Anthem Blue Cross and Blue Shield
P.O Box 105148
Atlanta, GA 30348

X

8/29/24
SCANNED

Anthem

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12720 1 AB 0.593 40
CLAUDE A SIMON
534 W 42ND ST APT 8
NEW YORK NY 10036-6221

NOTICE OF DENIAL OF MEDICAL COVERAGE

Your health plan statement

This is a summary of the health care services and benefits you received on the dates listed. It's also called an **Explanation of Benefits (EOB).** It explains the services, the cost of those services and the benefits from your plan that may be applied to the care you received. **THIS IS NOT A BILL.**

What you should do

Step 1:

Compare this statement to any bills for care you got from doctors, hospitals or other health care facilities.

Step 2:

If you have any questions, go to **www.anthem.com**. It's there for you 24/7. To go paperless and stop getting EOBs in the mail, log in at **www.anthem.com** and pick **Profile**. Choose **Email Preferences** and then select **Primary Email Address**. Click **Save/Update.**

Your Messages

To find out how to compare this payment to the allowable benefits under your plan, see the benefits or covered services section of your policy. Or call us at **844-395-1026.**

You might want to keep this copy for your income tax records.

To get help in a different language, call 844-395-1026.

Si desea ayuda en español, llame 844-395-1026.

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Account holder information

Name
Claude A Simon

Identification Number
311W09183

Product Name
Medicare Supplement Insurance

Contact information

Questions?
View your claim information online at **www.anthem.com.**

Or call Member Services at **844-395-1026.**
Hours are Mon-Fri (8:00 a.m. - 6:00 p.m.).

Suspect claim fraud?
Call our Fraud Hotline at: **800-423-7283.**

Section 1 - Claim summary

8/29/24
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Services provided for: Claude A Simon
Member's ID: 311W09183
Relationship: Account Holder
Date Prepared: 07/26/24

Claim Number: 274008698100
Services provided by: Gotsis, William
Medicare assignment status:
This provider accepted Medicare assignment.
Patient Account: 000175649788
Claim receipt date: 07/20/24

Explanation of payment:

- Q14 Prior payer's (or payers') patient responsibility (deductible, coinsur ance, co-payment) not covered.
- Q00 The impact of prior payer(s) adjudication including payments and/or adjustments.
- 23 THE IMPACT OF PRIOR PAYER(S) ADJUDICATION INCLUDING PAYMENTS AND/OR ADJUSTMENTS.

	Charges $		Payments $					
Date of service					You pay			
Services received								
Reason Code	**Total charged**	**Patient savings**	**Medicare pays**	**Your health plan pays**	**Copay**	**Deductible**	**Coinsurance**	**Services not covered**
07/10/24 Office Visit Q00, Q14	325.00	186.33	0.00	0.00	0.00	0.00	0.00	138.67
Subtotal	**325.00**	**186.33**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**138.67**

Section 1 - Claim summary
(continued)

Claim Number: 274140261500
Services provided by: Gotsis, William
Medicare assignment status:
This provider accepted Medicare assignment.
Patient Account: 000175649788
Claim receipt date: 07/23/24

Explanation of payment:

- Q14 Prior payer's (or payers') patient responsibility (deductible, coinsur ance, co-payment) not covered.
- Q00 The impact of prior payer(s) adjudication including payments and/or adjustments.
- 23 THE IMPACT OF PRIOR PAYER(S) ADJUDICATION INCLUDING PAYMENTS AND/OR ADJUSTMENTS.

	Charges $		Payments $					
Date of service					You pay			
Services received								
Reason Code	Total charged	Patient savings	Medicare pays	Your health plan pays	Copay	Deductible	Coinsurance	Services not covered
07/10/24 Cardiovascular Serv Q00, Q14	70.00	54.40	0.00	0.00	0.00	0.00	0.00	15.60
Subtotal	**70.00**	**54.40**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**15.60**
Total	**395.00**	**240.73**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**154.27**
					Total you pay: $154.27			

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Section 2 - 2024 Year-to-date summary

Your health plan at a glance...

