HealthChoice
PO BOX 24110
OKLAHOMA CITY, OK 73124

Provider Name
Provider Address 1
Provider Address 2
City, ST 99999-9999

PDF

HealthChoice
P.O. BOX 24110
OKLAHOMA CITY, OKLAHOMA 73124
Customer Service: 1-800-782-5218 TDD: 1-800-941-2160
OR 1-405-416-1800 OR 1-405-416-1525

Provider Name
Provider Address 1
Provider Address 2
City, ST 99999-9999

TAX#: 99999999999
DATE: 99/99/9999
Draft#: 999999999
EFT Trace ID: 999999999999999

PAID CLAIMS

SVC DATE			PROVIDER BILLED	PROVIDER WRITE OFF	EXPL CODE	AMOUNT ALLOWED	AMOUNT NOT COVERED	MEMBER COPAY	MEMBER DEDUCTIBLE	MEMBER CO-INSURANCE	TOTAL BENEFITS
CLAIM #: 999999999999999			PATIENT NAME: XXXXXXX XXXXXXX				MEMBER NAME: XXXXXXX XXXXXXX				
ACCOUNT #: XXXXX99999XXX			PATIENT ID: 99999999-00				MEMBER ID: 99999999-99				
SERVICE PROVIDER: Provider Name			Pin #: 99999				THIS CLAIM WAS PROCESSED AS NETWORK				
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
	CLAIM TOTAL		9,999,999.99	9,999,999.99		9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
										Paid by EGID	9,999,999.99
										Paid by Other Insurance	9,999,999.99
										Total Payment to Provider	9,999,999.99
										Certification Penalty	9,999,999.99
										Private Room Charge	9,999,999.99
										Member Owes to Provider	9,999,999.99
										Provider Write-Off	9,999,999.99
CLAIM #: 999999999999999			PATIENT NAME: XXXXXXX XXXXXXX				MEMBER NAME: XXXXXXX XXXXXXX				
ACCOUNT #: XXXXX99999XXX			PATIENT ID: 99999999-00				MEMBER ID: 99999999-99				
SERVICE PROVIDER: Provider Name			Pin #: 99999				THIS CLAIM WAS PROCESSED AS NETWORK				
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
	CLAIM TOTAL		9,999,999.99	9,999,999.99		9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
										Paid by EGID	9,999,999.99
										Paid by Other Insurance	9,999,999.99
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										Provider Write-Off	9,999,999.99
CLAIM #: 999999999999999			PATIENT NAME: XXXXXXX XXXXXXX				MEMBER NAME: XXXXXXX XXXXXXX				
ACCOUNT #: XXXXX99999XXX			PATIENT ID: 99999999-00				MEMBER ID: 99999999-99				
SERVICE PROVIDER: Provider Name			Pin #: 99999				THIS CLAIM WAS PROCESSED AS NETWORK				
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
	CLAIM TOTAL		9,999,999.99	9,999,999.99		9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
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Provider Name
Provider Address 1
Provider Address 2
City, ST 99999-9999

00000100020003

TAX#: 99999999999
DATE: 99/99/9999
Draft#: 999999999
EFT Trace ID: 999999999999999

DENIED CLAIMS

SVC DATE			PROVIDER BILLED	PROVIDER WRITE OFF	EXPL CODE	AMOUNT ALLOWED	AMOUNT NOT COVERED	MEMBER COPAY	MEMBER DEDUCTIBLE	MEMBER CO-INSURANCE	TOTAL BENEFITS
CLAIM #: 999999999999999			PATIENT NAME: XXXXXXX XXXXXXX				MEMBER NAME: XXXXXXX XXXXXXX				
ACCOUNT #: XXXXX99999XXX			PATIENT ID: 99999999-00				MEMBER ID: 99999999-99				
SERVICE PROVIDER: Provider Name			Pin #: 99999				THIS CLAIM WAS PROCESSED AS NETWORK				
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
		CLAIM TOTAL	9,999,999.99	9,999,999.99		9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
										Paid by EGID	9,999,999.99
										Paid by Other Insurance	9,999,999.99
										Total Payment to Provider	9,999,999.99
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										Member Owes to Provider	9,999,999.99
										Provider Write-Off	9,999,999.99
CLAIM #: 999999999999999			PATIENT NAME: XXXXXXX XXXXXXX				MEMBER NAME: XXXXXXX XXXXXXX				
ACCOUNT #: XXXXX99999XXX			PATIENT ID: 99999999-00				MEMBER ID: 99999999-99				
SERVICE PROVIDER: Provider Name			Pin #: 99999				THIS CLAIM WAS PROCESSED AS NETWORK				
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
		CLAIM TOTAL	9,999,999.99	9,999,999.99		9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
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Provider Name
Provider Address 1
Provider Address 2
City, ST 99999-9999

