

EXPLANATION OF BENEFITS

Please retain for Future Reference
 District Hospital PIN: 0001111111
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EMPLOYEE NAME
 ADDRESS
 CITY, STATE ZIP

Date Printed: 11/12/2005
Tax Identification Number: 0222222222
Check Number: 576/36369854
Check Amount: **\$0.00**

Notes: The benefits listed below reflect your portion of this payment.
 For Participating Physicians and Facilities Only – If your practice has a change of address and/or telephone number please contact Aetna online at:
<https://www.aetna.com/providerehealthoffice/>

Patient Name: EMPLOYEE OR DEPENDENT NAME

Patient Account: A234234234 Patient ID# 888888888888
 Member ID: 123123123

Relation: Self Member: Employee Name
 Diag: 7964 Group Name: Employer Name
 APC/DRG: Claim ID: EK5P5T25L00 Recd: 01/15/05

AETNA LIFE INSURANCE COMPANY
 Group Number: 660379-10-001 AB DAMG7D
 Product: PPO Medical
 Network ID: 00124 MASS/NEW HAMPSHIRE

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED OR ALLOWED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
11/02/05	1	99213-00	1	193.25	75.88				75.88		75.88	.00
11/02/05	1	86021-00	1	320.00	82.05				82.05		82.05	.00
TOTALS				513.25	157.93						157.93	0.00

ISSUED AMT: \$0.00

Remarks:
 1 – We have paid the maximum allowed by your plan of benefits for this service. The balance is the member’s responsibility.

For Questions Regarding This Claim:
 P.O. Box 2250, Anytown, USA 12345-6789
Call 1-800-777-7777 FOR ASSISTANCE

Note: All Inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: \$157.93

Claim Payment: \$0.00

TOTAL PAYMENT TO District Hospital: \$0.00

Protecting the privacy of member health information is a top priority at Aetna. When contacting us about this statement or for help with other questions, please be prepared to provide your Aetna provider number, tax identification number (TIN), or Social Security number (SSN), in addition to the Aetna member’s ID number.