YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL.

196*129932

HEALTH CARE FINANCING ADMINISTRATION

Dec 07, 1984

ARTHUR BEAL
881 HILLCREST
CAMBRIA
CA 93428

For more information call or write:
TRANSAMERICA OCCIDENTAL LIFE INSURANCE
Box 54905 Terminal Annex
Los Angeles, Ca 90054
Phone: 213 Area: 748-2311
Other Areas: 1-800-252-9020

This explains benefits on your assigned claim for $140.00 from ROGER B STEELE MD IN.

		Billed	Approved
Inpatient Visit Approved amount limited by Item 5b on back.	Sep 15, 1984	$ 35.00	$ 30.00
Inpatient Visit Approved amount limited by Item 5b on back.	Sep 16, 1984	$ 35.00	$ 30.00
Inpatient Visit Approved amount limited by Item 5b on back.	Sep 17, 1984	$ 35.00	$ 30.00
Inpatient Visit Approved amount limited by Item 5b on back.	Sep 18, 1984	$ 35.00	$ 30.00

Total approved amount. . . . . $ 120.00
Medicare payment (80% of the approved amount). . . . . $ 96.00

ROGER B STEELE MD IN agreed to charge no more for the above approved services than the amount approved by Medicare. We are paying a total of $96.00 to ROGER B STEELE MD IN.

You are responsible to the physician / supplier for the difference of $24.00 between the approved amount and the Medicare payment. If you have private insurance it may help with the part Medicare did not pay.

(You have met $75.00 of the $75.00 deductible for 1984)

DO YOU HAVE QUESTIONS ABOUT THE INFORMATION ABOVE?
We will be happy to answer any questions you have about this notice. If you believe payment was made for a service you did not receive, or there is some error, please write or call immediately. Use the address or phone number shown above.

IMPORTANT: IF YOU WANT A REVIEW OF THIS CLAIM, YOU MUST WRITE TO US BEFORE:**Jun 07, 1985**
TO REQUEST IT (See Item 1 on the back). If you write or call, please give us your:
Health Insurance Claim Number: **552 07 7350 A ** and Claim Control Number:**4292 656 040**

ALWAYS GIVE YOUR HEALTH INSURANCE CLAIM NUMBER AND CLAIM CONTROL NUMBER WHEN WRITING ABOUT YOUR CLAIM. BRING THIS NOTICE WITH YOU IF YOU INQUIRE IN PERSON.

1. IF YOU HAVE ANY QUESTIONS ABOUT THIS CLAIM

Call us if you have questions about this claim. The telephone numbers are shown on the front of this notice. We will tell you in detail what facts we used to decide what to approve.

If you decide to have this claim reviewed, we will tell you how to do it. And we'll suggest other facts and proofs that you should send to us. We will also answer any other questions. See item 2 below for a statement about your appeal rights.

2. YOUR RIGHT TO A REVIEW OF THIS CLAIM

You may ask to have this claim reviewed. This would be done by people who did not make the first decision about how much to approve. You also have the right to ask someone else to act for you in helping you get this claim reviewed. We can also help you request a review. Call or write us at the phone number and address shown on the front of this notice. A request for review must be in writing. You must write for it within 6 months of the date of this notice.

3. FOR OTHER INFORMATION ABOUT MEDICARE

If you have other questions about Medicare, read "Your Medicare Handbook." You may also write or phone us. The address and telephone numbers are shown on the front of this notice.

4. HOW MUCH MEDICARE PAYS

You must take care of the first part of your medical bills each year. This yearly share is called the DEDUCTIBLE. The amount of this year's deductible is printed on the other side of this notice. Each year, after you meet the deductible, we pay 80 percent of the Amount Approved for most of your remaining bills. (The Amounts Approved are shown on the other side.) Services that we pay at other rates are described below.

For treatment of mental illness as an outpatient Medicare pays 50 percent of the Amount Approved above your deductible amount. The bills for this care are added to your bills for other services to make up the deductible. The most we can pay for outpatient treatment of mental illness in a year is $250.

Medicare pays 80 percent of the Amount Approved for physical therapy services. However, there is a limit of $500 per year that we can pay for services by therapists who work for themselves.

Medicare can pay the full Amount Approved for some kinds of surgery in outpatient surgical centers. For some *used* medical equipment such as wheelchairs and hospital beds, the full Amount Approved is payable after the deductible has been met.

5. WHY THE AMOUNT APPROVED MAY BE LESS THAN THE AMOUNT BILLED

The Amount Approved is shown on the front of this notice. It does not necessarily reflect the current actual charges in your area. It is the lowest of the three amounts described below:

a. The first is what you were charged for the service. This is shown under "Billed" on the front of this notice.

b. The second is the midpoint of the charges your doctor or supplier of medical services made during the calendar year prior to last July. This is the customary charge.

c. The third is the prevailing charge for your area. This is the amount which is high enough to cover the customary charge in three out of four bills for this service. For physician services, this charge limit can increase each year only by a percentage determined by the Government to reflect overall changes in the economy.

If you think the payment on this claim is wrong, please call us toll-free at the number shown on the front of this notice.

ASSIGNMENT

Assignment is when your doctor or supplier of medical services agrees to accept the Amount Approved as the full amount he/she expects to be paid. With assignment, after the deductible has been met, we pay 80 percent and you pay 20 percent of the Amount Approved for most of your remaining bills. The Medicare check is sent directly to your doctor or supplier.

6. HOW YOU CAN USE THIS NOTICE

You can use this notice to show your doctor or supplier of medical services how much of your deductible you have met.

You can also send a copy of this notice to your private health insurance company if they need it to see how much Medicare paid. They will want to keep the copy you send to them. So you may want to make a copy to keep for yourself.

7. TIME LIMITS FOR FILING A REQUEST FOR MEDICARE PAYMENTS

To receive Medicare benefits you must send in a claim within the following time limits:

For Services Received	Send Claims By
10/1/81-9/30/82	12/31/83
10/1/82-9/30/83	12/31/84
10/1/83-9/30/84	12/31/85

These time limits may be extended if we, the Social Security Administration, or the Health Care Financing Administration made a mistake which caused you to delay sending in your claim. When this happens, you must send in your claim within 6 months after the month in which the mistake was corrected.