Delaware Physicians Care, Incorporated
252 Chapman Road, Suite 250
Newark, DE 19702

If you have any questions
Please contact the Claims Department at
(866) 543-2167, option 2 then option 1

Remit Date:	01/31/2006
Beginning Balance:	-232.10
Processed Amount:	1,422.38
Discount/Penalty:	-15..39
Net Amount:	1,406.99
Refund Amount:	116.50
Amount Recouped:	-232.10
Amount Paid:	1,291.39
Ending Balance:	0.00
Check #:	1234567
Check Amount:	1,291.39

Forwarding Service Requested

PROVIDER/FACILITY NAME
123 E. MAIN ST
P O BOX 1234
NEWARK, DE 19702

SAMPLE

PROVIDER NAME

TIN: 123456789
Benefit Plan: Delaware Medicaid

Patient: MEMBER NAME A **Patient Acct #:** 444444444 **Claim Status:** PAID
Member ID: 222222222 **Authorization ID:** **Claim #:** 06001777777777
Date of Birth: 03/26/1978 **Provider:** PROVIDER NAME **Refund Amount:**

Line #	Dates of Service (From – Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	01/05/06	95810		740	FFS	1	1,603.00	0.00	1,538.88	0.00	0.00	1,538.88	-15.39	1,523.49
					Claim Totals		1,603.00	0.00	1,538.88	0.00	0.00	1,538.88	-15.39	1,523.49

Patient: MEMBER NAME B **Patient Acct #:** 5555555555555 **Claim Status:** REVERSED
Member ID: 333333333 **Authorization ID:** **Claim #:** 0600388888888
Date of Birth: 06/30/1992 **Provider:** PROVIDER NAME **Refund Amount:** 116.50

Line #	Dates of Service (From – Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	12/10/05	99285			FFS	-1	-388.00	0.00	-116.50	0.00	0.00	-116.50	0.00	-116.50
					Claim Totals		-388.00	0.00	-116.50	0.00	0.00	-116.50	0.00	-116.50

Code/Description
Reversal of Claim # 033012345678
123 – Payer refund due to overpayment

Patient: MEMBER NAME C **Patient Acct #:** 555555555555 **Claim Status:** DENIED
Member ID: 666666666 **Authorization ID:** **Claim #:** 0536099999999
Date of Birth: 05/20/1962 **Provider:** PROVIDER NAME **Refund Amount:**

Line #	Dates of Service (From – Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	12/16/05	71010	26		FFS	0	43.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
					Claim Totals		43.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Code/Description
Line 1 M86 – Service denied because payment already made for similar procedure within set timeframe Service denied per finding of a Review Organization

SAMPLE

	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
Remit Totals	1,258.00	0.00	1,422.38	0.00	0.00	1,422.38	-15.39	1,406.99

SAMPLE

Delaware Physicians Care, Incorporated
252 Chapman Road, Suite 250
Newark, DE 19702

If you have any questions
Please contact the Claims Department at
(866) 543-2167, option 2 then option 1

Forwarding Service Requested

PROVIDER NAME
TIN: 123456789

SAMPLE

Remit Date: 01/31/2006
Check #: 1234567
Benefit Plan: Delaware Medicaid

Messages

Delaware Physicians Care, Incorporated offers the following resources and information to assist you with the handling of your claims and or appeals:

(1) **CLAIMS INQUIRY:** Please call (866) 543-2167 (option # 2 for provider, then option #1 for Claims Dept) to verify that your claim was processed correctly or for clarification of information before initiating an appeal.

(2) **HOW TO RESUBMIT A DENIED CLAIM OR REQUEST RECONSIDERATION OF A CLAIM**

– A **"RESUBMISSION"** is defined as a claim originally denied because of missing documentation, incorrect coding, etc., which is now being resubmitted with the required information.

– A **"RECONSIDERATION"** is defined as a request for review of a claim that a provider feels was incorrectly paid or denied because of processing errors.

When filing "**CORRECTED CLAIMS RESUBMISSIONS"** or **"RECONSIDERATIONS",** please include the following information to ensure the proper handling of your claims:

- A copy of the original claim (reprint or copy is acceptable) and any required documents
- A copy of the remittance advice on which the claim was denied or incorrectly paid
- Make a notation on the claim or remittance advice explaining why you are resubmitting the claim, and clearly indicate any corrections you have made. Please sign and date your notation and provide DPCI with a telephone number should we need to contact you.
- Each claim must be identified clearly with the words **"CORRECTED CLAIMS RESUBMISSION"** or **"RECONSIDERATION",** and submit a new claim with the requested change(s) and or attachments to:

Delaware Physicians Care, Incorporated
Claims Department
Attention: Claims Resubmission/Reconsideration
P. O. Box 61145
Phoenix, AZ 85082-1145
www.delawarephysicianscare.com

(3) **"DPCI APPEAL PROCESS":** The appeal process should be used **only** after attempts to resolve the matter informally through the Claims and Provider Services departments have failed. All letters submitted to DPCI Appeals Department must be identified clearly with the words **"FORMAL APPEAL".** The letter **must** include the following information:

- A statement as to why the provider believes the action by DPCI was incorrect.
- The provider must attach copies of any supporting documents such as claims, remits and medical records.
- Service / admission date, location of treatment, service, or procedure
- Please make sure to sign and date your **"Formal Appeal Letter"** and provide a telephone number should we need to contact you.

Delaware Physicians Care, Incorporated
Attn: Appeals Department
252 Chapman Rd, Suite 250
Newark, DE 19702

SAMPLE