ATTACHMENT 2
Sample Remittance and Status Report

REMITTANCE AND STATUS REPORT

WISCONSIN MEDICAID AND BADGERCARE PROGRAMS
6406 Bridge Road | Voice Response 800/947-3544 608/221-4247
Madison, WI 53784 | Policy/Billing 800/947-9627 608/221-9883

1H I.M. BILLING
ONE WEST WILLIAMS
ANYTOWN, WI 55555

R/S NUMBER 1 2 3 4 5 6 7 8 9 (2H, 5H)

PROVIDER NUMBER 12345678 (3H) REPORT SEQ NUMBER 3 (6H) DATE MM/DD/YY (4H) PAGE 2

PATIENT NAME/ID NUMBER	MEDICAL RECORD NO		PATIENT CONTROL NO	CLAIM NUMBER						
SERVICE DATES FROM | TO / U D / N S / PERF PROV/ RX NUMBER	DAYS QTY	PROC/ACCOM/ DRUG CDE/M1 M2 M3 M4	PROCEDURE/ACCOMODATION/DRUG DESCRIPTION	TOTAL BILLED	TOTAL ALLOWED	OTHER DEDUCTED CHARGES	COPAY	PAID AMOUNT	EOB CODES
PAID OR DENIED CLAIMS (1A, 2A, 3A, 4A, 5A)						(15A)	(16A)	(17A)	
RECIPIENT IM / 1234567890	1234 JED		124 209892XXXXXXXXX						
110603 110603 (7A) (8A) 81234567	100	99202 TJ	OFFICE / OP VISIT - NEW PATIEN	XXXX	XXXX	XXX	XXX	XXXX	12 (18A)
110703 110703 81234567	100	99214 TJ	OFFICE / OP VISIT - ESTABLISHE PATIEN	XXXX	XXXX	XXX	XXX	XXXX	12
(6A) (9A)	(10A)	(11A)	CLAIM TOTAL (12A)	XXXX (13A)	XXXX (14A)	XXX	XXX	XXXXX	
CLAIM TYPE SUB-TOTAL	1			XXXX	XXXX	XXX	XXX	XXXXX	
PAID CLAIM TOTALS	1			XXXX	XXXX	XXXX	XXX	XXXXX	
(1R) REMINDER:	CHECK #0123456789, ISSUED TO YOU MM/DD/YY FOR $2,618.67 REMAINS OUTSTANDING. PLEASE CASH THE CHECK OR CONTACT THE PROVIDER SERVICES UNIT IF THERE IS A PROBLEM.								
CLAIMS PAYMENT SUMMARY (1P)	CLAIMS PAID (2Pa)		CLAIMS AMOUNT (3Pa)	WITHHELD AMOUNT (4Pa)		CREDIT AMOUNT (5Pa)		NET 1099 AMOUNT (6Pa)	
CURRENT PROCESSED	1		XXX.XX	00		00		XXXXX	
YEAR - TO - DATE TOTAL	56	(2Pb)	XXXX.XX (3Pb)	00 (4Pb)		00 (5Pb)		XXXXXX (6Pb)	
THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE									
12 SERVICE PAID AT THE MAXIMUM AMOUNT ALLOWED BY MEDICAL ASSISTANCE REIMBURSEMENT POLICIES									