Appendix 8

Sample Remittance and Status (R/S) Report, Including Banner Page

Refer to Appendix 10 of this section for information on reading R/S Reports.

REMITTANCE AND STATUS REPORT

EDS – Fiscal Agent for
Wisconsin Medicaid
6406 Bridge Road
Madison, WI 53784

Automated Voice Response (800) 947-3544 (608) 221-4247
Provider Service (800) 947-9627 (608) 221-9883
Eligibility (608) 221-9254

I.M. BILLILNG
1 W. WILLIAMS
ANYTOWN, WI 55555

R/S NUMBER 1234567

PROVIDER NUMBER 87654321 REPORT SEQ NUMBER 3 DATE 06/03/99 PAGE 1

PATIENT NAME/ID NUMBER	MEDICAL RECORD NO	ACCOUNTING NO	CLAIM NUMBER															
SERVICE DATES FROM | TO	U D	N S	PERF PROV/ RX NUMBER	DAYS QTY	T S	PROC/ACCOM/ DRUG CDE/M1 M2	PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES					
ATTENTION: CASE MANAGEMENT AND COMMUNITY SUPPORT PROGRAM PROVIDERS: DUE TO A REIMBURSEMENT INCREASE, EDS INITIATED ADJUSTMENTS WILL BEGIN APPEARING ON REMITTANCE AND STATUS REPORTS DATED MARCH 27, 1998, FOR CLAIMS WITH DATES OF SERVICE ON AND AFTER JULY 1, 1997. FOR MORE INFORMATION, PLEASE REFER TO WISCONSIN MEDICAID PROVIDER UPDATE 98-03, DATED JANUARY 15, 1998.																		
ATTENTION DENTAL PROVIDERS: WI MEDICAID AND THE WDA ARE SPONSORING A SERIES OF TRAININGS: MAY 4-WAUSAU, MAY5-MADISON, MAY 7-MILW., MAY 12-GREENBAY, MAY 18-LACROSSE, MAY 19-EAUCLAIRE, AND MAY 12-ASHLAND. FOR MORE INFORMATION CALL THE WDA AT 800-364-7646, OR EDS BILLING AND POLICY CORRESPONDENTS AT 800-947-9627.																		
EDS FEDERAL CORP. WISC.																		

REMITTANCE AND STATUS REPORT

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1H — I.M. BILLING
1 W. WILLIAMS
ANYTOWN, WI 55555

2H — R/S NUMBER 1234567

PAYMENT ID NUMBER 87654321 — 3H REPORT SEQ NUMBER 6H 3 DATE 4H 06/03/99 PAGE 2 — 5H

PATIENT NAME/ID NUMBER	MEDICAL RECORD NO	ACCOUNTING NO / CLAIM NUMBER	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
SERVICE DATES FROM | TO / U D / N S / PERF PROV/ RX NUMBER	DAYS QTY / T S / PROC/ACCOM/ DRUG CDE/M1 M2	PROCEDURE/ACCOMODATION/DRUG DESCRIPTION					
PAID OR DENIED CLAIMS (1A) (2A)	(3A)	(4A) (5A)					
RECIPIENT IM/1234567890	1234JED	124 209892XXXXXXXXX					
050699 050699 81234567 (6A) (7A) (8A)	100 1 99201PD (11A)	OFFICE/OP VISIT-NEW PATIENT	XXXX	XXXX (15A) XXXX	(16A) 00	(17A) 00	12 20 (18A)
0590799 0590799 81234567	100 (10A) 1 992013PD	OFFICE/OP VISIT-ESTABLISHED	XXXX	XXXX XXXX	00	XXXXX	12 20
		CLAIM TOTAL (12A) (13A)	XXXX	(14A) XXXX XXXX	00		
CLAIM TYPE SUB-TOTAL (9A)	1		XXXX	XXXX XXXX	0000	XXXXX	
PAID CLAIM TOTALS	1		XXXX	XXXX XXXX	0000	XXXXX	
(1R) CLAIMS PAYMENT SUMMARY FOR CHECK NUMBER 7654321 IN AMOUNT OF $XX.XX							
	CLAIMS PAID	CLAIMS AMOUNT	WITHHELD AMOUNT		CREDIT AMOUNT		NET 1099 AMOUNT
(1P) CURRENT PROCESSED	1 (2Pa)	(3Pa) XX.XX	00	(4Pa)	00	(5Pa)	XXXX (6Pa)
YEAR TO DATE TOTAL	56 (2Pb)	(3Pb) XXXX.XX	00	(4Pb)	00	(5Pb)	XXXX.XX (6Pb)

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES USED ABOVE

12 SERVICE PAID AT THE MAXIMUM AMOUNT ALLOWED BY MEDICAL ASSISTANCE REIMBURSEMENT POLICIES
20 CLAIM REDUCED DUE TO PAYMENT SPENDDOWN