Explanation of Bill Review

AMETROS

FL DFS ID:
Client: AMETROS FINANCIAL CORPORATION
Adjuster:
Employer:

Patient: Roger Doe
10 Happy Road
Smile, FL

Claim #: XXXX2
DOI: 02/02/1992
Account #: XXXXX
Coverage: Workers Compensation

Claim Jurisdiction: FL
Carrier Received: 01/19/18
Date Received: 01/19/18
Date Printed: 01/24/18
Processor: M11
Review #: XXXX2
Document Name: CAXXXXX

Provider: NEURO HOSPITAL

Dates of Service: 12/20/17 - 12/20/17

Diagnosis Code(s):

G8921	Chronic pain due to trauma
G894	Chronic pain syndrome

TIN: XXXXXXX
Rendering Zip: XXXXX
Bill Type: Office Visit

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Qualify Code
1	12/20/17	62350	IMPLANT EPID CATH-MEDS; W/O LAMINEC	1	$3369.00	$2,739.00	$315.00	$15.75	$299.25	93
2	12/20/17	62362	IMPLANT/REPLAC DEVICE-EPID; PROGMBL	1	$3284.00	$2,671.00	$306.50	$15.32	$291.18	93
3	12/20/17	14301	SKIN TISSUE REARRANGEMENT	1	$8706.00	$7,342.00	$0.00	$68.20	$1295.80	93
			Totals:	**3**	**$15,359.00**	**$12,752.00**	**$621.50**	**$99.27**	**$1,886.23**	

Qualify Code Descriptions:

93 - PAID: NO MODIFICATION TO THE INFORMATION PROVIDED ON THE MEDICAL BILL: PAYMENT MADE PURSUANT TO CONTRACTUAL ARRANGEMENT. (Please find additional network name and contact information above).

Comments:

Notes:

This claim has been reviewed according to the Florida Workers' Compensation guidelines. This EOBR constitutes a notice of disallowance or adjustment of payment within the meaning of Section 440.13(7), F.S. The contact shown below, at the address listed above has been designated by the carrier to receive service on behalf of the carrier and all affected parties for the purpose of receiving the petitioner's service of a copy of a petition for reimbursement dispute resolution by certified mail, pursuant to Section 440.13(7) F.S