Montana Joint Economic Affairs Committee

Air Ambulance Subgroup

July 8, 2016

1. Network Adequacy. Comparing MT Emergency Helicopter Resources to Other States

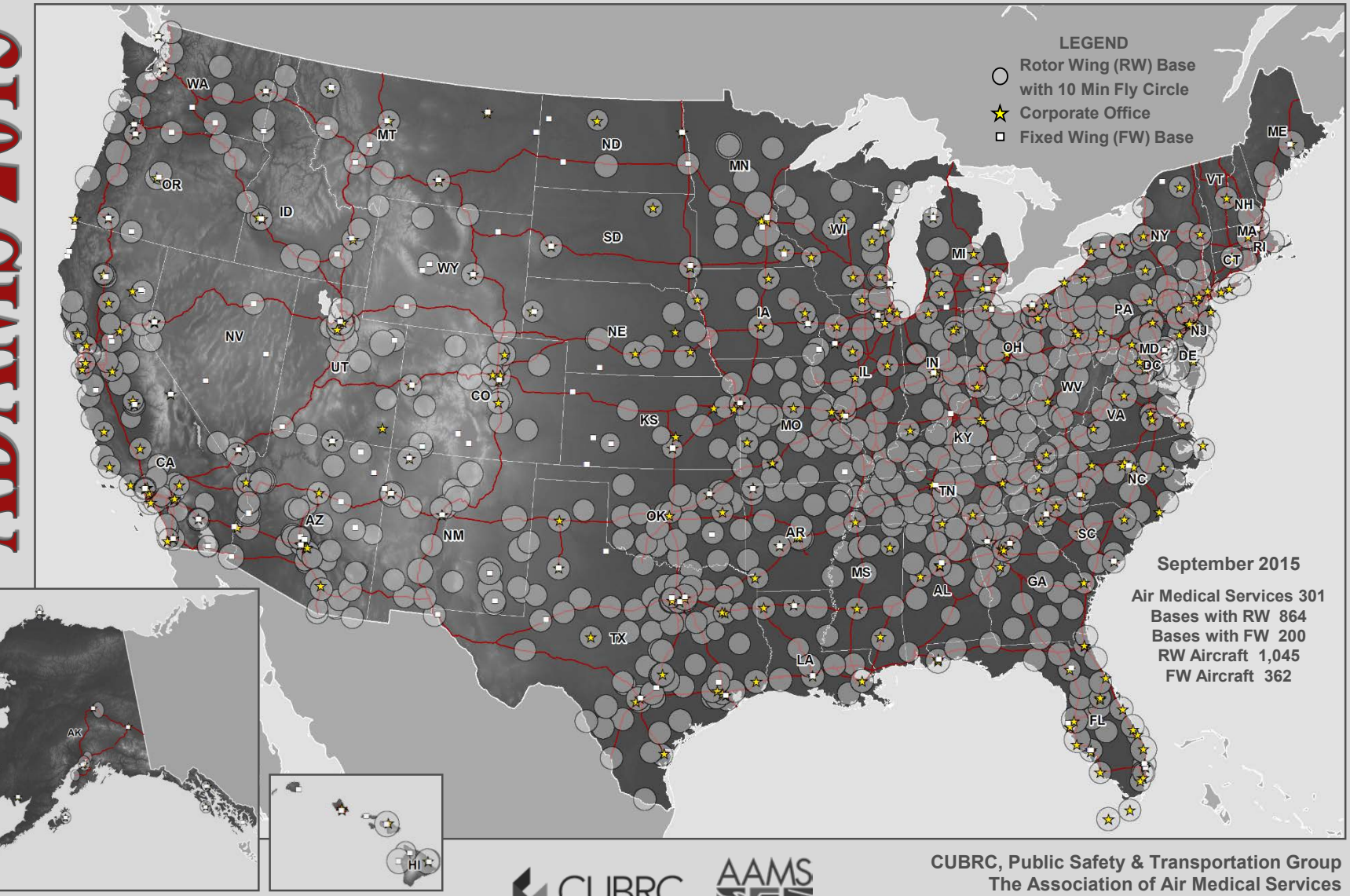
2. Samples of Insurance Carriers who pay appropriately and do not burden beneficiaries with balance bills for emergency air ambulance transports in MT.

