OF 3 F

Community First Health 12238 Silicon Dr

12238 Silicon Dr Ste 100 San Antonio, TX 78249

WHITE STOCK

201005030253



Electronic Service Requested

Ֆ 0-03Ֆ7 գլիկնդիմՈններիսիլիրը|||ինդենիկնա||ինրիրիլի

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



COMMUNITY FIRST

CHECK STOCK

Electronic Service Requested



For Questions Please Call 210-358-6200



2 OF 3 F

Provider's Name Here PROVIDER ADDRESS HERE CITY 7 ST 10000

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

	ient Name Provider:			FNAME1 ame Here			Patien	Member ID#: A00 t Account No: 000		Claim No: 100000000001 Prog #: MEDICAID					
Serv	Serv Dates LC Diag# PROC# Days/ Billed Cnt							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
Code		Desci	ription	Si	ub-total	102.00	76.84		76.84	.00	.00	.00	.00	.00	.00
41	··· f ···														

			10000000				0000001 00		Patient Name: LNAME2, FNAME2 Service Provider: Provider Name Here									
	rest Payme		TPP	Deduct	Coins	Copay	Denied	Explaination Codes	Billed									
.00 70	.00 76	.00	.00	.00	.00	.00	.00	01	76.84	102.00	1	521	6929	72	02/09/10	100		
.00 70	.00 76	.00	.00	.00	.00	.00	.00		76.84	102.00	Sub-total							
									г	GREEMENT	ACTUAL A	CONTRA	ription			Code		
	Inte	I	MEDICA TPP	Prog #: Deduct .00	Coins .00	.00	Denied .00	Explaination Codes	76.84 76.84	102.00	Days/Cnt Sub-total	PROC#	Diag# 6929 ription	72 Descri	Dates 02/09/10	Service Serv		

	ient Name: Provider:			FNAME3 ame Here			Patien	Member ID#: A00 t Account No: 000		Claim No: 100000000003 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
Code	Sub-total 102.0 Description						76.84		76.84	.00	.00	.00	.00	.00	.00

COMMUNITY FIRST

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

ORDER OF

PAY Two Hundred Thirty & 52/100 Dollars TO THE **Provider's Name Here**

Provider Address Here , ST 10000 City

Frost National Bank Corpus Christi, Texas

DATE	CHECK NO
04/02/10	000001
88-2322	AMOUNT
1149	\$****230.52

VOID AFTER 90 DAYS



RUN DATE: CHECK NO: WHITE STOCKAYMENT AMT: **PAYEE ID:** TIN:

05/03/2010 010000000001 230.52 0001 000000001

Continued from Previous Page



Electronic Service Requested

Remittance Advice and Explanation of Payment

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

													10000000 MEDICA		
Serv	Dates	LC	Diag#	PROC#	Days/ Cnt	Billed	Allowed	Explaination 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
				S	ub-total	102.00	.00		.00	.00	.00	.00	.00	.00	.00
Code 41			ription IEMBER	IS NOT EI	JGIBLE (ON THIS DA	TE OF SERV	VICE							

	ent Name: Provider:		· · · · · · · · · · · · · · · · · · ·	FNAME4 ame Here			Patien	Member ID#: A0 t Account No: 000	0000002 00 011	Claim No: 100000000005 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	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		Desci	ription												
01		PR PAID PER CONTRACTUAL AGREEMENT													

	ent Name Provider:			FNAME5 LAKE ME	DICAL (CLINIC	Patien	Member ID#: A00 t Account No: 000	0000003 00	Claim No: 100000000006 Prog #: MEDICAID					
Serv	rv Dates LC Diag# PROC# Days/ Billed Cnt						Allowed	Explaination 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
				S	ub-total	102.00	00 76.84 .00 .00 .00 .00						.00	.00	76.84
Code 01	···· · ··· · ··· · ··· · ··· · ·· ·														



 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. Medicald appeals must be filed within 120 days of the date of the MOST RECENT EOP. All Medicald 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

CONFIDENTIALITY NOTICE: The information contained in this communication is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If you are not the intended recipient, you are notified that any use, dissemination, forwarding, distribution, or copying of the communication is strictly prohibited. Please notify Community First Health Plans immediately, if you have received this by mistake by calling 210-358-6200.