



An Independent Licensee of the Blue Cross and Blue Shield Association



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636 GRAND AVENUE, DES MOINES, IA 50309-2565
 515-245-4688 or 1-800-362-2218

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	N O T E 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	9999999999	FNAME 99999	01/19/09	TR 9924525	3	1	400.00	150.00	.00	40.00	V
	9999999999	99999	01/19/09	23620	3	1	600.00	400.00	.00	45.00	V
XQQ123XX4444	0599999999900			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	9999999999	FNAME 99999	03/30/09	TR 99214	3	1	140.00	65.00	.00	75.00	1
XQH123XX5555	0599999999900			TOTALS	---	---	140.00	65.00	.00	75.00	
1-THESE SERVICES HAVE ALSO BEEN CONSIDERED BY MEDICARE. (M019)											
				TR 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	9999999999	FNAME 99999	04/03/09	AS 99212	3	1	48.00	.00	4.80	43.20	1
XQH123XX7777	0599999999900			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	9999999999	FNAME 99999	03/27/09	AS 99245	3	1	325.00	20.00	32.50	272.50	1
XQH123XX6666	0599999999900			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)											
				AS 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	
* * * * * C H E C K A M O U N T * * * * *											
							CHECK AMOUNT	---		475.70	



Wellmark BlueCross BlueShield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

PO Box 9232
Des Moines, Iowa 50306-9232
www.wellmark.com

Provider Claim Remittance

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	XQQ123XX4444 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	XQQ123XX5555 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	XQH123XX7777 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	XQH123XX6666 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