3. Historic BCBS air ambulance payments… what changed?

Atlas & Database of Air Medical Services

13th Edition National Air Medical Services GIS Database

ADAMS 2015



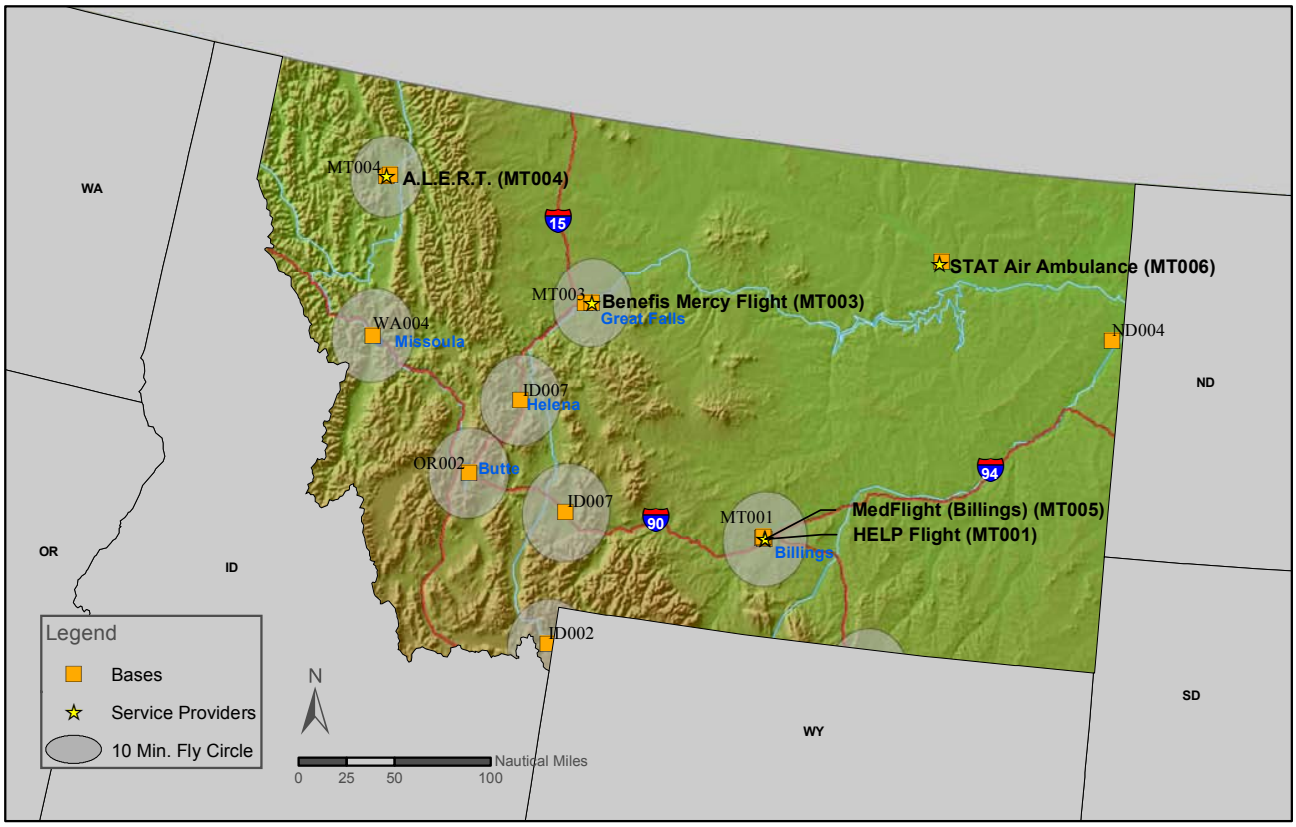
http://www.ADAMSairmed.org

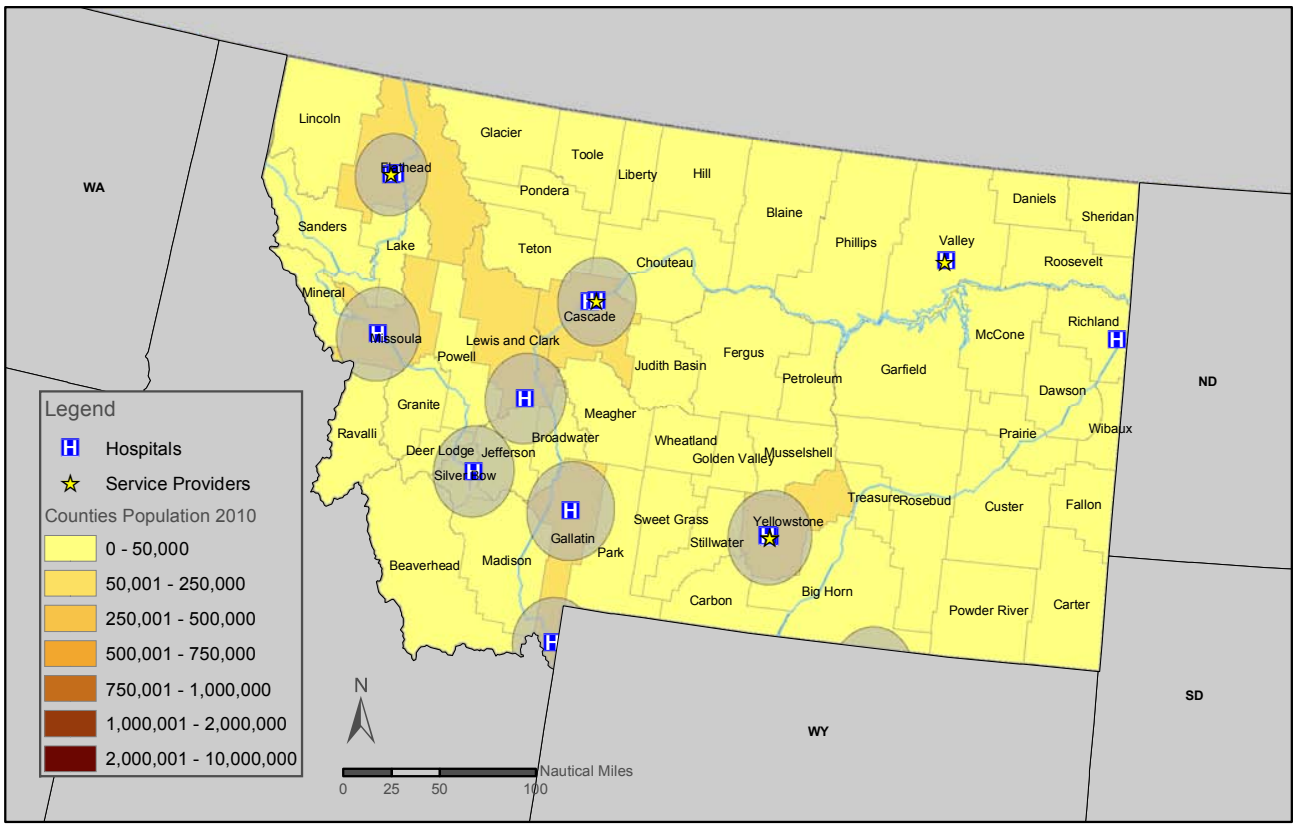
CUBRC

AAMS

CUBRC, Public Safety & Transportation Group
The Association of Air Medical Services
Funding provided by AAMS

