United HealthCare Services, Inc.
BUFFALO SERVICE CENTER
PO BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

WELLNESS CENTER OF CHESTER COU
JOSEPH P ZAPPY DC
403D GORDON DR
EXTON PA 19341

PAYMENT DATE: [redacted]
TIN: [redacted]
NPI: [redacted]
PAYEE NAME: WELLNESS CENTER OF CHESTER COU
PAYMENT NUMBER: [redacted]
PAYMENT AMOUNT: $30.00
GROUP NUMBER: [redacted]
GROUP NAME: [redacted]

PATIENT: [redacted]

SUBSCRIBER ID: [redacted] **SUBSCRIBER NAME:** [redacted] **CLAIM NUMBER:** [redacted]
CLAIM DATE: [redacted] **DATE RECEIVED:** [redacted] **PRODUCT:** [redacted]
REND PROV ID: [redacted] **REND PROV:** J. P ZAPPY DC

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
[redacted]					$70.00				$30.00	$25.00

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	SUB UNITS	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
[redacted]	[redacted]		98941			1	1	$70.00	$55.00	$25.00 $15.00	PR CO	3 45	$30.00	D1
CLAIM# [redacted]							SUBTOTAL	$70.00	$55.00	$40.00			$30.00	D1

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

TOTAL PAYABLE TO PROVIDER	$30.00	

NOTES

CO45 CONTRACTUAL OBLIGATIONS - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.

PR3 PATIENT RESPONSIBILITY - CO-PAYMENT AMOUNT

D1 NETWORK BENEFITS HAVE BEEN APPLIED. THE MEMBER IS ONLY RESPONSIBLE FOR THE COST SHARE (DEDUCTIBLE, COPAY AND COINSURANCE) AND ANY NON-COVERED AMOUNT AFTER THEY MEET THEIR BENEFIT LIMIT FOR A COVERED SERVICE.

If you disagree with a claim reimbursement decision
The member, health care professional or an authorized representative may contest the claim payment decision by submitting comments, documents or other information that shows why they believe the decision should be changed.

Network health care professionals: There is a 2-step reconsideration and appeal process. This process allows for a total of 12 months for timely submission for Step 1: Reconsideration and Step 2: Appeal. Claim reconsideration does not apply in some states based on applicable state law. The timetable may be different if required by law or by your participation agreement (contract). For more information and submission instructions, refer to Chapter 10 (Our claim process) of the Network Administrative Guide available at **UHCprovider.com/guides**. To appeal a clinical or prior authorization determination, follow the instructions in Chapter 7 (Medical management) of the guide.

Out-of-network health care professionals: As an out-of-network health care professional or facility, you can submit a request for an administrative review/reconsideration if permitted by state law. If you don't agree with the outcome of the review, you may submit an appeal on the member's behalf. You