PCOVERFORM

Community First Health
12238 Silicon Dr
Ste 100
San Antonio, TX 78249

Electronic Service Requested

WHITE STOCK

201005030253

TEST

1 OF 3 F

ENV 1

1 0.0317

Community First Health
12238 Silicon Dr
Ste 100
San Antonio, TX 78249

VOID

Exhibit 19

P6867028001

20100503025 3 UN

Community First Health Plan
12238 Silicon Dr, Ste 100
San Antonio, TX 78249

COMMUNITY FIRST HEALTH PLANS

CHECK STOCK

Electronic Service Requested

TEST

For Questions Please Call
210-358-6200

2 OF 3 F

ENV 1

Provider's Name Here
PROVIDER ADDRESS HERE
CITY , ST 10000
,

RUN DATE:	05/03/2010
CHECK NO:	010000000001
PAYMENT AMT:	230.52
PAYEE ID:	0001
TIN:	000000001

BC01

STATEMENT TOTAL

Beginning Negative Services Balance:	.00
Beginning Prepayment Balance:	.00
Total Beginning Balance:	.00
Claims Paid This Run:	230.52
Final Payment:	230.52

Patient Name: LNAME1,FNAME1 **Member ID#:** A00000001 00 **Claim No:** 100000000001
Service Provider: Provider Name Here **Patient Account No:** 00001 **Prog #:** MEDICAID

Serv	Dates	LC	Diag#	PROC#	Days/ Cnt	Billed	Allowed	Explaination Codes	Denied	Copay	Coins	Deduct	TPP	Interest	Payment
100	02/16/10	72	4659	521	1	102.00	76.84	41	76.84	.00	.00	.00	.00	.00	.00
					Sub-total	102.00	76.84		76.84	.00	.00	.00	.00	.00	.00

Code	Description
41	CL MEMBER IS NOT ELIGIBLE ON THIS DATE OF SERVICE

Patient Name: LNAME2, FNAME2 **Member ID#:** A00000001 00 **Claim No:** 100000000002
Service Provider: Provider Name Here **Patient Account No:** 00001 **Prog #:** MEDICAID

Serv	Dates	LC	Diag#	PROC#	Days/ Cnt	Billed	Allowed	Explaination Codes	Denied	Copay	Coins	Deduct	TPP	Interest	Payment
100	02/09/10	72	6929	521	1	102.00	76.84	01	.00	.00	.00	.00	.00	.00	76.84
					Sub-total	102.00	76.84		.00	.00	.00	.00	.00	.00	76.84

Code	Description
01	PR PAID PER CONTRACTUAL AGREEMENT

Patient Name: LNAME3, FNAME3 **Member ID#:** A00000001 00 **Claim No:** 100000000003
Service Provider: Provider Name Here **Patient Account No:** 00001 **Prog #:** MEDICAID

Serv	Dates	LC	Diag#	PROC#	Days/ Cnt	Billed	Allowed	Explaination Codes	Denied	Copay	Coins	Deduct	TPP	Interest	Payment
100	02/16/10	72	6926	521	1	102.00	76.84	41	76.84	.00	.00	.00	.00	.00	.00
					Sub-total	102.00	76.84		76.84	.00	.00	.00	.00	.00	.00

Code	Description

COMMUNITY FIRST HEALTH PLANS

12238 SILICON DR, Suite 100
San Antonio, TX 78249-3373

Frost National Bank
Corpus Christi, Texas

88-2322
1149

DATE	CHECK NO
04/02/10	000001
AMOUNT	
$*****230.52	

PAY Two Hundred Thirty & 52/100 Dollars

TO THE ORDER OF **Provider's Name Here**
Provider Address Here
City , ST 10000
,

VOID AFTER 90 DAYS

VOID

⑈000001⑈ ⑆114923222⑆ 29 2016737⑈

Community First Health Plan
12238 Silicon Dr, Ste 100
San Antonio, TX 78249

Electronic Service Requested

WHITE STOCK

TEST

RUN DATE:	05/03/2010
CHECK NO:	010000000001
PAYMENT AMT:	230.52
PAYEE ID:	0001
TIN:	000000001

BC01

Remittance Advice and Explanation of Payment

Continued from Previous Page

Code	Description
41	CL MEMBER IS NOT ELIGIBLE ON THIS DATE OF SERVICE

Patient Name: LNAME3, FNAME3 **Member ID#:** A00000001 00 **Claim No:** 100000000004
Service Provider: Provider Name Here **Patient Account No:** 00001 **Prog #:** MEDICAID