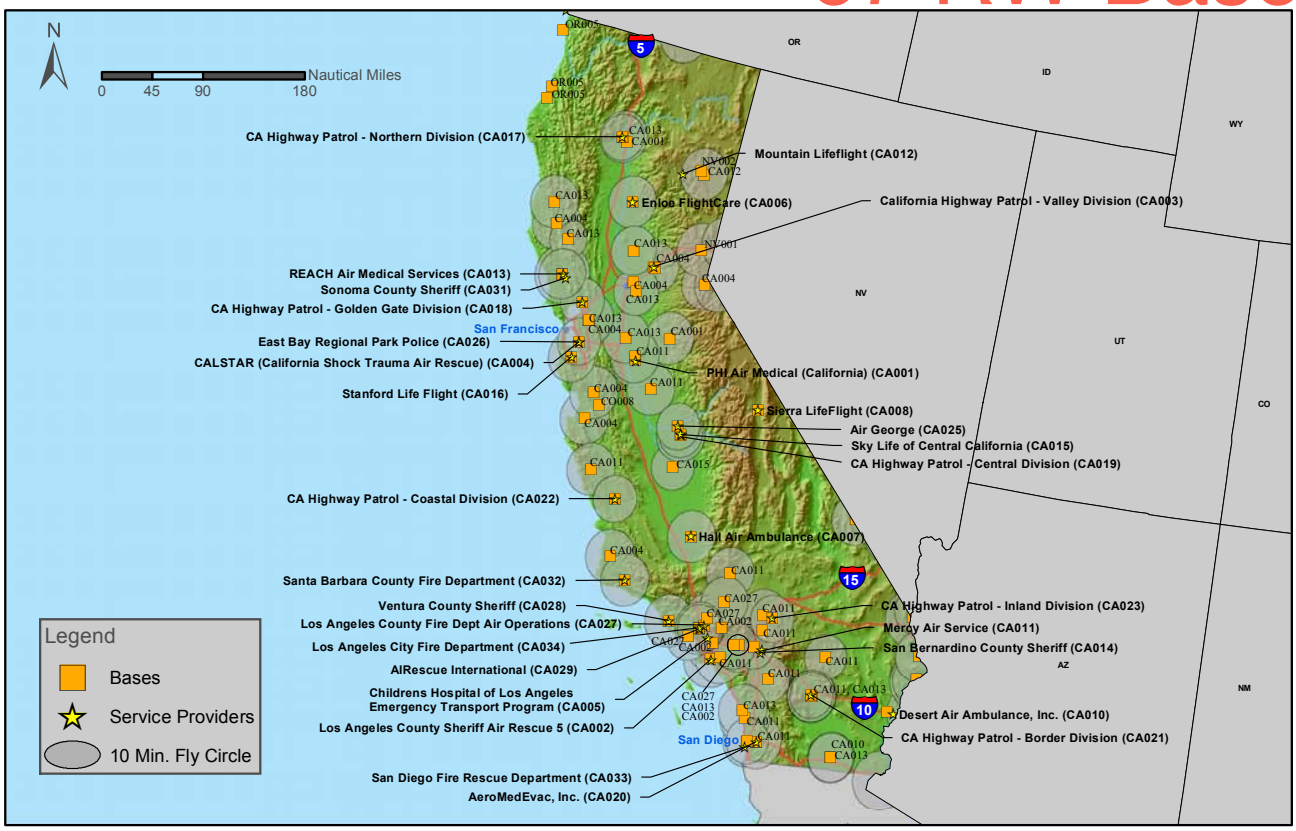
Montana 7 RW Bases

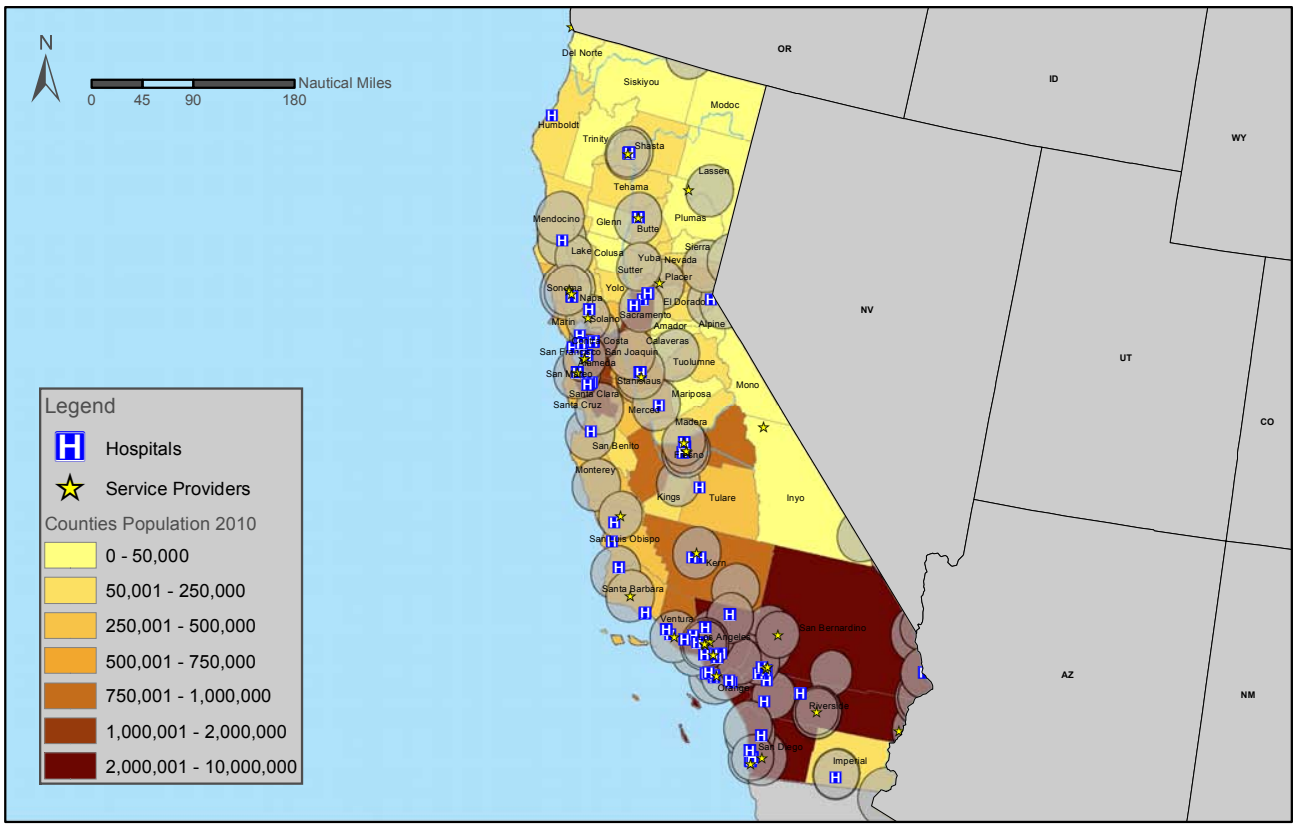




