Patient: ERICA KAHN

Date: August 16, 2024

Date:	August 16, 2024				Claim Finalized Date: 12/23/20							
	Provider: FLAGSTAFF Provider: FLAGSTAFF	Patient Responsibility				NETWORK	: Pł	HCSD				
Date of Service	Description	Billed Charges	Plan Allowed/ Qualified Payment Amount	Not Covered	Deductible	Co-Pay	Colnsurance	PAID Amount	PAID %	Remark Code		
08/16- 08/16/2024	Waiting Period	\$16,372.80	\$16,372.80	\$16,372.80	\$0.00	\$0.00	\$0.00	\$0.00		75		
	Gross Total	\$16,372.80	\$16,372.80	\$16,372.80	\$0.00	\$0.00	\$0.00	\$0.00				
Other Ins	urance/Adjustment							\$0.00				
Patient #:						A	mount Paid:	\$0.00				
Claim #:				An	ount Patie	nt May O	we Provider:	\$16,372.80				

	igust 19, 2024			,				Claim Final	ized Date: 12	2/23/2024
Pro Rendering Pro	Patient Responsibility				NON	-NETWORK				
Date of Service	Description	Billed Charges	Plan Allowed/ Qualified Payment Amount	Not Covered	Deductible	Co-Pay	Colnaurance	PAID Amount	PAID %	Remark Code
08/19/2024	Service is Not Covered under the Plan	\$467.52	\$467.52	\$467.52	\$0.00	\$0.00	\$0.00	\$0.00		47
08/19/2024	Service is Not Covered under the Plan	\$60.00	\$60.00	\$60.00	\$0.00	\$0.00	\$0.00	\$0.00		47
08/19/2024 C	ervice is Not overed under the an	\$1.00	\$1.00	\$1.00	\$0.00	\$0.00	\$0.00	\$0.00		47
08/19- Se	ervice is Not evered under the	\$1.00	\$1.00	\$1.00	\$0.00	\$0.00	\$0.00	\$0.00		47
	Gross Total	\$529.52	\$529.52	\$529.52	\$0.00	\$0.00	\$0.00	\$0.00		
Other Insuran	ce/Adjustment		-				<b>,</b>	\$0.00		
tient #:				Amount Paid:				\$0.00		
aim #:				An	ount Patie	nt May C	we Provider:	\$529.52		

Patient: ERICA KAHN

Date: August 23, 2024

Claim Finalized Date: 12/23/2024

Properting Properties	ovider: Circle Health	urgent Care, L	ic		atient Resp	onsibilit	y	NON-NETWORK			
Date of Service	Description	Billed Charges	Plan Allowed/ Qualified Payment Amount	Not Covered	Deductible	Co-Pay	Coinsurance	PAID Amount	PAID %	Remark Code	
08/23- 08/23/2024 V	Vaiting Period	\$1,230.75	\$1,230.75	\$1,230.75	\$0.00	\$0.00	\$0.00	\$0.00		75	
08/23- 08/23/2024 V	Vaiting Period	\$72.00	\$72.00	\$72.00	\$0.00	\$0.00	\$0.00	\$0.00		75	
	Gross Total	\$1,302.75	\$1,302.75	\$1,302.75	\$0.00	\$0.00	\$0.00	\$0.00			
Other Insura	ance/Adjustment							\$0.00			
Patient #:							Amount Paid:	\$0.00			
Claim #:	Amount Patient May Owe Provider:				\$1,302.75						

	TOLCHIERRADY Detions	Out-of-Pocke	t (OOP)	Patient's Status			
Year to Date (Y I ERICA KAHN	TD) SUMMARY - Patient	Deductible	OOP	MOOP	Remaining		
Network	Medical Year to Date (YTD) Summary	\$0.00	\$0.00	UNLIMITED	UNLIMITED		
Non-Network	Medical Year to Date (YTD) Summary	\$0.00	\$0.00	UNLIMITED	UNLIMITED		

<sup>1</sup> MOOP - Maximum Out-of-Pocket for Patient; Patient Responsibility amount are described in your benefits booklet; does not include "Not-Covered"

# REMARKS

- 75 The required waiting period for this service has not been met.
- 47 Service not covered under plan



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## **Explanation of Benefits**

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

## Forwarding Service Requested

ERICA KAHN

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Customer Service

Questions? Please call Customer Service at (866) 949-3581 Payer ID

Policyholder/Member Information

Group:

Group No.:

Enrollee: KAHN, ERICA

Enrollee ID:

Paid Date: 07/08/2025



Claim#:
Patient: KAHN, ERICA

Patient#:
Provider: DENVER HEALTH

Discount Allowed Deductible Co-pay Cov Amount Amoun

Patient's Res	sponsib	oility:	\$1,8	38.22				Total Payment			
		Land Jam and Inc.		Markey	formalys ng	teamernt	Less Coordination of Benefits				
Columi	Totals	\$2,302.66	\$1,838.22	v the m	\$464.44	\$0.00	\$0.00	\$0.00	\$0.00	ח סר סוו	\$0.00
08/29-08/29/2024	90471	\$63.32	\$47.49	99	\$15.83	\$0.00	\$0.00	\$0.00	\$0.00	0%	\$0.00
08/29-08/29/2024	90675	\$1,127.12	\$845.34	99	\$281.78	\$0.00	\$0.00	\$0.00	\$0.00	0%	\$0.00
08/29-08/29/2024	99282	\$1,112.22	\$945.39	B15	\$166.83	\$0.00	\$0.00	\$0.00	\$0.00	0%	\$0.00
of Service	Code	Billed	Covered	Code	Amount	Amount	Amount	Amount	Amount	Paid At	Amount

PER MULTIPLAN AGREEMENT

Remark Code Description

B15 30 DAY WAITING PERIOD 99 NOT A COVERED SERVICE **Procedure Code Description** 

99282 ER VISIT 90675 VACCINE 90471 VACCINE



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Clearwater FL

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## **Explanation of Benefits**

**RETAIN FOR TAX PURPOSES** THIS IS NOT A BILL

#### Forwarding Service Requested

ERICA KAHN

tains important information that you should retain for your records. This document serves as notice of benefit in part, for the requested treatment or service described in the requested treatment or service described in the requested treatment or service described in the record of the record of

Questions? Please call Customer Service at (866) 949-3581 Payer ID

#### Policyholder/Member Information

Group:

Group No.:

Enrollee: KAHN, ERICA

Enrollee ID:

Paid Date: 07/08/2025



Claim#:

Patient: KAHN, ERICA Patient#:

Provider: FLAGSTAFF EMERGENCY PHYSICIAN

of Service Co	roc. ode	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Covered Pa	aid At	Payment Amount
	284	\$706.00	\$706.00	99	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0%	\$0.00
Column To	tals	\$706.00	\$706.00	NUMBER DOV	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0 76	\$0.00
Patient's Responsibility: \$706.00				entasive, or b	asign be	our authorize	Less Coordination of Benefits			\$0.00	
vinso bourit Jaeba	enen	ol rie vol role			NAME OF THE PARTY	a awaii ie	of the appe	amontuo ha	Total Payn	nent	\$0.00

Remark Code Description

NOTA COVERED SERVICE

**Procedure Code Description** 

99284 **ER VISIT**