

Provider Explanation of Medical Payment Report



Provider Number 232083828 0008	Provider Name PETER A SNAIAKO MD PC	Date through which claims were processed 10/26/2006	THIS IS NOT A BILL Retain for Your Records	Page 1
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Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code	Allowed Amount	Not Covered/Discount	Deduct/Copay Amount	Coinsurance Amount	DRG/Per Diem Type	DRG/Per Diem Number	DRG/Per Diem Amount	DRG/Per Diem Benefit Amount	Plan Benefit	See Note
PATIENT NAME: _____ PATIENT#: 19251 OPERATION LOCATION/GROUP# 24694-9-3213136 RECEIVE DATE: 10/12/2006 PROCESS DATE: 10/23 MEMBER NAME: _____ SUBSCRIBER#: _____ REF#: 4680629198448 CHECK#: 00220728866															
1	10062006	74872		175.00			175.00							0.00	A
2	10062006	74374		160.00		95.17	64.83	20.00				0.00	0.00	0.00	B
3	10062006	74999		225.00		112.50	112.50					0.00	0.00	75.17	B
4	10062006	74942		200.00		95.29	104.71					0.00	0.00	112.50	B
5	10062006	55700		300.00		226.37	73.63					0.00	0.00	95.29	B
TOTAL				1060.00		529.33	530.67	20.00				0.00	0.00	226.37	B

\$2,258.91 HAS BEEN APPLIED TO THE UNLIMITED INDIVIDUAL LIFETIME MAXIMUM

BALANCE..... \$20.00

WHY WAIT FOR THE MAIL? VIEW ELIGIBILITY, BENEFITS OR CLAIM DETAILS ONLINE ANYTIME AT [HTTP://WWW.CIGNA.COM/HEALTH/PROVIDER/](http://WWW.CIGNA.COM/HEALTH/PROVIDER/)

PAYMENT OF \$509.33 TO PETER A SNAIAKO MD

IR4 DXF

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code	Allowed Amount	Not Covered/Discount	Deduct/Copay Amount	Coinsurance Amount	DRG/Per Diem Type	DRG/Per Diem Number	DRG/Per Diem Amount	DRG/Per Diem Benefit Amount	Plan Benefit	See Note
PATIENT NAME: _____ PATIENT#: 19251 OPERATION LOCATION/GROUP# 24694-9-3213136 RECEIVE DATE: 10/23/2006 PROCESS DATE: 11/26 MEMBER NAME: _____ SUBSCRIBER#: U1255449 REF#: 4680629894720 CHECK#: 00220728866															
4	10132006	99213		102.00		52.32	49.68	20.00				0.00	0.00	32.82	B
7	10132006	51798		30.00		17.25	12.75					0.00	0.00	17.25	B
TOTAL				132.00		70.07	61.93	20.00				0.00	0.00	50.07	B

\$2,308.98 HAS BEEN APPLIED TO THE UNLIMITED INDIVIDUAL LIFETIME MAXIMUM

BALANCE..... \$20.00

PAYMENT OF \$50.07 TO PETER A SNAIAKO MD

SYS 659

- A) ONE OF THE BILLED PROCEDURES HAS BEEN DENIED BECAUSE IT IS NOT TYPICALLY PERFORMED ON THE SAME DATE OF SERVICE AS THE OTHER BILLED PROCEDURES.
- B) THANK YOU FOR USING THE CIGNA HEALTHCARE PREFERRED PROVIDER ORGANIZATION NETWORK. THIS REPRESENTS YOUR SAVINGS. SO YOU ARE NOT REQUIRED TO PAY THIS AMOUNT. THIS PROVIDER IS PROHIBITED FROM BILLING THE PATIENT FOR THE DIFFERENCE. IF YOU HAVE ALREADY PAID THE AMOUNT IN FULL, PLEASE REQUEST REIMBURSEMENT FROM YOUR PROVIDER.



Patient Name: [REDACTED]

Patient Account: 19330 Patient ID #: 0590830043
 Member ID: W109996313

Relation: Spouse Member: BEVERLEY J GEORGE JORDAN
 DIAG: 79093 Group Name: TYCO INTERNATIONAL (US) INC.
 Claim ID: F0XJDWKC800 Recd 01/11/07

AETNA LIFE INSURANCE COMPANY
 Group Number: 880799-24-001 C P 1
 Product: Aetna Choice
 Network ID: 00408 AETNA CHOICE EX

SERVICE DATES	PL	SERVICE CODE	NUM SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	REF. REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
12/08/06	11	76942	1	200.00	153.00							15
12/08/06	11	76872	1	175.00	123.00							12
12/08/06	11	76376		275.00								12
12/08/06	11	55700	1	350.00	232.00	30.00		275.00 1			30.00	20
12/08/06	11	76999	1	300.00	150.00							15
TOTALS				1,300.00	658.00	30.00		275.00			30.00	62

ISSUED AMT: \$621

Remarks:
 1 - Aetna does not consider any portion of this service as a Reasonable Charge because the service is incidental to other services provided to this patient for which reimbursement was or will be considered.