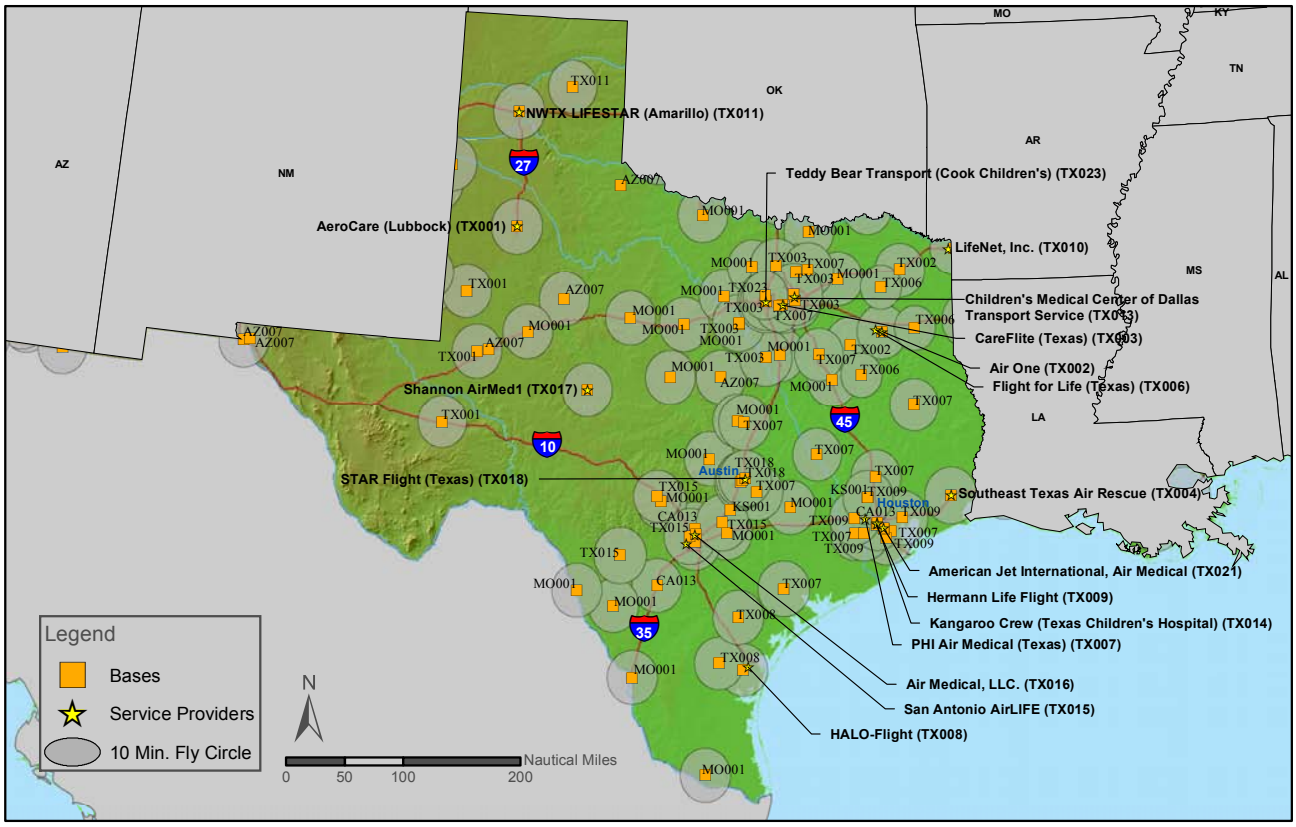
California

