

PROVIDER SUMMARY VOUCHER

Memorial Hospital
PO Box 1290

Latham, NY 12210
800-888-7777

JOHN A PROVIDER
230 ELM STREET
STE 200
ANY TOWN, USA 99999

Date: 08/17/06
Profile: LLL
Vendor #: A998877
Check #: 0000999999
Check Amount: 170.00

Date of Service	Proc Code	Mod Cod	Units	Charged Amount	Allowed Amount	Provider Withhold	Discount Amount	COB Amount	Prepaid Amount	Non-covered Amount	Deductible Amount	Co-Pay Amount	Co-Ins Amount	Paid Amount	Other Ins	EOP Codes
Patient: ELIZABETH L. PATIENT				Member #: 2005999999				Patient #: 90999999111				Claim #: 01 061206 99999 00002				
Provider: JOHN A PROVIDER				Provider #: 15059999				Parent/Group: CCC CCC001				GL Code: RCCC				
0403-040306	90806			90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 GF
0411-041106	90806		1	90.00	65.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	32.50	32.50	0.00	0.00 BS
0425-042506	90806		1	90.00	65.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	32.50	32.50	0.00	0.00 BS
0505-050506	90806		1	90.00	65.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	32.50	32.50	0.00	0.00 BS
0509-050906	90806			90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 YA IQ
0516-051606	90806			90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 YA IQ
Claim Totals:				540.00	195.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	97.50	97.50	0.00	

Precert Penalty: 0.00

Patient: ANGELA M. JACKSON				Member #: 2005888888				Patient #: 908888811				Claim #: 01 061206 88888 00001				
Provider: JOHN A PROVIDER				Provider #: 150576				Parent/Group: CCC CCC001				GL Code: RCCC				
0418-041806	90801			90.00	90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	50.00	0.00	0.00 G6 GS
0504-050406	90806		1	90.00	65.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	32.50	22.50	0.00	0.00 BS
0509-050906	90806			90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 YA IQ GS
0516-051606	90806			90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 YA IQ GS
0524-052406	90806			90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 YA IQ GS
0530-053006	90806			90.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 YA IQ GS
Claim Totals:				540.00	155.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	32.50	72.50	0.00	

Precert Penalty: 50.00

Statement Totals: 1080.00 350.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 130.00 170.00 0.00

Precert Penalty: 50.00

Provider Summary

JOHN A PROVIDER	1080.00	350.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	130.00	170.00	0.00	
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Precert Penalty: 50.00

EOP Code	Description
BS	BILLED AMOUNT EXCEEDS FEE SCHEDULE RATE
G6	DAILY THERAPY LIMITS EXCEEDED
GF	DUPLICATE CLAIM
GS	MAXIMUM NUMBER OF DAYS/VSTS PAID FOR THIS PERIOD
IQ	SERVICE INVALID FOR VENDOR
YA	RESUBMIT WITH CORRECT PAY TO LOCATION