For Questions Regarding This Claim
 P.O. BOX 981109 EL PASO, TX: 79998-1109
 CALL (888) 632-3862 FOR ASSISTANCE

Total Patient Responsibility: \$30.00
 Claim Payment: \$625.00

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

Total Payment to: PETER A SINAIKO MD \$755.00

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.



DATES OF SRVCE AMOUNT BILLED CONTRACT AMT	REVENUE CODE PROVDER NONCOV OTHER INS PAY	DRG/HCPCS/MOD/NDC MEMBER NONCOV DEDUCTIBLE	POS REMARK CODE CO-INSURANCE	TOTAL UNITS ALLOWED AMT CO-PAYMENT	MBR RESP PENALTY	AMOUNT PAID
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PATIENT CONTINUED FROM PREVIOUS PAGE

11/03-11/03/06 \$275.00 \$275.00	\$275.00 \$0.00	76376 \$0.00 \$0.00	11 BPC \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	/\$0.00
11/03-11/03/06 \$300.00 \$300.00	\$300.00 \$0.00	76999 \$0.00 \$0.00	11 BPC \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	/\$0.00
11/03-11/03/06 \$200.00 \$93.00	\$0.00 \$0.00	76942 \$0.00 \$0.00	11 \$0.00	1 \$200.00 \$0.00	\$0.00 \$0.00	/\$93.00
11/03-11/03/06 \$300.00 \$260.00	\$0.00 \$0.00	55700 \$0.00 \$0.00	11 \$0.00	1 \$300.00 \$0.00	\$0.00 \$0.00	/\$260.00

TOTALS FOR THIS CLAIM

AMOUNT BILLED	PROVDER NONCOV	MEMBER NONCOV	ALLOWED AMOUNT	MBR RESP	NUMBER CLAIMS
\$1,250.00	\$575.00	\$0.00	\$675.00	\$0.00	1
CONTRACT AMT	OTHER INS PAY	DEDUCTIBLE	CO-INSURANCE	CO-PAYMENT	PENALTY
\$928.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
					AMOUNT PAID
					\$353.00

TOTALS FOR THIS PATIENT

AMOUNT BILLED	PROVDER NONCOV	MEMBER NONCOV	ALLOWED AMOUNT	MBR RESP	NUMBER CLAIMS
\$1,352.00	\$575.00	\$0.00	\$777.00	\$15.00	2
CONTRACT AMT	OTHER INS PAY	DEDUCTIBLE	CO-INSURANCE	CO-PAYMENT	PENALTY
\$967.36	\$0.00	\$0.00	\$0.00	\$15.00	\$0.00
					AMOUNT PAID
					\$377.36

PATIENT NAME	INSURED NAME	USI NO MEMBER ID NO	PT ACCOUNT NO	SS: CLAIM NUMBER
		3006993600 14520655800	15628	MH: 2511150607867

11/03-11/03/06 \$175.00 \$0.00	\$0.00 \$0.00	76872 \$0.00 \$0.00	11 PBR BPC \$0.00	\$175.00 \$0.00	\$0.00 \$0.00	/\$0.00
11/03-11/03/06 \$275.00 \$275.00	\$275.00 \$0.00	76376 \$0.00 \$0.00	11 BPC \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	/\$0.00
11/03-11/03/06 \$300.00 \$300.00	\$300.00 \$0.00	76999 \$0.00 \$0.00	11 BPC \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	/\$0.00
11/03-11/03/06 \$200.00 \$93.00	\$0.00 \$0.00	76942 \$0.00 \$0.00	11 \$0.00	1 \$200.00 \$0.00	\$0.00 \$0.00	/\$93.00
11/03-11/03/06 \$300.00 \$260.00	\$0.00 \$0.00	55700 \$0.00 \$0.00	11 \$0.00	1 \$300.00 \$0.00	\$0.00 \$0.00	/\$260.00



and with Highmark Blue Shield - Independent Licensees of the Blue Cross and Blue Shield Association