TAX#: 99999999999
DATE: 99/99/9999
Draft#: 999999999
EFT Trace ID: 999999999999999

ADJUSTED CLAIMS

SVC DATE			PROVIDER BILLED	PROVIDER WRITE OFF	EXPL CODE	AMOUNT ALLOWED	AMOUNT NOT COVERED	MEMBER COPAY	MEMBER DEDUCTIBLE	MEMBER CO-INSURANCE	TOTAL BENEFITS
CLAIM #: 999999999999999			PATIENT NAME: XXXXXXX XXXXXXX				MEMBER NAME: XXXXXXX XXXXXXX				
ACCOUNT #: XXXXX99999XXX			PATIENT ID: 99999999-00				MEMBER ID: 99999999-99				
SERVICE PROVIDER: Provider Name			Pin #: 99999				THIS CLAIM WAS PROCESSED AS NETWORK				
99/99/99			(9,999,999.99)	(9,999,999.99)	XXX	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			(9,999,999.99)	(9,999,999.99)	XXX	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
		CLAIM TOTAL	9,999,999.99	9,999,999.99		9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
										Paid by EGID	9,999,999.99
										Paid by Other Insurance	9,999,999.99
										Total Payment to Provider	9,999,999.99
										Certification Penalty	9,999,999.99
										Private Room Charge	9,999,999.99
										Member Owes to Provider	9,999,999.99
										Provider Write-Off	9,999,999.99
CLAIM #: 999999999999999			PATIENT NAME: XXXXXXX XXXXXXX				MEMBER NAME: XXXXXXX XXXXXXX				
ACCOUNT #: XXXXX99999XXX			PATIENT ID: 99999999-00				MEMBER ID: 99999999-99				
SERVICE PROVIDER: Provider Name			Pin #: 99999				THIS CLAIM WAS PROCESSED AS NETWORK				
99/99/99			(9,999,999.99)	(9,999,999.99)	XXX	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
99/99/99			(9,999,999.99)	(9,999,999.99)	XXX	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(9,999,999.99
99/99/99			9,999,999.99	9,999,999.99	XXX	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
		CLAIM TOTAL	9,999,999.99	9,999,999.99		9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
										Paid by EGID	9,999,999.99
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Provider Name
Provider Address 1
Provider Address 2
City, ST 99999-9999

00000100030003

TAX#: 99999999999
DATE: 99/99/9999
Draft#: 999999999
EFT Trace ID: 999999999999999

SUMMARY PAGE

----------EARNINGS DATA----------

PAYMENTS:

CLAIMS PAYMENTS	9,999,999.99
INTEREST PAYMENTS	9,999,999.99

ACCOUNTS RECEIVABLES

	CLAIM #:	ACCOUNT #	PATIENT ID	RECOVERED AMT.	PATIENT NAME	AR # / DOS	REASON CODE:
RECOVERED FROM	999999999999999	9999999999999	99999999-99	(9,999,999.99)	XXXXXXX XXXXXXX	999999999999	YY
APPLIED TO	999999999999999	8888888888888	99999999-99		XXXX XXXX	99/99/99	

TOTAL ACCOUNT RECEIVABLES		(9,999,999.99)
NET CLAIM PAYMENTS		9,999,999.99
NET INTEREST PAYMENTS	(+)	9,999,999.99
NET TOTAL PAYMENT	(=)	9,999,999.99

EDI Payer ID: 99999

ELECTRONIC PAYMENT DRAFT NUMBER: 999999999 TAX ID: 99999999999 9,999,999.99

Description of Explanation Code
XXX Explanation of the code used

Accounts Receivable Reason(s)
YY Reason associated with code used

Messages

* Providers may promptly appeal this claim decision by submitting a personal letter to HP Administrative Services, LLC. All appeals must be made in writing within two (2) years from this date. Dispute Resolution (Network providers only)---An additional 90 days from the first notification will be given for disputes. If the attempt to resolve is not successful, payment shall be resolved in accordance with the Dispute Resolution Rights as defined in the Network Provider Contracts.
* For member eligibility verification and claim information, please reference ClaimLink at www.sib.ok.gov/providers
* The Out-of-Pocket Maximum does not include charges for non-covered services and balance billing charges from non-network providers.
* An 835 was not created for this RA

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