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SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
1-800-548-1224
Website:
provider.securityhealth.org

Summary page

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PROVIDER NAME
123 E MAIN ST
ANYTOWN, WI 00000

3 COMMERCIAL

4 Feb. 20, 2018

5 Provider ID: 222222

6 Capitated

7 Last statement	8 Last payment	9 Charged amount	10 Allowed amount	11 Provider responsibility	12 Patient responsibility	13 This payment
1.00	1.00	1.00	1.00	1.00	1.00	1.00

3 COMMERCIAL | 4 Feb. 20, 2018 | 5 Provider ID: 222222 | 6 Capitated

14 Service date	15 Service code	16 Quantity	17 Charged amount	18 Allowed amount	19 Provider responsibility	20 Provider ANSI	21 Patient responsibility	22 Patient ANSI	23 Reimbursement
24 DOE, JOHN E		25 Member ID: 1111111			26 Subscriber ID: 050000000000				
27 Claim number: 10000000		28 Patient account: 12345							
10/17/17	98940		1.00	1.00	1.00	45			1.00
	29 Patient Totals		**1.00**	**1.00**	**1.00**		**0.00**		**1.00**
DOE, JANE O		Member ID: 2222222			Subscriber ID: 050000000000				
Claim number: 10000000		Patient account: 23456							
10/17/17	72082		1.00	1.00					1.00
	Patient Totals		**1.00**	**1.00**	**0.00**		**0.00**		**1.00**
DEER, JON S		Member ID: 3333333			Subscriber ID: 00000000000				
Claim number: 0000000000		Patient account: 34567			30 Repricer used on these 2 charges: First Health Contract				
10/27/17	80307		1.00	1.00	1.00	45	1.00	1	
	G0480		1.00	1.00	1.00	45	1.00	1	
	Patient Totals		**1.00**	**1.00**	**1.00**		**1.00**		**1.00**

31 Provider responsibility

ANSI Code - 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Total ANSI 45 = 1.00

33 **Total Provider Responsibility = 1.00**

32 Patient responsibility

ANSI Code - 1 Deductible Amount

Total ANSI 1 = 1.00

34 **Total Patient Responsibility = 1.00**

35 **Provider rights and responsibilities**

Dates of Service after 7/1/2016: Providers must appeal within 365 calendar days of the provider statement on which the charge was denied or partial payment of claims was made.

Provider appeals must be submitted using Security Health Plan's *Formal Provider Appeal* form located at www.securityhealth.org/providerappeal. The form must be complete and provide an explanation of why the services should be reviewed and reconsidered with any additional supporting documentation. If appeals are received without use of this form, they will not be processed as a formal provider appeal.

The completed *Formal Provider Appeal* form and supporting documentation should be submitted by:

Fax: 715-221-9650

Email: shp.claims.provider.appeals@securityhealth.org

Mail: Security Health Plan
Attn: Claims Department - Appeals
P.O. Box 8000
Marshfield, WI 54449-8000

If additional information is needed upon Security Health Plan's receipt of the appeal, the provider has 30 days from the date of Security Health Plan's request to supply that information. If the information is not received within 30 days of the request, the appeal is considered invalid.

Security Health Plan responsibility

Formal appeals will be reviewed by the Security Health Plan Provider Appeals Committee.

Security Health Plan staff make every effort to resolve providers' appeals with thorough consideration of initial and subsequent information provided through the appeals process.

Security Health Plan will respond in writing within 45 calendar days of receiving the completed appeal. An appeal is considered a complete appeal when all information requested by Security Health Plan has been received.

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123 E MAIN ST
ANYTOWN, WI 00000