SCCIPA
Santa Clara County IPA

Check Detail/Remittance Advice

Payee Name: TIM B TRUONG DO

Vendor #: S0862041972_1

Tax ID: 862041972 **Address:** 466 E CALAVERAS BLVD, STE C, MILPITAS, CA 950355453 **Check Date:** 1/19/2024 **Check #:** 960713

Provider Name: TIM B TRUONG DO **Provider #:** 021492

Claim #	Member ID / Name	Date of Service	Billed	Allowed	Excluded Codes	Excl for Cap	Deductible	Copay/ Coinsurance	Reduction*	Payment
13322559	905770979-002 KURMAYAGARI,VRISAN REDDY			**Patient ID:** RMC215220		**Carrier:** BLUE SHIELD COMMERCIAL				
90460	IMMUN ADMIN THRU AGE 18, FIRST VACCINE	2024/05/01	$45.00	$15.00	$0.00 A	$0.00	$0.00	$0.00	$0.00	$15.00
90686	FLU VAC NO PRSV 4 VAL	2024/05/01	$47.00	$26.82	$0.00 A	$0.00	$0.00	$0.00	$0.00	$26.82
		Claim Sub Total	$92.00	$41.82	$0.00	$0.00	$0.00	$0.00	$0.00	$41.82
13325319	100024552 TON,MY TO			**Patient ID:** RMC326523 NBRN		**Carrier:** VALLEY HEALTH PLAN HMO				
41010	INCISION OF TONGUE FOLD	2024/09/01	$700.00	$297.24	$0.00 A	$0.00	$0.00	$0.00	$0.00	$297.24
		Claim Sub Total	$700.00	$297.24	$0.00	$0.00	$0.00	$0.00	$0.00	$297.24
		Provider Sub Total	$792.00	$339.06	$0.00	$0.00	$0.00	$0.00	$0.00	$339.06

Code	Description
A	Allowable based on contracted fee schedule/provider's IPA affiliation. Do not balance bill patient. Non-contracted provider allowable is based on R&C. Medicare non-contracted provider allowable based on lesser of billed charges or Medicare Fee Schedule

	Billed	Allowed	Excluded	Excl for Cap	Deductible	Copay/ Coinsurance	Reduction*	Payment
Vendor Sub Total	$792.00	$339.06	$0.00	$0.00	$0.00	$0.00	$0.00	$339.06

* As required by CMS' Federally Mandated Sequestration, a reduction has been applied to the net payment. The patient may not be balance billed for this amount.

SCCIPA
Santa Clara County IPA

Check Detail/Remittance Advice

CA COMMERCIAL CLAIMS

1. Contracted Paid/Denied Claims:
   Under the Knox Keene Act, an eligible member to whom services were provided shall not be liable for any portion of the bill, except for applicable cost share, which may include deductible, co-insurance and/or copayments. The contracted provider should not bill the member or attempt to collect against the member, unless the member was not eligible at the time the services were rendered or non-emergency services were not authorized and/or directed by the participating medical group or primary care physician.

   Pursuant to the Knox Keene Act of the State of California, the enrollee to whom prior approved services were provided is not liable for any portion of the bill, except for co-payments, deductibles, other cost sharing components, or non-covered benefits as defined in the enrollee's Evidence of Coverage documents.

   In the event the member appeared eligible no more than 72 hours prior to services being rendered and an authorization or eligibility is provided that the specific provider relied upon to render services and the member later appears ineligible on date of services, Knox-Keene requires that the provider and member be held harmless and you cannot recover payment.

2. Non-Contracted
   a. Paid Claims:
      For dates of services on or after July 1, 2017; non-contracted providers may NOT balance bill a member for non-emergency services when covered services are rendered in a Participating Facility. The Health Plans have many participating specialists and regional facilities available to SCCIPA. In the event SCCIPA elects to use a non-participating Facility and SCCIPA does not enter into a Letter of Agreement that protects the member, all authorized services for non-emergency providers must be paid at billed charges minus the member's applicable cost-sharing.
   b. Denied Claims:
      You may file a written appeal to: SCCIPA P.O. Box 5860 San Mateo, CA 94402 with a clear & concise reason for questioning/disputing the denial decision.

3. PDR Process (Contracted & Non-Contracted Emergency Services Claims)
   Under AB1455 if you feel there is an error in payment, you may dispute in writing to: SCCIPA P.O. Box 5860 San Mateo, CA 94402. A complete description of the dispute process can be found Online or you may call 1-800-977-7478 to have one sent to you.

   Pursuant to California Code of Regulations Title 28, Sections 1300.71 and 1300.71.38, a provider may file a written dispute to: SCCIPA to challenge, appeal, or request for a reconsideration on a claim(s) that has been denied, adjusted, or contested.

