

SAMPLE

1 Your Name Here
123 Main Street
Anywhere, USA 12345

2 ABC Company
3 Group Number: Group 123
4 Issue Date: January 1, 2016
5 Member Number: 123456789

Monthly Explanation of Benefits

This is not a Bill

1 Your Name Here Page 1 of 2

6 7	Patient's Name Type of Service	Service Date(s)	Amount Claimed	Discount	Other Adjust ments	Other Plan Payment	14 Patient Responsibility After Payments				Total Benefits	Paid At	Remark Codes		
							Ineligible	Co-Pay	Deductible	Out of Pocket					
Sample Patient # 1															
Claim Number: 15012750-01		8	9	10	11	12	13	15	16	17	18	19	20	21	22
			Provider: Doctor #124								Finalized: 1/26/15				
MEDICAL SUPPLY		12/20/14	451.52	0.00	0.00	0.00	0.00	0.00	0.00	50.00	120.46	281.06	70%		
Totals:			451.52	0.00	0.00	0.00	0.00	0.00	0.00	50.00	120.46	281.06			
23 Patient Responsibility											451.52				
Claim Number: 15012750-02		Provider: Doctor #125										Finalized: 1/26/15			
MEDICAL SUPPLY		12/18/14	190.83	0.00	0.00	0.00	0.00	0.00	0.00	0.00	57.25	133.58	70%		
Totals:			190.83	0.00	0.00	0.00	0.00	0.00	0.00	0.00	57.25	133.58			
Patient Responsibility											190.83				
Claim Number: 15012750-03		Provider: Doctor #126										Finalized: 1/26/15			
MEDICAL SUPPLY		12/17/14	184.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	55.35	129.15	70%		
Totals:			184.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	55.35	129.15			
Patient Responsibility											184.50				

This claim and all other claims shall remain subject to all Policy provisions and Exclusions/Limitations. We reserve the right to investigate for Pre-Existing Conditions and applicable Exclusions/Limitations.

Explanation:

- Insured Member's full name and address
- Employer's company name
- Health plan Group Number
- Date this EOB was issued
- Insured Member's number
- Patient (*Insured or covered family member receiving healthcare services*)
- Type of service received
- Date service was received
- Physician (*or other*) rendering healthcare service
- Claim amount charged for the service provided
- Discount to amount charged (*if applicable*)
- Other adjustment to amount charged (*if applicable*)
- Payment made by a plan that is not the ABC Company health plan
- Over-and-above payments made by the health plan, amount that patient must pay
- Amount of "Patient Responsibility" **14** that is not covered by the health plan
- Patient Responsibility: co-pay amount
- Patient Responsibility: deductible amount
- Patient Responsibility: out-of-pocket amount
- Date on which the claim was completed
- Total benefits paid after discount, adjustment, other plan payment and patient responsibility amounts
- The "Total Benefits" paid as a percentage of the "Amount Claimed" less co-pay, deductible and ineligible amounts
- Codes that provide additional explanation for adjustments to amounts paid
- Total amount for which the patient is responsible
- Services received by that patient from additional healthcare service providers during this statement period