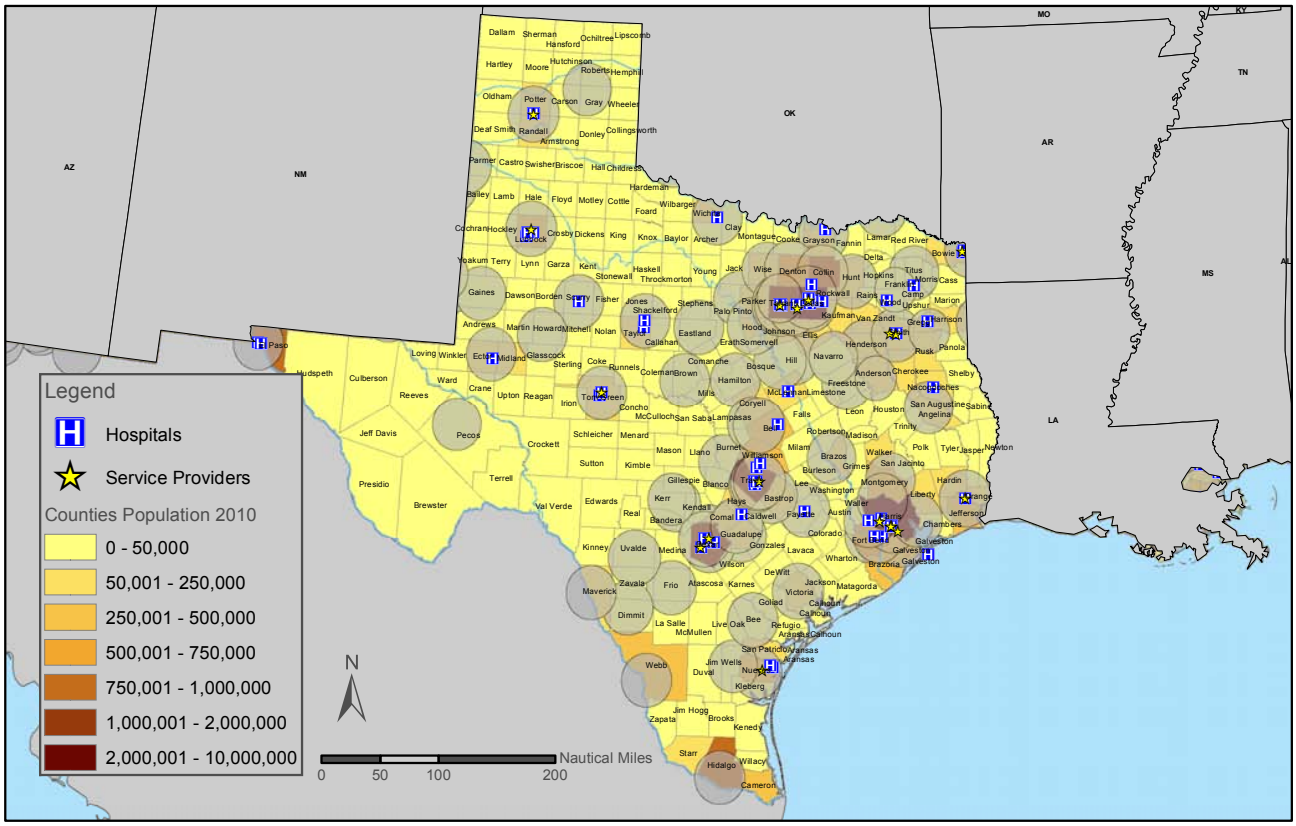
67 RW Bases



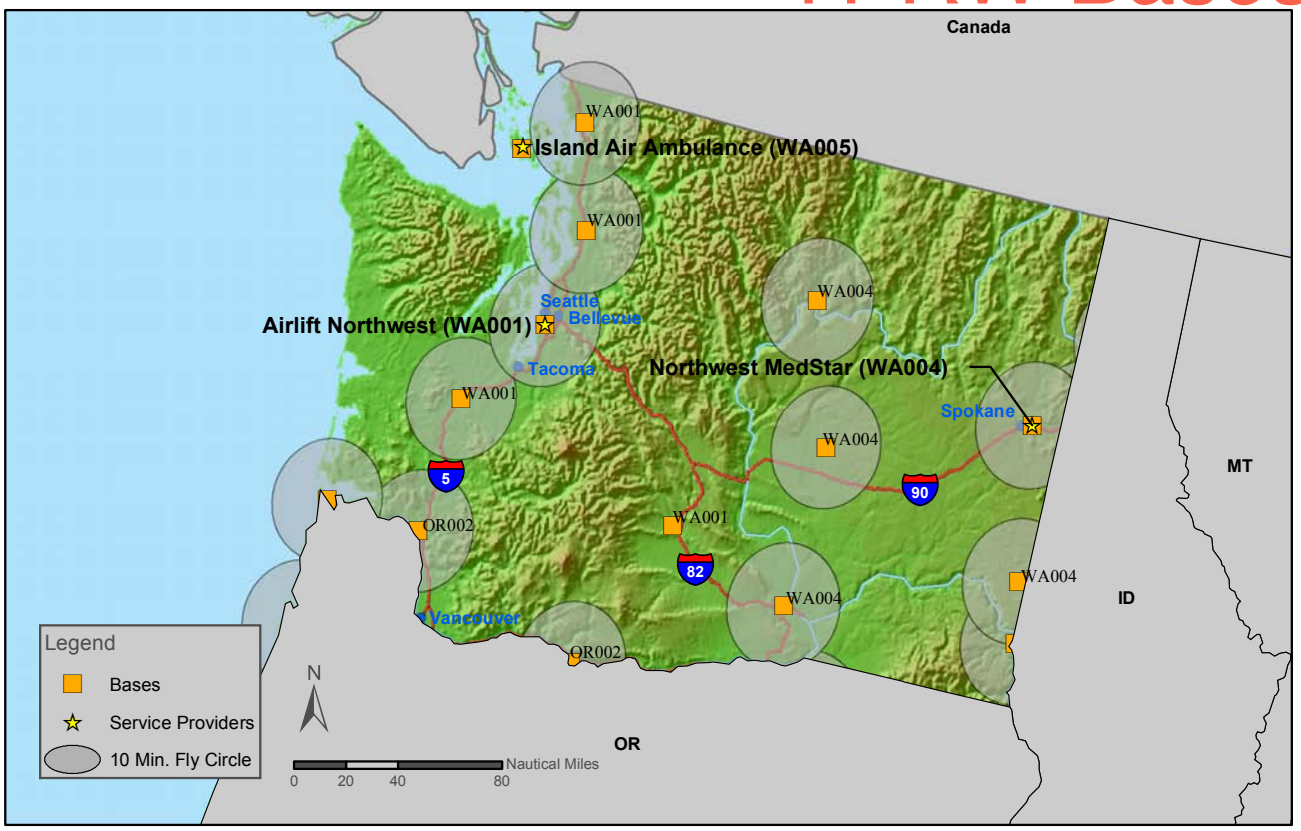


