

YOUR INSURANCE COMPANY
345 ANY STREET
ANYTOWN, PA 12345

THIS IS NOT A BILL

TO:
TEST PATIENT
123 ANY STREET
ANYTOWN, PA 12345

CLAIM # 0000000000
MEMBER ID# 000000000
MEMBER NAME: PATIENT, TEST

SVC#	SVC DATE	PROVIDER	SERVICE PROVIDED	AMOUNT BILLED	AMOUNT ALLOWED	AMOUNT DENIED	AMOUNT DEDUCT	AMOUNT PAID	AMOUNT APPLIED TO DEDUCTIBLE
001	06/25/2009	PROVEN DIAGNOSTICS	BMP	\$ 100.00	\$ 20.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 20.00

CLAIM SUMMARY INFORMATION:

TOTAL AMOUNT PAYABLE TO PROVIDER BY PLAN: \$0.00
TOTAL AMOUNT PAYABLE TO PROVIDER BY MEDICARE: \$0.00
TOTAL AMOUNT PAYABLE BY THIRD PARTY: \$0.00
DEDUCTIBLE: \$20.00
COPAY: \$0.00
CO-INSURANCE: \$0.00
TOTAL APPLIED TO ANNUAL OUT-OF-POCKET EXPENSES: \$20.00

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