   Provider Disputes must be filed to SCCIPA within 365 days from the last date of written notification that led to the dispute. For instructions and forms for submitting a dispute, go to our website at www.SCCIPA.com or contact our Provider Services Department at 1-800-977-7478.

   The dispute request must include the following information:
   1. Name address and phone number of the provider of service;
   2. Provider's tax id number
   3. Patient name
   4. Insurer's information
   5. Date of service
   6. A complete and accurate explanation of the issue supporting documentation including copies of claims, claim number, medical records, or supporting documentation to challenge reports, as necessary, from the initial adverse determination.

4. Non-Emergency Services Independent Dispute Resolution Process (AB 72 IDRP)
   The law requires that the Department of Managed Health Care conduct an independent dispute resolution process (AB 72 IDRP) that allows a non-contracting provider who rendered services at, or as a result of services at, a contracting health facility, or a payor, to dispute whether payment of the specified rate was appropriate. Once a non-contracting provider or payor submits an AB 72 IDRP Application, the opposing party is required by law to participate in the AB 72 IDRP. AB 72 does not apply to emergency services and care.

*As required by CMS' Federally Mandated Sequestration, a reduction has been applied to the net payment. The patient may not be balance billed for this amount.

SCCIPA
Santa Clara County IPA

Check Detail/Remittance Advice

Eligible Claims

Eligible claim disputes are those disputes that are subject to DMHC jurisdiction and meet all of the following criteria:

- The disputed claim must be for services rendered on or after July 1, 2017.
- The disputed claim must be for non-emergency services. If there is an unresolved dispute as to whether the health care service(s) at issue is non-emergent, the claim does not qualify for the AB 72 IDRP.
- The disputed claim must be for covered services provided at a contracting health facility, or provided as a result of covered services at a contracting health facility, by a non-contracting individual health professional.
- The non-contracting provider has completed the health plan or payor's Provider Dispute Resolution (PDR) process within the last 365 days.
- The non-contracting provider is not a dentist.
- The payor is not a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services

For more information or to submit a dispute under the IDRP process, please go the California Department of Managed Health Care's website at:
https://www.dmhc.ca.gov/fileacomplaint/providercomplaintagainstaplan/nonemergencyservicesindependentdisputeresolutionprocess.aspx

ATTENTION NON-CONTRACTED MEDICARE PROVIDERS

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 60 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for appeal
_ A signed Waiver of Liability form (you may obtain a copy by going to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip)
_ A copy of the original claim
_ A copy of the remittance notice showing the claim denial
_ Any additional information, clinical records or documentation

Appeals of Denied Claims must be submitted directly to the Medicare Advantage Health Plan at the address listed below:

*As required by CMS' Federally Mandated Sequestration, a reduction has been applied to the net payment. The patient may not be balance billed for this amount.

SCCIPA
Santa Clara County IPA

Check Detail/Remittance Advice

Aetna Medicare Part C Appeals & Grievances
P.O. Box 14067
Lexington, KY 40512

Alignment Health Plan
P.O. Box 14010
Orange, CA 92863-9936

Brand New Day
ATTN: Appeal and Grievance Dept
P.O. Box 93122
Long Beach, CA 90809

Commonwealth Care Alliance (CCA)
18000 Studebaker Rd Ste 960
Cerritos, CA 90703

Essence Healthcare
Fax: 833-955-2442
Email: appeals@essencehealthcare.com

Health Net
Medicare Claims
P.O. Box 9030
Farmington, MO 63640-9030

United Healthcare
P.O. Box 6106
Cypress, CA 90630
MS: CA124-0157

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted health care professionals may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider contends the amount paid by the Plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

_ A statement indicating factual or legal basis for the dispute
_ A copy of the original claim
_ A copy of the remittance notice showing the claim payment
_ Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to: SCCIPA Provider Dispute Resolution Team
P.O. Box 5860
San Mateo, CA 94402

If you have additional questions relating to a dispute decision made, you may contact us at:
Phone: 1-800-977-7478
Mail: SCCIPA Provider Dispute Resolution Team, P.O. Box 5860, San Mateo, CA 94402
Online: Access Express Claims Inquiry, click "MESSAGE ABOUT THIS CLAIM"

Billing Alerts

Section 1905(n) of the Social Security Act prohibits a provider from billing an individual with coverage as a Qualified Medicare Beneficiary (QMB), with or without other Medicaid coverage, or someone receiving Supplemental Security Income benefits and Medicare for the Medicare deductible or coinsurance.

*As required by CMS' Federally Mandated Sequestration, a reduction has been applied to the net payment. The patient may not be balance billed for this amount.