Serv	Dates	LC	Diag#	PROC#	Days/ Cnt	Billed	Allowed	Explanation Codes	Denied	Copay	Coins	Deduct	TPP	Interest	Payment
100	02/08/10	72	3829	521	1	102.00	.00	41	.00	.00	.00	.00	.00	.00	.00
				Sub-total		102.00	.00		.00	.00	.00	.00	.00	.00	.00

Code	Description
41	CL MEMBER IS NOT ELIGIBLE ON THIS DATE OF SERVICE

Patient Name: LNAME4, FNAME4 **Member ID#:** A00000002 00 **Claim No:** 100000000005
Service Provider: Provider Name Here **Patient Account No:** 00011 **Prog #:** MEDICAID

Serv	Dates	LC	Diag#	PROC#	Days/ Cnt	Billed	Allowed	Explanation Codes	Denied	Copay	Coins	Deduct	TPP	Interest	Payment
100	02/16/10	72	78900	521	1	102.00	76.84	01	.00	.00	.00	.00	.00	.00	76.84
				Sub-total		102.00	76.84		.00	.00	.00	.00	.00	.00	76.84

Code	Description
01	PR PAID PER CONTRACTUAL AGREEMENT

Patient Name: LNAME5, FNAME5 **Member ID#:** A00000003 00 **Claim No:** 100000000006
Service Provider: CANYON LAKE ME DICAL CLINIC **Patient Account No:** 00022 **Prog #:** MEDICAID

Serv	Dates	LC	Diag#	PROC#	Days/ Cnt	Billed	Allowed	Explanation Codes	Denied	Copay	Coins	Deduct	TPP	Interest	Payment
100	02/08/10	72	4659	521	1	102.00	76.84	01	.00	.00	.00	.00	.00	.00	76.84
				Sub-total		102.00	76.84		.00	.00	.00	.00	.00	.00	76.84

Code	Description
01	PR PAID PER CONTRACTUAL AGREEMENT

VOID

RUN DATE:	09/04/2013
CHECK NO:	010001089337
PAYMENT AMT:	1,507.43
PAYEE ID:	7779
TIN:	453808279

BC01

Remittance Advice and Explanation of Payment

Continued from Previous Page

INITIAL CLAIMS FILING DEADLINE: Claims must be received within 95 days from the date of service or the final disposition date on primary carrier EOP.

PROOF OF TIMELY FILING: CFHP accepts a certified receipt, a dated fax transmission confirmation with CFHP fax number, electronic confirmation from THIN and/or a log listing claims by member and date of service if signed and dated by both the provider and a CFHP representative.

APPEALS: An appeal is a request for reconsideration of a previously adjudicated claim. Providers have the right to appeal a claim that has been denied by CFHP.
However, the Provider must submit the appeal within the following time frames:
1. HMO/ASO/CHIP appeals must be received within 90 days of the ORIGINAL EOP.
2. Medicaid appeals must be filed within 120 days of the date of the MOST RECENT EOP. All Medicaid claims must be finalized within 24-months from their dates of service.
The appeal must be submitted on paper, or for participating providers only, via the Provider Web Portal. All appeals must clearly state **APPEAL** on the claim. Resubmission of a claim without correcting the claim as identified on the EOP is not considered an appeal. Submit written appeals to:
Community First Health Plans, Inc.
ATTN: Claims Appeal
P. O. Box 853927
Richardson, Texas 75085-3927
A written appeal must be submitted in the following manner:
1. Complete a CFHP Appeal Submission Form and include the CFHP claim number with a clear explanation of the reason for the appeal.
2. If an EOP is submitted with your Claims Appeal Submission form, make a copy of the EOP on which the claim is reported DE-IDENTIFYING information for other members on the EOP. Circle or highlight the claim in question on the EOP.
3. Submit a clean claim with the correct information. Do not write on the original claims and resubmit.

If an incomplete appeal is received, the Provider will be notified via the EOP