1124UCDS03010010141

VENDOR ID: 0021981000
 VENDOR NAME: PETER A. SINAIKO
 CHECK NBR 3102400559 DATE 11/24/2006 PAGE 12 OF 18

DATES OF SRVCE AMOUNT BILLED CONTRACT AMT	REVENUE CODE PROVDER NONCOV OTHER INS. PAY	DRG/HCPCS/MOD/NDC MEMBER NONCOV DEDUCTIBLE	POS REMARK CODE	TOTAL UNITS ALLOWED AMT	MBR RESP	SS: CLAIM NUMBER MH: 2511150607866
PATIENT NAME		INSURED NAME		PT ACCOUNT NO 13555		
[REDACTED]		[REDACTED]		MEMBER ID NO 7014352500 17830020400		
11/03-11/03/06 \$175.00 \$0.00	\$0.00 \$0.00	76872 \$0.00 \$0.00	11 PBR BPC \$0.00	\$175.00 \$0.00	\$0.00 \$0.00	\$0.00
PATIENT CONTINUED ON NEXT PAGE						



VENDOR ID: 0021981000
VENDOR NAME: PETER A. SINAIKO
CHECK NBR 3102400559 DATE 11/24/2006 PAGE 18 OF 18

1124UCDS03010010144

DATES OF SRVCE AMOUNT BILLED CONTRACT AMT	REVENUE CODE PROVIDER NONCOV OTHER INS PAY	ORG/HCP/CS/MOD/NDC MEMBER NONCOV DEDUCTIBLE	POS REMARK CODE CO-INSURANCE	TOTAL UNITS ALLOWED AMT CO-PAYMENT	MBR RESP PENALTY	AMOUNT PAID
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REMARK CODES:

~~RPC~~ CAP SERVICE PROVIDER NO PREAPPROVAL
P33 THIS SERVICE IS CONSIDERED INTEGRAL TO THE PRIMARY
PROCEDURE, THEREFORE NO ADDITIONAL PAYMENT IS DUE.

PDS KEY:

21 HOSPITAL INPATIENT
11 OFFICE VISIT



VENDOR ID: 0021981000
 VENDOR NAME: PETER A. SINAIKO
 CHECK NBR 3102380898 DATE 11/16/2006 PAGE 17 OF 17

DATE OF SRVCE AMOUNT BILLED CONTRACT AMT	REVENUE CODE PROVDER NONCOV OTHER INS PAY	DRG/HCPCS/MOD/NDC MEMBER NONCOV DEDUCTIBLE	POS REMARK CODE CO-INSURANCE	TOTAL UNITS ALLOWED AMT CO-PAYMENT	MBR RESP PENALTY	AMOUNT PAID
TOTALS FOR THIS CLAIM TOTALS FOR THIS PATIENT TOTALS FOR H OUTPATIENT - HMO POS DOMESTIC CLAIMS						
AMOUNT BILLED \$13,397.00	PROVDER NONCOV \$0.00	MEMBER NONCOV \$0.00	ALLOWED AMOUNT \$124.00	MBR RESP \$702.40	NUMBER CLAIMS 1	AMOUNT PAID
CONTRACT AMT \$0,070.48	OTHER INS PAY \$0.00	DEDUCTIBLE \$0.00	CO-INSURANCE \$0.00	CO-PAYMENT \$645.00	PENALTY \$0.00	
TOTALS FOR PETER A. SINAIKO TOTALS FOR THIS PAYMENT						
AMOUNT BILLED \$13,397.00	PROVDER NONCOV \$0.00	MEMBER NONCOV \$0.00	ALLOWED AMOUNT \$13,397.00	MBR RESP \$702.40	NUMBER CLAIMS 34	AMOUNT PAID
CONTRACT AMT \$0,070.48	OTHER INS PAY \$0.00	DEDUCTIBLE \$0.00	CO-INSURANCE \$57.40	CO-PAYMENT \$645.00	PENALTY \$0.00	
REMARK CODES: B03 INFORMATIONAL REMARK CODE; NO ACTION REQUIRED BY THE MEMBER OR PROVIDER. PBR THE SERVICE IS CONSIDERED MUTUALLY EXCLUSIVE. REIMBURSEMENT IS INCLUDED IN PAYMENT FOR OTHER PROCEDURES. B76 CLAIM PROCESSED AT THE SELF REFERRED BENEFIT P33 THIS SERVICE IS CONSIDERED INTEGRAL TO THE PRIMARY PROCEDURE. THEREFORE NO ADDITIONAL PAYMENT IS DUE						
POS KEY: 21 HOSPITAL INPATIENT 11 OFFICE VISIT 22 HOSPITAL OUTPATIENT						

