

What to Look for on Your EOB Statement

Please remember these important tips when viewing your EOB statement:

- Review the contract information section to determine which family member the statement is for and then verify that the information is correct.
- Review the “Patient’s Name” section to determine the patient who accepted services.
- Review the “Deductibles” and “Copays” section to determine the dollar amount covered for health care expenses and the amounts you are responsible for specified by your contractual benefits.
- Match the information in the “Description of Services” section with your doctor or hospital bills to verify that all services listed are services you or a family member received.
- Follow the step-by-step payment calculators in the “Description of Services” section to see how we arrived at our payment and how much you may owe for each service.
- Review “Other Amounts Not Covered” section to establish the amount of expenses enclosed with your benefits.
- Read the “Messages” and “Address and Phone” section to view any applicable messages or to reach a Blue Cross Blue Shield customer service representative with questions or inquiries.

Understanding Your Explanation of Benefits Statement



A Reference Guide to Help Members

Dear Member:

We developed this Reference Guide to help you understand your Explanation of Benefit Payments (EOB) statement.

You will receive an EOB statement after we process your claim. The EOB statement shows you what services have been paid by Blue Cross Blue Shield and what you may owe through deductibles and copayments. The EOB will also show non-covered services for which we did not make payment.

Always check your EOB statement closely to make sure that you received the services listed. It is very important that you notify Blue Cross Blue Shield if you did not receive the services or there are any discrepancies.

If you have questions about your EOB statement, please call your Blue Cross Blue Shield Customer Service Office listed on the back of your ID card.

We hope your EOB statement will meet your needs for clear and complete information about your claims.



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- ① **Patient's Name:** the name of the patient who received services.
- ② **Provider Name:** the name of the provider (e.g. physician, hospital, or lab) who performed the services for the patient. The provider name shown may be different than your physician's name because services such as tests, x-rays, and consultations may be provided by other health care professionals or facilities as directed by your physician.

Note: If payment was directed to a provider, the message "PAYMENT WAS MADE TO PROVIDER" will appear.

- ③ **Claim Number:** the number assigned to that patient's claim.
- ④ **Dates of Service:** the dates reported to each service performed for the patient.
- ⑤ **Description of Services:** a brief description of each service.
- ⑥ **Amount Charged:** the amount billed by your physician, pharmacy, hospital, lab or other health care professional who performed each service. (Note: if Medicare Complimentary services are involved, the amount in the column will represent the amount billed to Medicare.)
- ⑦ **Allowed Amount:** the amount we have approved for payment prior to deductibles, coinsurance or other member expenses (if any).
- ⑧ **Other Insurance:** the amount paid by other insurance, including Medicare.
- ⑨ **Deductible:** a fixed dollar amount that you must pay for covered health care expenses before your benefits are provided. You are responsible for this amount.

Explanation of Benefit Payments

THIS IS NOT A BILL
THIS STATEMENT REPORTS ON A CLAIM(S) WE RECENTLY PROCESSED FOR YOU AND/OR YOUR DEPENDENTS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OR WRITE:

STATEMENT DATE		
MO	DAY	YR

CHECK REF. NO. 1023040506
CONTRACT # BMF 1234567890 ⑮
GROUP # 1234567 1234 ⑯

⑱ **BLUE CROSS BLUE SHIELD OFFICE**
 111 ANYWHERE STREET
 HOMETOWN, USA 22222
 (333) 987-6543

SEE BACK FOR EXPLANATION OF COLUMNS

④ DATES OF SERVICE	⑤ DESCRIPTION OF SERVICES	⑥ AMOUNT CHARGED	⑦ ALLOWED AMOUNT	⑧ OTHER INSURANCE	YOUR RESPONSIBILITY				⑬ AMOUNT PAID	⑭ RSN CODE
					⑨ DEDUCTIBLE	⑩ COPAY	⑪ COINSURANCE	⑫ OTHER AMOUNTS NOT COVERED		
①	②	③		⑰						
	PATIENT: LAST NAME, FIRST NAME			PROVIDER, PHYSICIAN, SPECIALIST OR LAB						
	CLAIM 123456789123456									
STAGGERED TOTALS										
PLEASE KEEP FOR YOUR RECORDS. THIS IS THE ONLY COPY OF THIS FORM AVAILABLE										

- ⑩ **Copay:** a predetermined amount specified by your contractual benefits. You are responsible for this amount.
- ⑪ **Coinsurance:** a percentage of the cost (allowable charge) for which you are responsible as defined by your covered benefits.
- ⑫ **Other Amounts Not Covered:** this amount represents expenses not covered or in excess of your benefits. You may be responsible for this amount to your health care provider.
- ⑬ **Amount Paid:** the total amount paid to you or your provider for the services performed.
- ⑭ **Reason Code:** codes are shown in this column which refer to specific messages below each claim. These messages clarify a payment situation or explain why you may be responsible for a service.
- ⑮ **Contract No.:** this is the identification number of the subscriber/employee. It is also the number printed on your Blue Cross Blue Shield ID card. Please reference this number if you call or write with questions.
- ⑯ **Group No.:** this is the number used to identify the account in which you are enrolled.
- ⑰ **Messages:** additional messages, if applicable, will appear in this section.
- ⑱ **Address and Phone:** the Blue Cross Blue Shield office where all questions should be directed. A customer service representative will assist you with your inquiries.