number: 1 of UNK

Type of Image: BILL/INVOICE

Image Available: No

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**1)** Cont Edt 2) Next Scr  **3)** Sort PDI  **4)** Kill PDI  **5)** Not Aval  **6)** Unrd Img

**7)** PDI Revw 8) Pause  **9)** Comments **10)** Btch Cmp **11)** PPR  **12)** PPRs-PDI

**[Edit Claim Data Screen]**

**PDI# 201807191000013 Related Claims:**

No. Claim # RO Cl # Bene Typ Vendor D.O.S D/C

--- ------- ------- --------------- --- ---------- ---------- ---

1) RLT8197 DURHAM,NELLIE E OUT SMITHFIELD 3/6/2018

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Select: 1) Edit

2) Continue

3) Process New Page

Choose:

V>IEW OR <P>RINT? V

DUZ: 830388 Health Administration Center Page: 1

Date: MAR 16, 2018 Post-Processing Claim Report

Time: 1412

PDI: 201807191000013- BATCH: Claim #: RLT8197

EIN: 043431959- - Status: In-Progress

Program: CHAMPVA

Vendor: SMITHFIELD PEDS Type: Outpatient

Pay Prov?: Yes Ser/Admis Date: MAR 6,2018

Sponsor: DURHAM,JAMES O Comp. Date:

Bene: DURHAM,NELLIE E POS: DOCTOR'S OFFIC

Bene Sex: F Bene DOB: 02/11/23 PL ZIP: 77536

Press <RETURN> to continue, <^> to exit.

DX's/Px's/NDC's P/L Unt/Qty Total Chg TotalAA Mcaid OHI #1 PD OHI #1 PR Deduct Payments AI Reas

AlwUnt Chg/Unt AA/Unt Addl OHI OHI PR Bal Cst Share

------------------- ------- ----------- ----------- ----------- ----------- ----------- ----------- ----------- -- ----

R50.9 1 AC

99204-AN 1 1,000.00 169.51 100.00 900.00 AC

1 1,000.00 169.51

99204-PA 1 1,000.00 169.51 100.00 900.00 AC

1 1,000.00 169.51

99204-AS 1 1,000.00 17.63 100.00 900.00 AC

1 1,000.00 17.63

99204-NP 1 1,000.00 17.63 100.00 900.00 AC

1 1,000.00 17.63

-----------------------------------------------------------------------------------------------------------------------------

Totals: 4,000.00 374.28 400.00 3,600.00 0.00

Press <RETURN> to Continue, <^> to exit.

Total Charges Billed: 4,000.00 CITI Maximum Reimbursement Rate: N/A

Calculated Allowable Amount: 374.28 MEDICAID Amount: N/A

Amount Applied to Deductible: N/A Amount Paid by TPL: N/A

Cost Share Credited to Cat Cap: N/A Amount Reversed from Deductible: N/A

Amount Paid by Other Insurance(s): 400.00 Amount Reversed from Cat Cap: N/A

Patient Responsibility Amount: 3,600.00 Amount Reduced from Previous Payment: N/A

Amount Paid by Beneficiary to Vendor: 0.00 Last PDI Payment Difference: 0.00

Total Amount to be PAID on claim: N/A Total Payment for Current PDI# 201807191000013: 0.00

Amount PAID to Vendor: N/A

Amount PAID to Beneficiary: N/A

Press <RETURN> to Continue, <^> to exit.

Actions for Claim:

1) Quality Assurance - CPD (In Prog)

Claim Reasons: 356 - REMINDER - MAIL CLAIMS TO: CHAMPVA, PO Box 469064, DENVER, CO 80246-9064

371 - WHEN RESUBMITTING CLAIMS YOU MUST ATTACH THE CHAMPVA EOB FOR PROPER PROCESSING.

Press <RETURN> to continue.

VIEWING OF PPR

Select The Desired Active Claim: EXIT// RLT8197

**1)** Quit  **2)** Select  **3)** Fast Rev **4)** Rej Clm 5) Acc Clm  **6)** Scroll  **7)** Adm Susp **8)** Comment  **9)** Men Hlth **M)** ore..

