NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

RECIPIENT, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER **3400000** REPORT SEQ. NUMBER DATE **08/01/2003** PAGE **2**

NAME / RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION		TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLA-NATION CODES
		Paid Claims											
		Outpatient											
RECIPIENT	*JANE A*	**CO=92**	**RCC=**	**CLAIM NUMBER= 252002001001001NCXIX**									
900000000k							**MED REC= 123456**				**ATTN PROV= 0.8000 8926**		
NCXIX	**10162002**	**10162002**	**2 B**	**250**	**PHARMACY-GEN**	**78 00**	**00**	**78 00**	**38 68**	**39 32**	**3932**	**00**	**8926**
NCXIX	**10162002**	**10162002**	**1 B**	**341**	**NUCLEAR MEDICINE**	**576 00**	**00**	**576 00**	**285 69**	**290 31**	**20110**	**89 21**	**8826**

DED= .00 PT LIB= .00 CO PAY= .00 TPL= 88.01 DIFF= 152.41 654 00 0 65400 324 37 329 63 24042 89 21

ORIGINAL BILLED AMOUNT= 654.00 ORIGINAL DETAIL COUNT = 2 TOTAL FINANCIAL PAYERS= 1