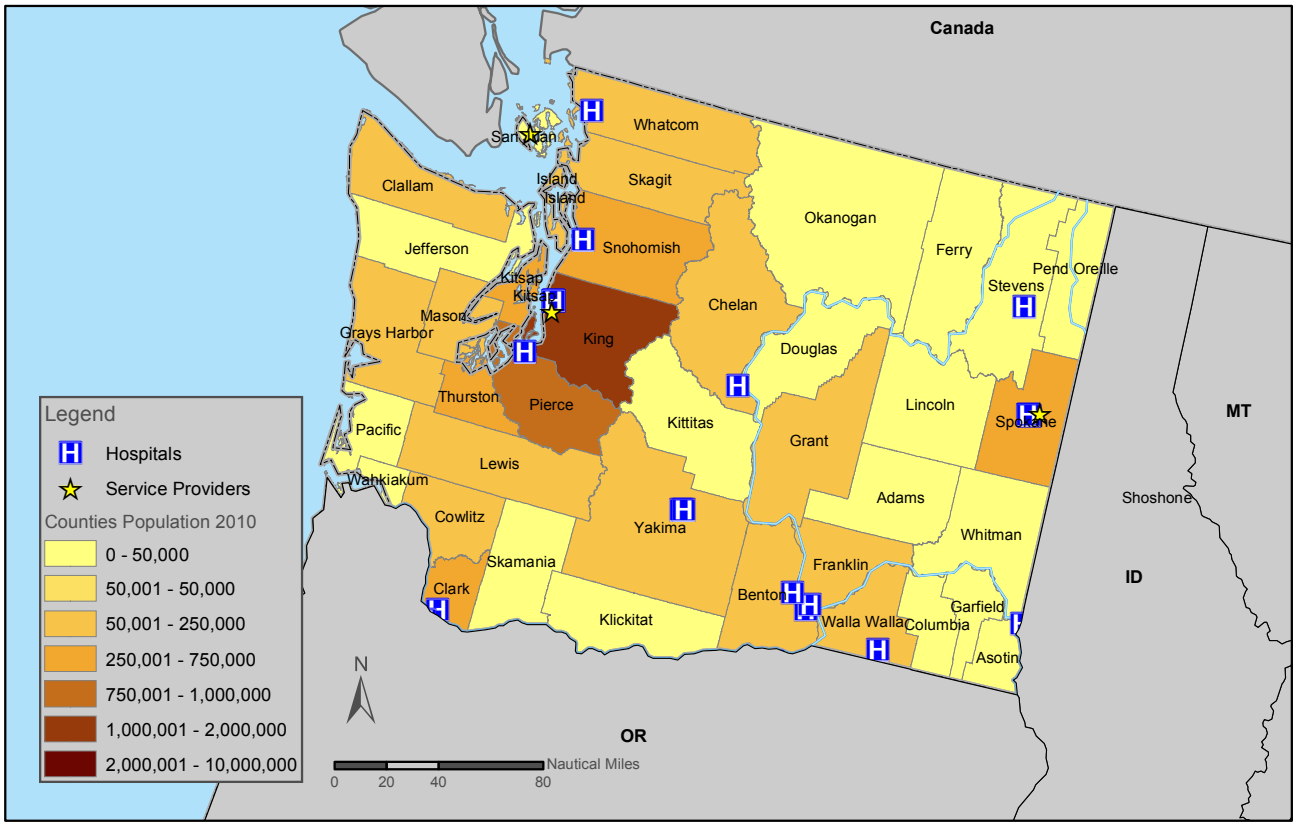
Texas 78 RW Bases



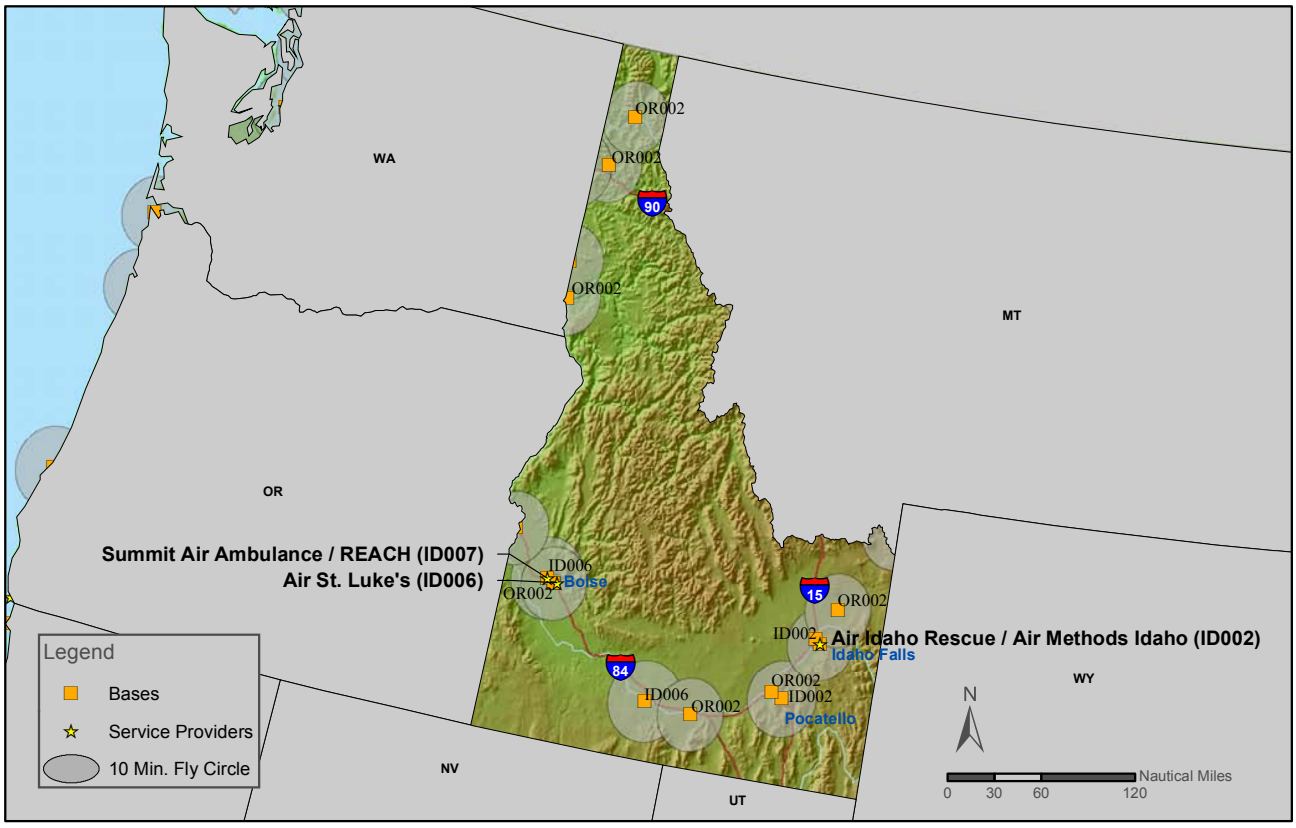


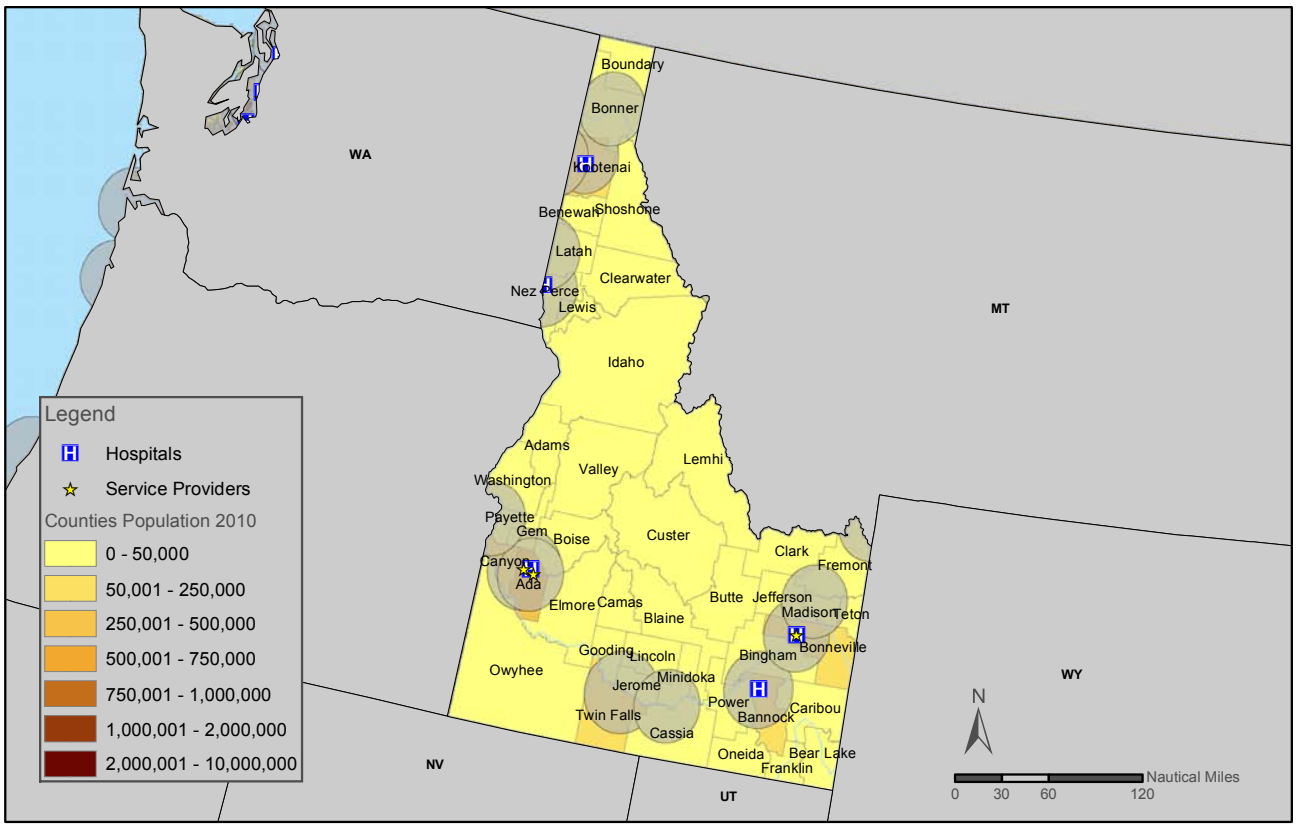
Washington 11 RW Bases