**Select:** Select// 5

<V>IEW OR <P>RINT? V

DUZ: 588202 Health Administration Center Page: 1

Date: MAR 16, 2018 Post-Processing Claim Report

Time: 1505

PDI: 201807191000013- BATCH: Claim #: RLT8197

EIN: 043431959- - Status: Payment Req.

Program: CHAMPVA

Vendor: SMITHFIELD PEDS Type: Outpatient

Pay Prov?: Yes Ser/Admis Date: MAR 6,2018

Sponsor: DURHAM,JAMES O Comp. Date:

Bene: DURHAM,NELLIE E POS: DOCTOR'S OFFIC

Bene Sex: F Bene DOB: 02/11/23 PL ZIP: 77536

Press <RETURN> to continue, <^> to exit.

DX's/Px's/NDC's P/L Unt/Qty Total Chg TotalAA Mcaid OHI #1 PD OHI #1 PR Deduct Payments AI Reas

AlwUnt Chg/Unt AA/Unt Addl OHI OHI PR Bal Cst Share

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R50.9 1 AC

99204-AN 1 1,000.00 169.51 100.00 900.00 0.00 169.51 AC

1 1,000.00 169.51 0.00

99204-PA 1 1,000.00 169.51 100.00 900.00 0.00 169.51 AC

1 1,000.00 169.51 0.00

99204-AS 1 1,000.00 17.63 100.00 900.00 0.00 17.63 AC

1 1,000.00 17.63 0.00

99204-NP 1 1,000.00 17.63 100.00 900.00 0.00 17.63 AC

1 1,000.00 17.63 0.00

-----------------------------------------------------------------------------------------------------------------------------

Totals: 4,000.00 374.28 400.00 3,600.00 0.00 374.28

0.00

Press <RETURN> to Continue, <^> to exit.

Total Charges Billed: 4,000.00 CITI Maximum Reimbursement Rate: N/A

Calculated Allowable Amount: 374.28 MEDICAID Amount: N/A

Amount Applied to Deductible: 0.00 Amount Paid by TPL: N/A

Cost Share Credited to Cat Cap: 0.00 Amount Reversed from Deductible: N/A

Amount Paid by Other Insurance(s): 400.00 Amount Reversed from Cat Cap: N/A

Patient Responsibility Amount: 3,600.00 Amount Reduced from Previous Payment: N/A

Amount Paid by Beneficiary to Vendor: 0.00 Last PDI Payment Difference: 0.00

Total Amount to be PAID on claim: 374.28 Total Payment for Current PDI# 201807191000013: +374.28

Amount PAID to Vendor: 374.28

Amount PAID to Beneficiary: 0.00

Press <RETURN> to Continue, <^> to exit.

CHAMPVA Beneficiary Deductible 2018: 0.00

CHAMPVA Family Deductible 2018: 0.00

CHAMPVA Family Catastrophic Cap 2018: 0.00

Press <RETURN> to Continue, <^> to exit.

Actions for Claim:

1) Quality Assurance (Comp) 2) SNA CAPPS (Pending Batch Process)

Claim Reasons: 319 - CFR 17.272(B)(3) REQUIRES PROVIDER TO ACCEPT CHAMPVA ALLOWABLE AS FULL PAYMENT.

322 - COST SHARE FOR CLAIM MAY NOT ALWAYS BE PATIENT LIABILITY; OHI / CAT CAP MAY IMPACT.

356 - REMINDER - MAIL CLAIMS TO: CHAMPVA, PO Box 469064, DENVER, CO 80246-9064

371 - WHEN RESUBMITTING CLAIMS YOU MUST ATTACH THE CHAMPVA EOB FOR PROPER PROCESSING.

Press <RETURN> to continue.

