



An Independent Licensee of the Blue Cross and Blue Shield Association

PROVIDER REMITTANCE ADVICE

1601 WEST MADISON
SIOUX FALLS, SD 57104

FACILITY NAME
STREET ADDRESS
CITY, STATE, ZIP CODE

HOSPITAL NO:
012345678912345 012345
0123456789
PROCESS DATE: 09/04/09
CONTROL NUMBER: 123456789

1

NOTES INDICATED BY A LETTER WILL BE FOUND ON THE BACK OF THIS FORM. NUMBERED MESSAGES ARE COMPUTER PRINTED IN BODY OF FORM.

PATIENT NAME (Line 1)		DATES OF SERVICE FROM (LINE 1) THROUGH (LINE 2)	NO. OF DAYS ALLOW	SVC CAT PR	TOTAL CHARGE	ALLOWED CHARGE	INSURED'S LIABILITY	PROVIDERS LIABILITY	BENEFIT AMOUNT	NOTES
PATIENT ACCOUNT NUMBER (Line 2)	INSURED ID CLAIM NO. (Line 3)									
***** A D S I N P A T I E N T P A I D C L A I M S *****										
PATIENT NAME		070109	21	C1	150,000.00	79,980.00	20.00	70,000.00	79,980.00	
O 999 3 693		072209	21	BL						
ZYH123XX7777 059999999999900										
PERSONAL ITEMS OR HOSPITAL BILLED NONCOVERED SERVICES ARE EXCLUDED. (E588)										
BL SUBTOTAL -----			21		150,000.00	79,980.00	20.00	70,000.00	79,980.00	
SUBTOTALS -----			21		150,000.00	79,980.00	20.00	70,000.00	79,980.00	
***** A D S O U T P A T I E N T P A I D C L A I M S *****										
PATIENT NAME		033109		P	275.00	220.00	44.00	55.00	176.00	
O 111		033109		BL						
ZYH123XX9999 059999999999900										
THIS CLAIM INCLUDES OUTPATIENT FEE SCHEDULE PRICED LINES. (P016)										
PATIENT LIABILITY INCLUDES DEDUCTIBLE, COPAY, & COINSURANCE APPLIED TO THIS CLAIM. (Z990)										
PATIENT NAME				P	600.00	600.00	60.00	0.00	540.00	
O 333				BL						
ZYH123XX8888 050999999999900										
PATIENT LIABILITY INCLUDES DEDUCTIBLE, COPAY, & COINSURANCE APPLIED TO THIS CLAIM. (Z990)										
BL SUBTOTAL -----					875.00	820.00	104.00	55.00	716.00	
SUBTOTALS -----					875.00	820.00	104.00	55.00	716.00	
***** P A Y M E N T S U M M A R I Z A T I O N *****										
ADS										
INPATIENT PAID TOTAL			21		150,000.00	79,980.00	20.00	70,000.00	79,980.00	
OUTPATIENT PAID TOTAL			21		875.00	820.00	104.00	55.00	716.00	
SUBTOTAL ADS			21		150,875.00	80,800.00	124.00	70,055.00	80,696.00	
ADD BACK: CR ADJ/CASH REC			21		0.00	0.00	0.00	0.00	0.00	
TOTAL ADS			21		150,875.00	80,800.00	124.00	70,055.00	80,696.00	



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012345678912345 012345
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PATIENT NAME (Line 1)		DATES OF SERVICE FROM (LINE 1) THROUGH (LINE 2)	NO. OF DAYS DAYS ALLOW	SVC CAT PR	TOTAL CHARGE	ALLOWED CHARGE	INSURED'S LIABILITY	PROVIDERS LIABILITY	BENEFIT AMOUNT	NOTES
PATIENT ACCOUNT NUMBER (Line 2)										
INSURED ID	CLAIM NO. (Line 3)									
*****		G R A N D T O T A L S U M M A R Y * * * * *								
INPATIENT PAID TOTAL					150,000:00	79,980:00	20:00	70,000:00	79,980:00	
OUTPATIENT PAID TOTAL					875:00	820:00	104:00	55:00	716:00	
TOTAL ALL CATEGORIES					150,875:00	80,800:00	124:00	70,055:00	80,696:00	
ADD BACK: CR ADJ/CASH REC					0:00	0:00	0:00	0:00	0:00	
SUBTOTAL ALL CATEGORIES					150,875:00	80,800:00	124:00	70,055:00	80,696:00	
ADD: REJECTED & ZERO PAY					0:00	0:00	0:00	0:00	0:00	
TOTAL BEFORE RECOUPMENT					150,875:00	80,800:00	124:00	70,055:00	80,696:00	
LESS: RECOUPMENTS									00:00	
AMOUNT OF CHECK									80,696:00	



PO Box 5023
 Sioux Falls, SD 57117-5023
 www.wellmark.com

Provider Claim Remittance

An Independent Licensee of the Blue Cross and Blue Shield Association

NPI Number: 0123456789

Issue Date: 09/04/09

Facility Name: Hospital Name

Paid Claims

Patient Name	Identification Number	Insured Name	Dates of Service	Procedure Code	DRG/SOI EAPG	Units	Amount Charged	Network Savings	Member Responsibility				Amount Paid by Plan	Notes
									Deductible	Copayment	Coinsurance	Amount Not Covered		
PATIENT NAME 0 999	ZYH123XX7777 05999999999900	LNAME, FNAME	07/01/09 07/22/09		693/3	21	\$150,000.00	\$70,000.00	\$0.00	\$0.00	\$0.00	\$20.00	\$79,980.00	1

Notes:
 1 - Personal items or hospital billed non-covered services are excluded. (E588)

PATIENT NAME 0 111	ZYH123XX9999 05999999999900	LNAME, FNAME	03/31/09	0320 73030		1	\$130.00	\$25.00	\$0.00	\$0.00	\$21.00	\$0.00	\$84.00	1
				0324 71020		1	\$145.00	\$30.00	\$0.00	\$0.00	\$23.00	\$0.00	\$92.00	1
Totals							\$275.00	\$55.00	\$0.00	\$0.00	\$44.00	\$0.00	\$176.00	

Notes:
 1 - This claim includes outpatient fee schedule priced lines. (P016)

PATIENT NAME 0 333	ZYH123XX8888 05999999999900	LNAME, FNAME	03/12/09	0420		1	\$125.00	\$0.00	\$0.00	\$0.00	\$12.50	\$0.00	\$112.50	
				0424		1	\$300.00	\$0.00	\$0.00	\$0.00	\$30.00	\$0.00	\$270.00	
			03/17/09	0420		1	\$100.00	\$0.00	\$0.00	\$0.00	\$10.00	\$0.00	\$90.00	
			03/20/09	0420		1	\$75.00	\$0.00	\$0.00	\$0.00	\$7.50	\$0.00	\$67.50	
Totals							\$600.00	\$0.00	\$0.00	\$0.00	\$60.00	\$0.00	\$540.00	

Final Summary of All Claims

	Amount Charged	Network Savings	Member Responsibility				Amount Paid by Plan
			Deductible	Copayment	Coinsurance	Amount Not Covered	
Summary Total of Paid Claims:	\$150,875.00	\$70,055.00	\$0.00	\$0.00	\$104.00	\$20.00	\$80,696.00
Grand Total of All Claims:	\$150,875.00	\$70,055.00	\$0.00	\$0.00	\$104.00	\$20.00	\$80,696.00
Total Amount Paid by Plan:							\$80,696.00

Summary of Payment(s):	Type	Payment Number	Payment Amount
	CHK	123456789	\$80,696.00
Grand Total of Payment(s):			\$80,696.00