ALLIED

Allied
PO BOX 211651
EAGAN MN 55121-6051

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

********************ALL FOR AADC 303
PB-DSM-27-ENV 7387 22
RAJ ROY
820 MARSH TRAIL CIR
SANDY SPRINGS GA 30328-5733

Customer Service

Questions? Contact us at the phone number listed on your Subscriber ID card.

For more information about your health plan, log in or register your account at alliedbenefit.com/Members.

Date: 11/28/2023
Enrollee: RAJ ROY
Group#: L210621
Group: APPTAD INC

Dates of Service: 06/16/2023 thru 07/19/2023

Dear RAJ ROY ,

The information below is a summary of the healthcare claims you incurred for the period 06/16/2023 through 07/19/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB)*. This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may recieve from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$619.00

This is the total amount billed for the dates of service of 06/16/2023 thru 07/19/2023.

Total Amount Paid By Plan

$145.65

This is the amount the plan paid in total for services rendered from 06/16/2023 thru 07/19/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$65.00

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Patient Responsibility	Payment Amount
5285243801	RAJ ROY	$252.00	$25.00	$195.35	$31.65	$0.00	$0.00	$25.00	$31.65
	Totals	$619.00	$25.00	$195.35	$185.65	$0.00	$40.00	$65.00	$145.65

Claim#: 5285243801
Patient: RAJ ROY

Patient#: 53385166
Provider: LABCORP BURLINGTON

Dates of Service	Service Code	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount
06/16-06/16/2023	37	$98.00	$0.00	46	$80.59	$17.41	$0.00	$0.00	$17.41	100%	$17.41
06/16-06/16/2023	37	$68.10	$0.00	46	$60.59	$7.51	$0.00	$0.00	$7.51	100%	$7.51
06/16-06/16/2023	37	$60.90	$0.00	46	$54.17	$6.73	$0.00	$0.00	$6.73	100%	$6.73
06/16-06/16/2023	61	$25.00	$25.00	28	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
Column Totals		$252.00	$25.00		$195.35	$31.65	$0.00	$0.00	$31.65		$31.65
									Other Credits or Adjustments		$0.00
									Total Net Payment		$31.65

Patient's Responsibility: $25.00

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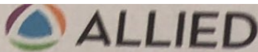

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Explanation of Benefits

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PB-DSM-33-ENV 23044 61
RAJ ROY
820 MARSH TRAIL CIR
SANDY SPRINGS GA 30328-5733

Customer Service

Questions? Contact us at the phone number listed on your Subscriber ID card.

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Date: 10/2/2023
Enrollee: RAJ ROY
Group#: L210621
Group: APPTAD INC

Dates of Service: 03/13/2023 thru 05/24/2023

Dear RAJ ROY ,

The information below is a summary of the healthcare claims you incurred for the period 03/13/2023 through 05/24/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB)*. <u>This is not a bill.</u> It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may recieve from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$1,047.00

This is the total amount billed for the dates of service of 03/13/2023 thru 05/24/2023.

Total Amount Paid By Plan

$285.69

This is the amount the plan paid in total for services rendered from 03/13/2023 thru 05/24/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$141.01

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Patient Responsibility	Payment Amount
5239500701	RAJ ROY	$360.00	$0.00	$208.02	$151.98	$0.00	$40.00	$40.00	$111.98
	Totals	$1,047.00	$0.00	$208.02	$426.70	$21.01	$120.00	$141.01	$285.69

Claim#: 5239500701
Patient: RAJ ROY

Patient#: 1149868V15482
Provider: POTTI MD, KARTHYA

Dates of Service	Service Code	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount
03/13-03/13/2023	34	$306.00	$0.00	46	$154.02	$151.98	$0.00	$40.00	$111.98	100%	$111.98
03/13-03/13/2023	34	$54.00	$0.00	46 ep	$54.00	$0.00	$0.00	$0.00	$0.00	100%	$0.00
Column Totals		$360.00	$0.00		$208.02	$151.98	$0.00	$40.00	$111.98		$111.98
								Other Credits or Adjustments			$0.00
								Total Net Payment			$111.98

Patient's Responsibility: **$40.00**

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ACCOUNT DETAILS

Hospital Services

Patient Name: Roy,Raj Kishor

JOHNS HOPKINS HOWARD COUNTY MEDICAL CENTER

Service #: 1001371217

Emergency From: 03/06/23 To: 03/07/23

Primary Payor: CIGNA

Secondary Payor:

Important message about your account: Our records show that you are now responsible for the service balance. Please make your payment today. Thank you for choosing Johns Hopkins Medicine for your healthcare needs.

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
	Emergency Room	$415.82			
	Laboratory	$48.55			
	Pharmacy	$0.40			
10/24/23	Cigna Adjustments		$9.28		
	Patient Adjustments			$4.55	
	Service Total	**$464.77**	**$9.28**	**$4.55**	**$450.94**
	Totals	**$464.77**	**$9.28**	**$4.55**	**$450.94**

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