UNITED HEALTHCARE INSURANCE COMPANY
 SPRINGFIELD SERVICE CENTER
 PO BOX 30555
 SALT LAKE CITY, UT 84130-0555
 PHONE: (866) 672-5311



DATE: 02/01/07
 TIN: 23-2983828
 GROUP #: 0228485
 GROUP NAME: ORACLE, INC.
 CHECK NUMBER: UQ 93103060
 CHECK AMOUNT: \$578.06

PROVIDER EXPLANATION OF BENEFITS

PETER A SINAIKO
 PETER A SINAIKO MD
 940 TOWN CENTER DR STE F100
 LANGHORNE PA 19047

PATIENT DETAIL

PRODUCT	MEM. ID	PATIENT NAME	PAT REL	PATIENT ACCOUNT	MEMBER NAME	CONTROL NUMBER	DATE RECEIVED	PROVIDER OF SERVICE
CHOYC+	A 822893368	[REDACTED]	EE	18218	[REDACTED]	01531175329-01	01/22/07	P. A SINAIKO MD
CHOYC+	A 822893368	[REDACTED]	EE	18218	[REDACTED]	01522198473-01	01/11/07	P. A SINAIKO MD

SERVICE DETAIL

PATIENT NAME	DATES OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT/COPAY	PLAN COV	PAID TO PROVIDER	RMK CD	PATIENT RESP.
[REDACTED]	01/11/07	99213	102.00		51.50	50.50	10.00	100%	40.50 D1		
		SUBTOTAL	102.00		51.50	50.50	10.00	100%	40.50#		10.00
	01/05/07	76872	175.00		75.15	99.85		100%	99.85 07		
	01/05/07	76376	275.00		129.62	145.38		100%	145.38 01		
	01/05/07	76999	300.00	300.00	300.00				.00 14		
	01/05/07	76942	200.00		101.29	98.71		100%	98.71 01		
	01/05/07	557000	350.00		156.38	193.62		100%	193.62 D1		
		SUBTOTAL	1,300.00	300.00	762.44	537.56			537.56#		

TOTAL PAID TO PROVIDER \$578.06

- REMARKS
- (D1) THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAX FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.
 - (I4) THIS IS NOT A SEPARATELY REIMBURSABLE SERVICE OR SUPPLY. AS A REMINDER; SUPPLY CODES SHOULD BE SUBMITTED WITH I CODES.
 - (#) PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

Detach Check

Detach Check

EXPLANATION OF BENEFITS

PETER SINAIKO
 PROVIDER #: 168543
 FILE NAME : 07H2_0915055.001

HIGHMARK MEDICARE SERVICES
 CHECK DATE: 12/15/2006
 CHECK# : 107857931

PERF	PROV	SERV	DATES	POS	NO	PROC & MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD

						EIC 188262510A		ACMT 19271		ICM 1106332326430		MA01 MA18
179931G	GCN	1117	111706	11	1	76372	175.00	128.06	0.00	25.61	CO-42	46.94
											PR-2	25.61
179931G	GCN	1117	111706	11	1	76376	275.00	159.39	0.00	31.88	CO-42	115.61
											ER-2	31.88
179931G	GCN	1117	111706	11	1	76999	300.00	0.00	0.00	0.00	CO-B15	300.00
											MS0	0.00
179931G	GCN	1117	111706	11	1	76942	200.00	159.82	0.00	31.96	CO-42	40.18
											PR-2	31.96
179931G	GCN	1117	111706	11	1	55700 22	350.00	241.95	0.00	48.39	CO-42	108.05
											PR-2	48.39
PAT RESP 137.84 CLAIM TOTALS 1300.00 689.22 0.00 137.84											748.62	551.38
CLAIM INFORMATION FORWARDED TO: BCBS OF MICHIGAN											ASG Y	551.38 NET

CHECK AMOUNT	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
551.38	1	1300.00	689.22	0.00	137.84	748.62	551.38

FILE	TOTAL CHECKS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
1	1	1300.00	689.22	0.00	137.84	748.62	551.38

 GLOSSARY OF EXPLANATION CODES:

MA01 (Initial Part B determination, carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. (more)
 MA18 The claim information is also being forwarded to the patient's supplemental insurer. (more)

Claim Adjustment Group Codes:

- CO = Contractual Obligations
- CR = Correction and Reversals
- OA = Other Adjustments
- PI = Payor Initiated Reductions
- PR = Patient Responsibility