These totals are accurate as of this claim. If you received care more recently,unprocessed claims for that care will not yet be reflected in the totals shown here.

Your foreign travel lifetime maximum is	$50,000.00
Payments applied to date	-$0.00
Remaining to meet	$50,000.00

Your foreign travel deductible applied

	Foreign travel deductible maximum $250.00	
Individual	**- Applied to date**	**= Remaining deductible**
Claude A Simon	$0.00	$250.00

Section 3 - Additional information

Additional information you may need

► What if I don't understand why a service was denied?
To find out more about why a service was denied, you can call the Member Services number on your member ID card.

► What if I don't agree with this decision?
You have the right to appeal it. This means you can tell us you don't agree with a decision that was made to not cover an item or service. That can mean part of the service or the whole service. You must tell us you are appealing the decision within either 15 months of the date of service or 180 days from the date you were told of our decision, whichever is later.

► How do I appeal a decision?
To ask for an appeal, you will need to send us a letter at this address:

Anthem Blue Cross and Blue Shield
Medicare Appeals and Grievances
4361 Irwin Simpson Road
Mason, Ohio 45040

It's best if you ask for your appeal in writing. But unless it says in your benefit rules that your appeal has to be in writing, you can also call the number on your member ID card or go to **www.anthem.com.**

► What if my situation is urgent?
You'll need to request an expedited appeal. If it's urgent, your review will generally be done in 30 business days. Follow the directions above for filing an internal appeal.

An urgent situation is one in which:

- Your health may be in jeopardy, or
- In your doctor's opinion, your pain can't be adequately controlled while you wait.

► Who may file an appeal?
You or someone you name to act for you (your authorized representative) may appeal. Please provide a signed document that includes:

- Member name
- Address
- Birth date
- Daytime phone number
- ID number
- Date of service and/or appeal issue
- Specific consent to appeal
- Provider name, address and phone number.

Send the document to the Medicare Appeals and Grievances at the address provided under the "How do I appeal a decision?" section.

► Can I provide more information about my claim?
Yes, you can send more information. Send it to the Medicare Appeals and Grievances. Use the address provided under the "How do I appeal a decision?" section.

► Can I request copies of information relevant to my claim?
Yes and they won't cost you anything. Also, if you think that a mistake was made because we had the wrong billing codes, you can call the Member Services number on your member ID card.

► What happens next?
When you appeal, we will review our original decision. You will be told what the new decision is in writing within 60 calendar days. This is unless your benefit rules say otherwise. If we still deny the payment, coverage or service or you don't get a response in a timely manner, you have one more option. You can ask that your appeal get reviewed by a third party. There may be some limits that apply, so please refer to your Policy or contact New York State Department of Financial Services. This would be the last review and the decision would become final.

► Other resources to help you:
Please refer to your Policy or contact the New York State Department of Financial Services

Section 4 - Definitions

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Copay
It's the flat-dollar amount you may pay for certain benefit plan services, such as doctor visits.

Deductible
It's the flat-dollar amount you may pay for certain benefit plan services before your health plan begins to pay. Some plans may have more than one deductible.

Coinsurance
A percentage that you pay after you have met your plan's deductible. The plan pays a certain percentage and you pay a certain percentage.

Out-of-pocket maximum
The most you have to pay each year for expenses covered by your plan. It includes the deductible and coinsurance amounts. Once you reach this amount, you do not pay anything for most services.

Patient savings
Your are not responsible for the amount displayed and the provider can't charge you. This amount can include services from a provider who participates in a contractual agreement with Anthem Blue Cross and Blue Shield Medicare contractual write off amounts, federal regulatory reductions, penalties, etc.

Services not covered
Charges you must pay because they aren't covered under your plan. This part of the claim is denied. The provider may bill you for these charges.

Total Charged
Total amount your provider billed.

Total you pay
This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, copay and other services not covered.

How we figure out what to pay

Medicare usually pays 80% of the allowed amount minus any Federal regulatory reductions or penalties. Medicare Supplement pays the other 20%. This is subject to any plan copays, deductibles or coinsurance you owe. Some Medicare Supplemental plans have special benefits. For plan details, call us at the number on the back of your ID card.