VIEWING OF PPR

Select OPTION NAME: CHMLCMA5 Zip code/CPT4 code display

Zip code/CPT4 code display

**CMAC Data**

**Zip** Code: 77536

**CHAMPUS Locality** No.: 379

**CPT** Code: 99204

**CMAC Data** Year: 18

**Facility Non-Facility Professional Technical**

**- Physician**  $ 133.44 $ 169.51

**-** Non-Physician $ 113.42 $ 144.08

<RETURN> to continue:

DUZ: 55202 Health Administration Center Page: 1

Date: MAR 20, 2018 Post-Processing Claim Report

Time: 1518

PDI: 201807291000022- BATCH: Claim #: RLT8212

EIN: 026362741- - Status: Payment Req.

Program: CHAMPVA

Vendor: JOHNSON THEODORE S Type: Outpatient

Pay Prov?: Yes Ser/Admis Date: MAR 3,2018

Sponsor: CHAMPVA,PATIENT1 Comp. Date:

Bene: CHAMPVA,CHILD1 POS: DOCTOR'S OFFIC

Bene Sex: M Bene DOB: 08/30/17 PL ZIP: 23456

Press <RETURN> to continue, <^> to exit.

DX's/Px's/NDC's P/L Unt/Qty Total Chg TotalAA Mcaid OHI #1 PD OHI #1 PR Deduct Payments AI Reas

AlwUnt Chg/Unt AA/Unt Addl OHI OHI PR Bal Cst Share

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R50.9 1 AC

99204-AN 1 200.00 164.96 0.00 123.72 AC

1 200.00 164.96 41.24

99204-PA 1 200.00 164.96 0.00 123.72 AC

1 200.00 164.96 41.24

99204-AS 1 200.00 17.16 0.00 12.87 AC

1 200.00 17.16 4.29

99204-NP 1 200.00 17.16 0.00 12.87 AC

1 200.00 17.16 4.29

-----------------------------------------------------------------------------------------------------------------------------

Totals: 800.00 364.23 0.00 273.18

91.06

Press <RETURN> to Continue, <^> to exit.

Total Charges Billed: 800.00 CITI Maximum Reimbursement Rate: N/A

Calculated Allowable Amount: 364.23 MEDICAID Amount: N/A

Amount Applied to Deductible: 0.00 Amount Paid by TPL: N/A

Cost Share Credited to Cat Cap: 91.06 Amount Reversed from Deductible: N/A

Amount Paid by Other Insurance(s): N/A Amount Reversed from Cat Cap: N/A

Patient Responsibility Amount: N/A Amount Reduced from Previous Payment: N/A

Amount Paid by Beneficiary to Vendor: 0.00 Last PDI Payment Difference: 0.00

Total Amount to be PAID on claim: 273.18 Total Payment for Current PDI# 201807291000022: +273.18

Amount PAID to Vendor: 273.18

Amount PAID to Beneficiary: 0.00

Press <RETURN> to Continue, <^> to exit.

CHAMPVA Beneficiary Deductible 2018: 50.00 (satisfied)

CHAMPVA Family Deductible 2018: 50.00

CHAMPVA Family Catastrophic Cap 2018: 591.95

Press <RETURN> to Continue, <^> to exit.

Actions for Claim:

1) ASQ (Complete) 2) Quality Assurance (Comp)

3) SNA CAPPS (Pending Batch Process)

Claim Reasons: 319 - CFR 17.272(B)(3) REQUIRES PROVIDER TO ACCEPT CHAMPVA ALLOWABLE AS FULL PAYMENT.

322 - COST SHARE FOR CLAIM MAY NOT ALWAYS BE PATIENT LIABILITY; OHI / CAT CAP MAY IMPACT.

356 - REMINDER - MAIL CLAIMS TO: CHAMPVA, PO Box 469064, DENVER, CO 80246-9064

371 - WHEN RESUBMITTING CLAIMS YOU MUST ATTACH THE CHAMPVA EOB FOR PROPER PROCESSING.

Press <RETURN> to continue.

