BlueCross BlueShield of Minnesota
An Independent licensee of the Blue Cross and Blue Shield Association

P.O. Box 64560
St. Paul, MN 55164-0560

Explanation of Health Care Benefits

THIS IS NOT A BILL. This is an explanation of the claim processed on your plan benefits in effect when the service was performed. Please keep this form for your tax records.

Year to Date Deductible
Contact: For Customer Service – Please Call
OR TOLL FREE

Patient ID	Group/Policy	Date Received	Date Processed	Claim Number

Subscriber/Member Name					
Patient Name					
Provider					
Patient Control Number					
Dates of Service	From	From	From	From	From
	To	To	To	To	To
Description					
Charges					
Provider Responsibility Amount					
Allowed Amount					
Amount Paid by Other Insurance					
Deductible Amount					
Copay Amount					
Coinsurance Amount					
Paid Amount					
Patient Noncovered Amount					
Amount You Owe					
Notes ID					

1 2 3 4 5 6

Notes

Total Charges
Total Benefit Amount
Total Amount Paid by Other Insurance
Total Amount You Owe

See reverse side for Complaint/Appeal, Fraud and other important information.

C1603 (7/09)

Understanding your Explanation *of* Health Care Benefits Form

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The Explanation of Health Care Benefits explains how we process your claims. You'll see a sample on the back of this brochure. Each section on the sample is numbered to make it easy to find the description below.

1 Who

This area shows who received and who performed the services indicated on the claim.

Provider
This is the name of the provider from whom you received the services. A provider can be a doctor or other health care professional, a hospital or another organization that offers health care services.

Patient Control Number
The provider assigned identifier used to track a claim from creation through payment.

2 How much

Provider Responsibility Amount
The provider is responsible for this difference between the charged amount and the allowed amount.

Allowed Amount
This is the amount the provider receives and is established in annual partnership with providers.

3 Computation

Deductions in this area are your responsibility as noted in your contract.

Amount Paid by Other Insurance
This is the amount that was paid by Medicare or another health plan.

Deductible Amount
This is the amount of covered expense that must be reached before benefits can be paid by Blue Cross.

Copay Amount
This is a fixed amount you may be required to pay for some services like office visits, emergency room visits or pharmacy purchases.

Your deductible and copay amount will be added together when both are applied to the same claim.

Coinsurance Amount
This reflects the percentage of the payment for which you are responsible, for example 20 percent. (This does not refer to other insurance coverage.)

4 Claim Status

This section is a recap of what is and is not covered.

Paid Amount
This is the total amount that Blue Cross will pay for this claim.

Patient Noncovered Amount
This is the amount for services or supplies that are excluded by your contract.

Amount You Owe
This is the total of all the amounts for which you are responsible for this claim.

5 Notes

More information about how we handled your claim may be included here. Match the number in this area to the number and explanation printed on the lower part of the form for the appropriate message.

6 Totals

This area is a summary of how we processed your claim. Refer to the upper portion of the form for details.