



An Independent Licensee of the Blue Cross and Blue Shield Association

1601 W. MADISON ST., SIOUX FALLS, SD 57104
605-373-7292 or 1-800-774-3892

PRACTITIONER CLAIMS REPORT

DOCUMENT SERIAL NUMBER	NPI / PROVIDER #	PROCESS DATE	PCR REFERENCE NUMBER
999999999	0123456789/99999	09-04-09	999999999

PAGE NUMBER
1

PHYSICIAN NAME
CLINIC NAME
STREET ADDRESS
CITY, STATE, ZIP CODE

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

PATIENT NAME (Line 1) PATIENT ACCOUNT NUMBER (Line 2) IDENTIFICATION NUMBER (Line 3)	NPI CLAIM NO.	INSURED NAME PROVIDER NO.	DATE OF SERVICE	PROCEDURE CODE	P. O. S.	NO. OF TIMES PER- FORM- ED	CHARGE	PROVIDER AGREEMENT	INSURED'S LIABILITY	BENEFIT AMOUNT	NO TE S	
* * * * * T R A D I T I O N A L P A I D C L A I M S * * * * *												
PATIENT NAME O 555	999999999 999999999	FNAME 99999	01/19/09	CB 9924525	3	1	400.00	150.00	.00	40.00	V	
ZYS123XX4444	0599999999900	99999	01/19/09	23620	3	1	600.00	400.00	.00	45.00	V	
							TOTALS	1000.00	550.00	.00	85.00	1
1-BENEFITS WERE COORDINATED ON THIS CARRIER (Z190) CLAIM. \$365.00 WAS REPORTED AS PAID BY THE PRIMARY												
PATIENT NAME O 333	999999999 999999999	FNAME 99999	03/30/09	CB 99214	3	1	140.00	65.00	.00	75.00	1	
ZYS123XX5555	0599999999900	99999		TOTALS	---	---	140.00	65.00	.00	75.00		
1-THESE SERVICES HAVE ALSO BEEN CONSIDERED BY MEDICARE. (M019)												
							CB SUBTOTAL	1140.00	615.00	.00	160.00	
							TRADITIONAL PAID CLAIM SUBTOTALS	1140.00	615.00	.00	160.00	
* * * * * A D S P A I D C L A I M S * * * * *												
PATIENT NAME O 222	999999999 999999999	FNAME 99999	04/03/09	BL 99212	3	1	48.00	.00	4.80	43.20	1	
ZYH123XX7777	0599999999900	99999		TOTALS	---	---	48.00	.00	4.80	43.20	1	
1-PATIENT LIABILITY INCLUDES DEDUCTIBLE, COPAY AND COINSURANCE APPLIES TO THIS CLAIM. (Z990)												
PATIENT NAME O 111	999999999 999999999	FNAME 99999	03/27/09	BL 99245	3	1	325.00	20.00	32.50	272.50	1	
ZYH123XX6666	0599999999900	99999		TOTALS	---	---	325.00	20.00	32.50	272.50	2	
1-THE CHARGE EXCEEDS THE MAXIMUM ALLOWABLE FEE FOR THESE SERVICES (P016)												
2-PATIENT LIABILITY INCLUDES DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS CLAIM. (Z990)												
							BL SUBTOTAL	373.00	20.00	37.30	315.70	
							ADS PAID CLAIM SUBTOTALS	373.00	20.00	37.30	315.70	
* * * * * S U M M A R I Z A T I O N * * * * *												
							TRADITIONAL TOTAL PAID CLAIMS	1140.00	615.00	.00	160.00	
							ADS TOTAL PAID CLAIMS	373.00	20.00	37.30	315.70	
							CHECK AMOUNT	---	---	---	475.70	



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

Provider Name: Clinic Name

Paid Claims

Patient Name Patient Account Number	Identification Number Claim Number	Insured Name LNAME, FNAME	NPI Number	Dates of Service	Procedure Code	Units	Amount Charged	Network Savings	Member Responsibility				Amount Paid by Plan	Notes
									Deductible	Copayment	Coinsurance	Amount Not Covered		
PATIENT NAME 0 555	ZYS123XX4444 05999999999900	LNAME, FNAME	999999999	01/19/09	9924525	1	\$400.00	\$150.00	\$0.00	\$0.00	\$0.00	\$0.00	\$40.00	
			999999999		23620	1	\$600.00	\$400.00	\$0.00	\$0.00	\$0.00	\$0.00	\$45.00	
Totals							\$1000.00	\$550.00	\$0.00	\$0.00	\$0.00	\$0.00	\$85.00	
Other Insurance Paid: \$365.00														
PATIENT NAME 0 333	ZYS123XX5555 05999999999900	LNAME, FNAME	999999999	03/03/09	99214	1	\$140.00	\$65.00	\$0.00	\$0.00	\$0.00	\$0.00	\$75.00	
Totals							\$140.00	\$65.00	\$0.00	\$0.00	\$0.00	\$0.00	\$75.00	
Medicare Approved Amount: \$75.00 Medicare Paid Amount: \$0.00														
PATIENT NAME 0 222	ZYH123XX7777 05999999999900	LNAME, FNAME	999999999	04/03/09	99212	1	\$48.00	\$0.00	\$0.00	\$0.00	\$4.80	\$0.00	\$43.20	
Totals							\$48.00	\$0.00	\$0.00	\$0.00	\$4.80	\$0.00	\$43.20	
PATIENT NAME 0 111	ZYH123XX6666 05999999999900	LNAME, FNAME	999999999	03/27/09	99245	1	\$325.00	\$20.00	\$0.00	\$0.00	\$32.50	\$0.00	\$272.50	
Totals							\$325.00	\$20.00	\$0.00	\$0.00	\$32.50	\$0.00	\$272.50	

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:	\$1,513.00	\$635.00	\$0.00	\$0.00	\$37.30	\$0.00	\$475.70
Grand Total of All Claims:	\$1,513.00	\$635.00	\$0.00	\$0.00	\$37.30	\$0.00	\$475.70
Total Amount Paid by Plan:							\$475.70

	Type	Payment Number	Payment Amount
Summary of Payment(s):	CHK	123456789	\$475.70
Grand Total of Payment(s):			\$475.70