New Explanation of Benefits Form

This is a sample of our new Explanation of Benefits form, along with descriptions of various sections. This will help plan members and providers understand how benefits are paid.

Office of Group Benefits
P.O. Box 44036
Baton Rouge LA 70804-4036

SAMPLE

Address Service Requested

How to read your Explanation of Benefits (EOB)

Office of Group Benefits
P.O. Box 44036
Baton Rouge LA 70804-4036

The Patient's Name

Enrollee: John Doe
Patient: Jane Doe
Patient #: 9999999
Soc Sec #: 999-88-9999
Provider Name: Sample Hospital
Claim#: 99999999-04
Date: 12/20/2000

The Claim Number

IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII

John Doe
PO BOX 000
Kalamazoo, MI 49005-0671

The Employee's Name and Address

You may call these numbers if you have a question

Customer Service Information

Baton Rouge: 1-800-272-8451	Monroe: 1-800-335-6206
Alexandria: 1-800-813-1578	New Orleans: 1-800-335-6208
Lafayette: 1-800-414-6409	Shreveport: 1-800-813-1574
Lake Charles: 1-800-525-3256	TDD (Baton Rouge): 1-800-259-6771

The amount the patient is responsible to pay to a provider when a service is rendered

Dates of Service	Service Code	Total Amount	Not Covered	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-Pay Amount	Balance	Paid At	Payment Amount
03/01-03/01/2000	MD	50.00	0.00		0.00	50.00	50.00	0.00	0.00	100%	0.00
03/01-03/01/2000	MD	400.00	336.00	03	0.00	64.00	64.00	0.00	0.00	100%	0.00
03/01-03/01/2000	MD	100.00	24.55	03	0.00	75.45	75.45	0.00	0.00	100%	0.00
	Totals	550.00	360.55		0.00	189.45	189.45	0.00	0.00		0.00
										Other Insurance Credits or Adjustments	0.00
										Total Net Payment	0.00

Total Patient Responsibility 189.45

Charges not eligible, which could be a discount written off by the provider, or a charge the patient is responsible to pay

The amount applied to the deductible on this claim.

This could include an amount applied to your deductible, a co-pay amount paid to a provider, coinsurance (your %) a charge excluded by the plan, or a charge previously considered

Accumulators

Your 2000 deductible has been satisfied

The total amount applied to the deductible year-to-date for this claimant and for the family

Payment To:	Check No.	Amount
Sample Hospital	20407187	26.73

Service Code

MD MEDICAL

Reason Code Description

03 EXCEEDS FEE SCHEDULE

An explanation by line number of the reasons certain charges were excluded.

Messages