**CMAC Data**

**Zip** Code: 23456

**CHAMPUS Locality** No.: 384

**CPT** Code: 99204

**CMAC Data** Year: 18

**Facility Non-Facility Professional Technical**

**- Physician**  $ 129.82 $ 164.96

**-** Non-Physician $ 110.35 $ 140.22

<RETURN> to continue:

**CMAC Data**

**Zip** Code: 80909

**CHAMPUS Locality** No.: 314

**CPT** Code: 99204

**CMAC Data** Year: 18

**Facility Non-Facility Professional Technical**

**- Physician**  $ 132.40 $ 168.68

**-** Non-Physician $ 112.54 $ 143.38

<RETURN> to continue:

DUZ: 830388 Health Administration Center Page: 1

Date: MAR 21, 2018 Post-Processing Claim Report

Time: 919

PDI: 201807391000004- BATCH: Claim #: RLT8225

EIN: 043431959- - Status: Payment Req.

Program: CHAMPVA

Vendor: SMITHFIELD PEDS Type: Outpatient

Pay Prov?: Yes Ser/Admis Date: MAR 4,2018

Sponsor: HAYNES JR,MICHAEL H Comp. Date:

Bene: HAYNES,DEBORAH POS: DOCTOR'S OFFIC

Bene Sex: F Bene DOB: 09/01/63 PL ZIP: 89111

Press <RETURN> to continue, <^> to exit.

DX's/Px's/NDC's P/L Unt/Qty Total Chg TotalAA Mcaid OHI #1 PD OHI #1 PR Deduct Payments AI Reas

AlwUnt Chg/Unt AA/Unt Addl OHI OHI PR Bal Cst Share

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R50.9 1 AC

99204-SA 1 1,000.00 168.08 0.00 126.06 AC

1 1,000.00 168.08 42.02

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Totals: 1,000.00 168.08 0.00 126.06

42.02

Press <RETURN> to Continue, <^> to exit.

Total Charges Billed: 1,000.00 CITI Maximum Reimbursement Rate: N/A

Calculated Allowable Amount: 168.08 MEDICAID Amount: N/A

Amount Applied to Deductible: 0.00 Amount Paid by TPL: N/A

Cost Share Credited to Cat Cap: 42.02 Amount Reversed from Deductible: N/A

Amount Paid by Other Insurance(s): N/A Amount Reversed from Cat Cap: N/A

Patient Responsibility Amount: N/A Amount Reduced from Previous Payment: N/A

Amount Paid by Beneficiary to Vendor: 0.00 Last PDI Payment Difference: 0.00

Total Amount to be PAID on claim: 126.06 Total Payment for Current PDI# 201807391000004: +126.06

Amount PAID to Vendor: 126.06

Amount PAID to Beneficiary: 0.00

Press <RETURN> to Continue, <^> to exit.

CHAMPVA Beneficiary Deductible 2018: 50.00 (satisfied)

CHAMPVA Family Deductible 2018: 50.00

CHAMPVA Family Catastrophic Cap 2018: 147.70

Press <RETURN> to Continue, <^> to exit.

Actions for Claim:

1) SNA CAPPS (Pending Batch Process) 2) ClaimCheck (Complete)

Claim Reasons: 319 - CFR 17.272(B)(3) REQUIRES PROVIDER TO ACCEPT CHAMPVA ALLOWABLE AS FULL PAYMENT.

322 - COST SHARE FOR CLAIM MAY NOT ALWAYS BE PATIENT LIABILITY; OHI / CAT CAP MAY IMPACT.

356 - REMINDER - MAIL CLAIMS TO: CHAMPVA, PO Box 469064, DENVER, CO 80246-9064

371 - WHEN RESUBMITTING CLAIMS YOU MUST ATTACH THE CHAMPVA EOB FOR PROPER PROCESSING.

Press <RETURN> to continue.

**CMAC Data**

**Zip** Code: 89111

**CHAMPUS Locality** No.: 350

**CPT** Code: 99204

**CMAC Data** Year: 18

**Facility Non-Facility Professional Technical**

**- Physician**  $ 131.83 $ 168.08

**-** Non-Physician $ 112.06 $ 142.87

<RETURN> to continue: