EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 PAGE 1

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
				PAID CLAIMS MEDICAL								
JONES MARY D CO=81 RCC=				**CLAIM NUMBER=101999165181580***NCXIX*								
988888888A					MED REC=9999999				ATTN PROV=89XXXX		1.0000	
NCXIX	06011999	06011999	1 3	99244 25 OUTPT. CONSULT, SEVERE- PHY	23000	11029	11971	00	11971	00	11971	534
NCXIX	06011999	06011999	1 3	93526 26 COMB RT HEART CATHETERIZATI	130000	00	130000	00	130000	00	130000	99
NCXIX	06011999	06011999	1 3	93543 INJECTION FOR HEART X-RAY	25100	22328	2772	00	2772	00	2772	98
NCXIX	06011999	06011999	1 3	93545 INJECTION FOR HEART X-RAY	42500	39585	2915	00	2915	00	2915	98
NCXIX	06011999	06011999	1 5	93555 26 IMAGING SUPERVISION, INTERP	26000	22581	3419	00	3419	00	3419	98
NCXIX	06011999	06011999	1 5	93556 26 IMAGING SUPERVISION, INTERP	36500	32438	4062	00	4062	00	4062	98
DEDUCTIBLE= .00 PAT LIAB= .00				*CO PAY= .00 TPL= .00*	*283100*	*127961*	*155139*	*00*	*155139*	*00*	*155139*	
ORIGINAL BILLED AMOUNT= 2831.00				*ORIGINAL DETAIL COUNT=*	*6*		*TOTAL FINANCIAL PAYERS=*			*1*		
MOORE JOE D CO=77 RCC=				**CLAIM NUMBER=101999170192650***NCXIX*								
999777777A					MED REC=00008888888				ATTN PROV=8900000		1.0000	
NCXIX	05311999	05311999	4 3	84520 UREA NITROGEN; QUANTITATIVE	2000	1061	939	00	939	00	939	2955
NCXIX	05311999	05311999	1 3	82565 CREATININE; BLOOD	2300	2300	00	00	00	00	00	2954
NCXIX	05311999	05311999	1 3	84132 POTASSIUM SERUM	2000	2000	00	00	00	00	00	2954
NCXIX	05311999	05311999	1 3	85014 BLOOD COUNT; OTHER THAN SPU	1400	1073	327	00	327	00	327	98
NCXIX	05311999	05311999	1 3	85018 HEMOGLOBIN	1800	1473	327	00	327	00	327	98
NCXIX	06011999	06011999	1 3	93010 ELECTROCARDIOGRAM REPORT	3500	2491	1009	00	1009	00	1009	534
DEDUCTIBLE= .00 PAT LIAB= .00				*CO PAY= .00 TPL= .00*	*13000*	*10398*	*2602*	*00*	*2602*	*00*	*2602*	
ORIGINAL BILLED AMOUNT= 130.00				*ORIGINAL DETAIL COUNT=*	*6*		*TOTAL FINANCIAL PAYERS=*			*1*		
2	CLAIMS		15	MEDICAL *******		138359		00		00		
					296100		157741		157741		157741	
****-->	TOTAL PAID CLAIMS			2 CLAIMS		138359		00		00		
					296100		157741		157741		157741	

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 PAGE 2

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
ADJUSTED CLAIMS PROFESSIONAL ADJUSTMENT												
BARNES LARRY D CO=43 RCC=				CLAIM NUMBER=901999183001888*NCXIX* **ADJ**DEBIT TO 101998100300888*NCXIX*								
977788888A								PAID 12231998		ATTN PROV=		8926
NCXIX	08131998	08141998	2 3	99232 HOSP VISIT, MODERATE. PHYS	18200	8096	10104	8083	2021	00	2021	8926
86 ADJUSTMENT OF CLAIM *NCXIX* 101998100300888 MED REC=00009033333												
21 DUPLICATE OF CLAIM *NCXIX* 101999046666666 PAID 03011999												
NCXIX	08171998	08171998	1 3	99231 HOSP VISIT, STABLE. PHYS T	5900	2474	3426	2741	685	00	685	8926
86 ADJUSTMENT OF CLAIM *NCXIX* 101998100300888												
NCXIX	18181998	08181998	1 3	99232 HOSP VISIT, MODERATE. PHYS	9100	4048	5052	4042	1010	00	1010	8926
86 ADJUSTMENT OF CLAIM *NCXIX* 101998100300888												
NCXIX	08191998	08191998	1 3	99238 HOSPITAL DISCHARGE DAY MANA	10200	4227	5973	4778	1195	00	1195	8926
86 ADJUSTMENT OF CLAIM *NCXIX* 101998100300888												
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*43400*	*18845*	*24555*	*19644*	*4911*	*00*	*4911*	
1 CLAIMS			5	PROFESSIONAL ADJUSTMENT		18845		19644		00		
					43400		24555		4911		4911	
****--> TOTAL ADJUSTED CLAIMS			1	CLAIMS		18845		19644		00		
					43400		24555		4911		4911	

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 280767 PAGE 3

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
DENIED CLAIMS MEDICAL												
JONES JERRY D CO=77				CLAIM NUMBER=901999197050025*NCXIX*								
977777777A				MED REC= 00006100000					ATTN PROV= 8910000			
NCXIX	11091998	11091998	1 3	86316 TUMOR ANTIGEN IMMUNOASSAY	8200	5324	2876	00	00	00	00	21
21 DUPLICATE OF CLAIM *NCXIX* 101999047777777 PAID 0531999												
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*8200*	*5324*	*2876*	*00*	*0*	*00*	*0*	
ORIGINAL BILLED AMOUNT= 82.00 ORIGINAL DETAIL COUNT= 1 TOTAL FINANCIAL PAYERS= 1												
PERRY JOHHNY A CO=48				CLAIM NUMBER=901999172168421*NCXIX*								
944444444B				MED REC= 10455555					ATTN PROV= 7924000			
NCXIX	06081999	06081999	1 3	99213 OV ESTAB. PT, MODERATE. PHYS	6200	6200	00	00	00	00	00	270
NCXIX	06081999	06081999	1 3	82962 BLOOD GLUCOSE BY MONITORING D Q4	1300	1300	00	00	00	00	00	270
DEDUCTIBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= .00					*7500*	*7500*	*00*	*00*	*00*	*00*	*00*	
ORIGINAL BILLED AMOUNT= 75.00 ORIGINAL DETAIL COUNT= 2 TOTAL FINANCIAL PAYERS= 1												
2 CLAIMS	3			MEDICAL *******	15700	12824	2876	00	00	00	00	
****--> TOTAL DENIED CLAIMS				2 CLAIMS	15700	12824	2876	00	00	00	00	

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 PAGE 4

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

CLAIMS IN PROCESS - THESE CLAIMS ARE BEING PROCESSED AS LISTED
PROFESSIONAL

945751888A	GARRETT	JOE	R09081998	09111998	CLAIM= 101999167167167NCXIX	23600	MED REC= 00006655555	102
901200000A	MCCONNELL	JERRY	04281999	04281999	CLAIM= 101999155166144NCXIX	26500	MED REC= 00009160000	102
900534500A	SHEPHERD	DAVID	J11011998	11011998	CLAIM= 101999167111111NCXIX	3500	MED REC= 00006644444	102
945999200A	BEAN	ALICE	J02011999	02011999	CLAIM= 101999134988888NCXIX	223	MED REC= 00004333333	101
249666666A	BROWN	WADE	01141999	01141999	CLAIM= 901999155555555NCXIX	1047	MED REC= 00009588888	101
252645999A	DIXON	EDNA	07121998	07121998	CLAIM= 901999160999999NCXIX	1370	MED REC= 00004444444	101

6 CLAIMS PROFESSIONAL ******** 56240

****--> TOTAL PENDING CLAIMS 6 CLAIMS 56240

FINANCIAL ITEMS: ADJUSTMENTS (PRINCIPAL, PENALTY, INTEREST), REFUND, PAYOUT ACTIVITY

RECIPIENT NAME/ RECIPIENT ID	FROM DOS/ TXN DATES	ADJUSTMENT ICN/ ORIGINAL CCN	TRANSFER CCN	PROVIDER % W/H / ADJUSTMENT % W/H <100%	TXF IND	ORIGINAL/ TRANSFER AMOUNT (A)	FROM PRIOR CYCLE (B)	AMOUNT COLLECTED (C)	WRITE-OFF AMOUNT (D)	ENDING BALANCE (B-C-D=E) (E)	EOB
ADJUSTMENTS NEGATIVE											
PRINCIPAL											
JONES MIRA	09/01/1999	931999307990020NCXIX	1999254751630NCXIX	99%/	N	50000	50000	00	00	50000	0112
900846721Q	11/15/1999	1999309750040NCXIX									
				SUB TOTAL:		50000	50000	00	00	50000	
INTEREST											
MOORE JOHN	08/01/1999	931999400500040NCXIX	1999254751631NCXIX		N	1627	1627	00	00	1627	2256
976542318P	10/20/1999	1999293502360NCXIX									
YOUTH GLADYS	08/01/1999	931999504221001NCXIX			N	2075	2075	00	00	2075	2256
976542318P	11/25/1999	1999329502360NCXIX									
				SUB TOTAL:		3702	3702	00	00	3702	
				TOTAL PPI:		53702	53702	00	00	53702	

(TOTAL OF COLUMN C FOR PRINCIPAL, PENALTY, AND INTEREST = WITHHELD AMOUNT ON CLAIMS PAYMENT SUMMARY PAGE)

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 PAGE 5

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

FINANCIAL ITEMS: ADJUSTMENTS (PRINCIPAL, PENALTY, INTEREST), REFUND, PAYOUT ACTIVITY

RECIPIENT NAME/ RECIPIENT ID	FROM DOS/ TXN DATES	REFUND CCN/ ORIGINAL CCN/ICN	AR CCN	REFUND AMOUNT (A)	BAL FROM PRIOR CYCLE (B)	$ APPLIED THIS CYCLE (C)	ENDING BALANCE (B-C=E) (E)	EOB
REFUNDS								
INMAN WILL!	04/22/1998	1999153000002*NCXIX*		4359	4359	517	3842	2242
246705500A	05/03/1999	101999109666666*NCXIX*						
ROPER JOE	03/28/1998	1999177400050*NCXIX*		2755	2755	2755	00	2242
246705500A	02/01/1999	101999204772555*NCXIX*						
			TOTAL:	7114	7114	3272	3842	

(TOTAL OF COLUMN C=TO CREDIT AMOUNT ON CLAIMS PAYMENT SUMMARY PAGE)

TOTAL FINANCIAL ITEMS	5	********	60816	60816	56974	

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 PAGE 6

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MMDD CCYY)	SERVICE DATES TO (MMDD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

CLAIMS PAYMENT SUMMARY EFT NUMBER 123456

	CLAIMS PAID	A PAID CLAIMS AMOUNT	B WITHHELD AMOUNT(*)	C NET PAY AMOUNT (A-B)	D CREDIT AMOUNT	E NET 1099 AMOUNT (C-D)	F IRS WITHHELD AMOUNT	G POS & EDI	H OTHER W/H	I ADJUSTED (NET PAY (C-F-G-H)
CURRENT PROCESSED	5	1626.52	.00	1626.52	32.72	1593.80	.00	.00	.00	1626.52
YEAR-TO-DATE TOTAL	12	5000.00	.00	5000.00	32.72	4967.28	.00	.00	.00	5000.00

1099 INFORMATION 1099 - THIS INFORMATION IF BEING FURNISHED TO THE INTERNAL REVENUE SERVICE
PROVIDER TAX ID: 62-2222222 PROVIDER TAX NAME: XYZ CORPORATION
PAYER ID: ELECTRONIC DATA SYSTEMS CORPORATION, PO BOX 30968 RALEIGH, NC 27622 #75-2548211

PLEASE VERIFY THE FOLLOWING IDENTIFICATION NUMBERS THAT HAVE BEEN ASSIGNED TO YOU. IF ANY OF THE NUMBERS ARE INCORRECT, PLEASE SEND CORRECTIONS TO:

EDS
PO BOX 300009
RALEIGH, NORTH CAROLINA 27622

CLIA - NONE ASSIGNED
UPIN - NONE ASSIGNED

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED THROUGHOUT THE REPORT

98 FEE ADJUSTED TO MAXIMUM PAYABLE
99 PAID AS BILLED
101 PENDING NORMAL IN-HOUSE PROCESSING
102 PENDING IN-HOUSE REVIEW
112 CHECK AMOUNT REDUCED BY RECOUPMENT AMOUNT
270 BILLING PROVIDER IS NOT THE RECIPIENT'S CAROLINA ACCESS PCP. CONTACT THE PCP FOR AUTHORIZATION; PUT AUTHORIZATION NUMBER IN BLOCK 19 ON THE HCFA-1500 OR FORM LOCATOR 11 OF THE UB-92
534 COPAY PREVIOUSLY DEDUCTED FOR THIS DATE OF SERVICE
2242 REFUND APPLIED TO OUTSTANDING PRINCIPAL, PENALTY, AND INTEREST BALANCES (REFER TO WRITE-OFF EOB). 1099 CREDITED FOR RETURN OF MEDICAID PAYMENTS
2954 REIMBURSEMENT WAS MADE ON PREVIOUSLY PAID DETAIL. PAYMENT IS DETERMINED BY # OF AUTOMATED TESTS BILLED. PAYMENT OF # OF UNITS ARE REFLECTED ON 1ST DETAIL. SEE 5/98 BULLETIN.
2955 PAYMENT REDUCED TO EQUAL THE NUMBER OF AUTOMATED LAB TESTS BILLED FOR THIS RECIPIENT. ADDITIONAL PAYMENT WAS MADE ON A PREVIOUSLY PAID DETAIL. SEE 5/98 BULLETIN
8926 ALLOWABLE REDUCED FOR OTHER INSURANCE PAYMENT

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 PAGE 7

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM MM DD CCYY	SERVICE DATES TO MM DD CCYY	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

SPECIAL NOTE: IF YOUR REMITTANCE ADVICE IS TEN PAGES OR MORE AND YOU ARE DUE A PAPER CHECK FOR CLAIMS REIMBURSEMENT, YOUR CHECK WILL BE MAILED IN A SEPARATE ENVELOPE.

EXAMPLE 1

NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

XYZ CORPORATION
ACCOUNTS RECEIVABLE DEPT
P O BOX 1111
ANYWHERE NC 22222

280767

PROVIDER NUMBER 8900000 REPORT SEQ. NUMBER 21 DATE 10/27/1999 PAGE 8

NAME / RECIPIENT ID / POPULATION GROUP	SERVICE DATES FROM (MM DD CCYY)	SERVICE DATES TO (MM DD CCYY)	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES

TOTALS BY POPULATION GROUPING:

POPULATION GROUPING NUMBER	POPULATION GROUPING DESCRIPTION	CURRENT PAID AMOUNT	YTD PAID AMOUNT
NCXIX	MEDICAID	1626.52	3000.00
CA-I	CCN1	0	1100.00
CA-II	CCN2	0	900.00
TOTAL PAID		1626.52	5000.00