EXPLANATION OF BENEFITS

PETER SINAIKO
 PROVIDER #: 168543
 FILE NAME : 07H2_0915055.002

HIGHMARK MEDICARE SERVICES
 CHECK DATE: 02/05/2007
 CHECK# : 107958131

PERF	PROV	SERV DATES	POS NOS	PROC & MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PDI
PAT RESP		41.89			232.00	209.45	0.00	41.89	PR-2 19.01	167.56
CLAIM INFORMATION FORWARDED TO: HIGHMARK INC.									64.44	167.56 NET
[REDACTED]									ASG Y	
179931GCM		1117 111705 11 1		HIC 138262510A 76999	300.00	0.00	0.00	0.00	ACNT 19271 ICM 1107009428280	MADI 300.00
PAT RESP		0.00			300.00	0.00	0.00	0.00	CO-B15 M80	0.00
CLAIM TOTALS									300.00	0.00
									ASG Y	0.00 NET

DX?

PETER SINAIKO
 PROVIDER #: 168543
 FILE NAME : 07H2_0915055.002

EXPLANATION OF BENEFITS

EIGHMARK MEDICARE SERVICES
 CHECK DATE: 02/05/2007
 CHECK# : 107958131

PERF PROV	SERV DATES	POS/NOS	PROC & MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PG
PAT RESP	162.83		CLAIM TOTALS	575.00	290.14	131.00	31.83	447.69	127.31
CLAIM INFORMATION FORWARDED TO: AETNA, INC.								ASG Y	127.31 NET

				1107016232560				MA01 MA18		
				ACNT 10561				MA01 MA18		
HIC 194121418A				175.00	136.73	0.00	27.35	CO-42	38.27	109.38
1799316CN	0105 010507	11 1	76872					PR-2	27.35	
1799316CN	0105 010507	11 1	76376	275.00	54.78	0.00	10.96	CO-42	220.22	43.82
1799316CN	0105 010507	11 1	76999	300.00	0.00	0.00	0.00	PR-2	10.96	
1799316CN	0105 010507	11 1	76942	200.00	119.55	0.00	23.91	CO-B15	300.00	0.00
1799316CN	0105 010507	11 1	55700	350.00	266.03	0.00	53.21	M80		
								CO-42	80.45	95.61
								PR-2	23.91	
								CO-42	83.97	212.82
								PR-2	53.21	
									838.34	461.66
PAT RESP	115.43		CLAIM TOTALS	1300.00	577.09	0.00	115.43	ASG Y		461.66 NET
CLAIM INFORMATION FORWARDED TO: EIGHMARK INC.										

Provider Number: 000168543

Provider Name: PETER SINAIKO, MD, PC

DECEMBER 15, 2006

DATE(S) OF SVC	NUM OF SVCS	REVENUE/ PROCEDURE CODE	PAY- MENT CODE	PROVIDER CHARGE	OUR ALLOWANCE	NON- CHARGEABLE AMOUNT	NON- CHG CODE	MEMBER LIABILITY AMOUNT	MEM LJAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
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PATIENT ACCT #:
MEMBER ID: PFP800636350

PATIENT:
MEMBER: [REDACTED]

CLAIM NUMBER:
06331090414

11/17/06	1	76872	023	175.00	99.00	76.00	25				99.00	J0080
11/17/06	1	76376	023	275.00	156.50	118.50	25				156.50	J0080
11/17/06	1	76942	023	200.00	78.00	122.00	25				78.00	J0080
11/17/06	1	55700-22	023	350.00	265.00	85.00	25				265.00	J6057, J0080
CLAIM TOTALS						401.50					598.50	

PATIENT ACCT #:
MEMBER ID: PFP80063635000

PATIENT:
MEMBER: [REDACTED]

CLAIM NUMBER:
06345566922

11/17/06	1	76999		300.00		300.00	07					E5291, J0080 J2050
CLAIM TOTALS						300.00						

MESSAGE(S):

- J0080 If you have questions, please call 1-866-731-8080.
- J6057 Unusual Procedural Services were reported. The supporting documentation was considered, but does not warrant an additional payment.
- E5291 Reimbursement for this service is considered to be a portion of another service which has been allowed. Therefore, no payment can be made for this service.
- J2050 Charges not shown on this Explanation of Benefits are being processed separately.

PAYMENT CODES:

023 = PREMIERBLUE SHIELD

NON-CHARGEABLE AMOUNT CODES:

- 07 = Rejected Non-Billable Services
- 25 = Differential

MEMBER LIABILITY CODES:

Did you know?

HIPAA-covered entities are required to obtain a National Provider Identifier (NPI) by 5/23/07. On that date, Highmark will require all NPI-eligible providers to use NPIs on claims. Apply now for an NPI at <https://nppes.cms.fhs.gov>. Watch your Highmark provider newsletter for updates.