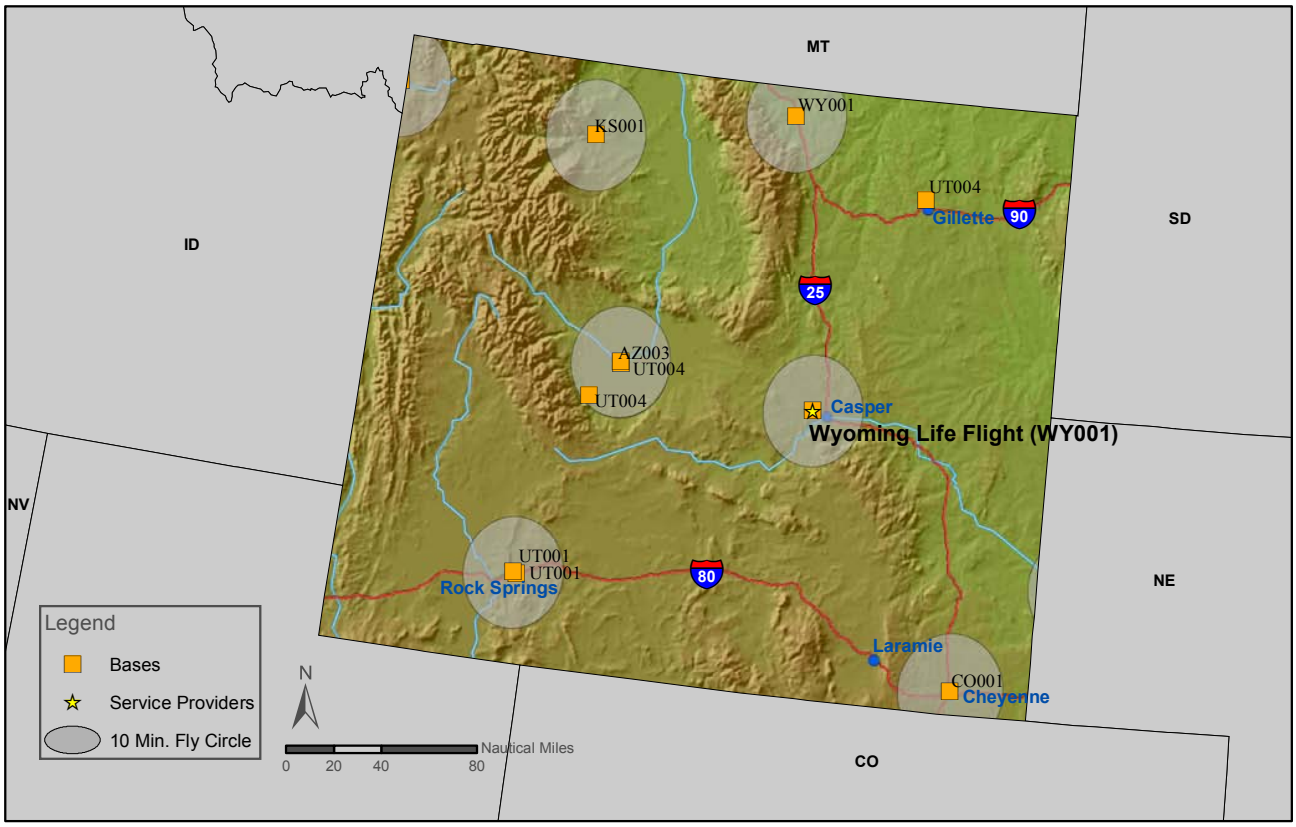


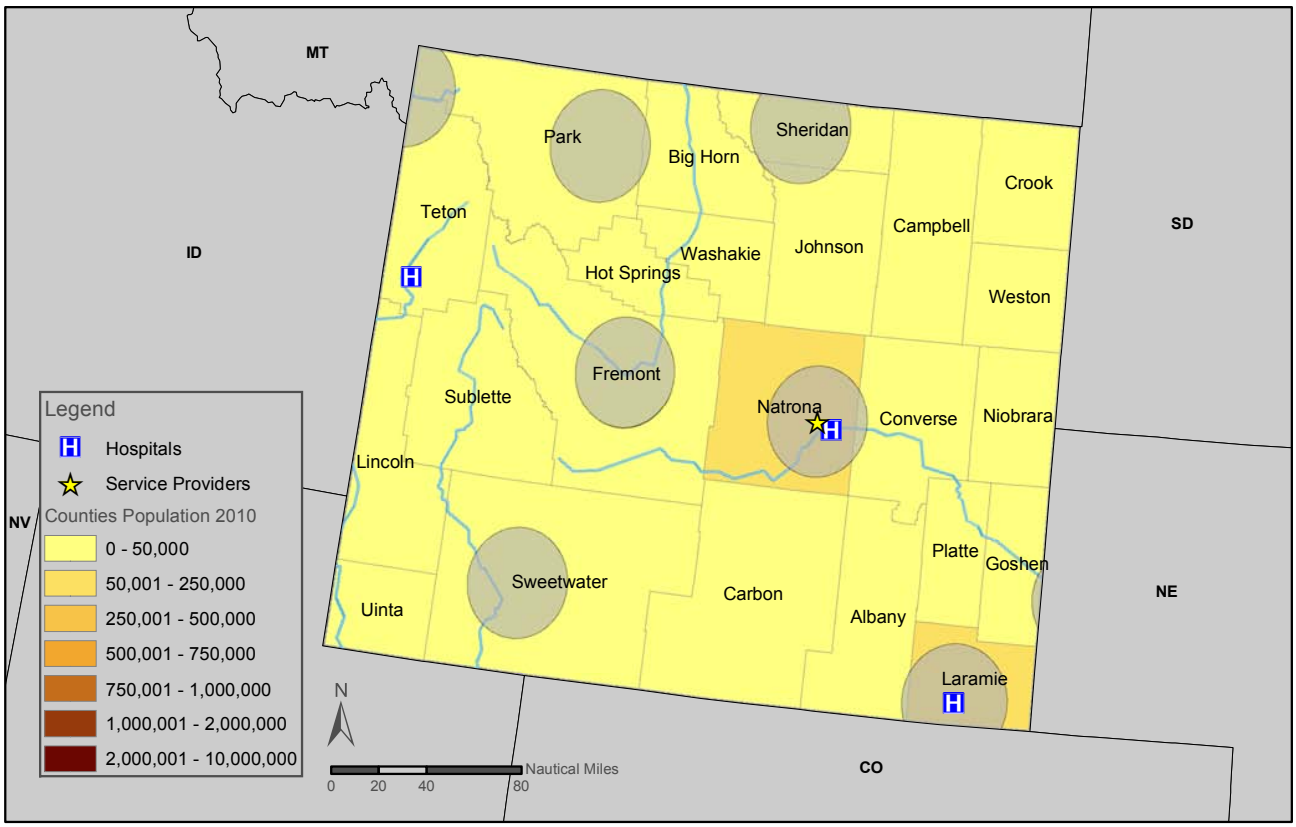
Idaho 10 RW Bases





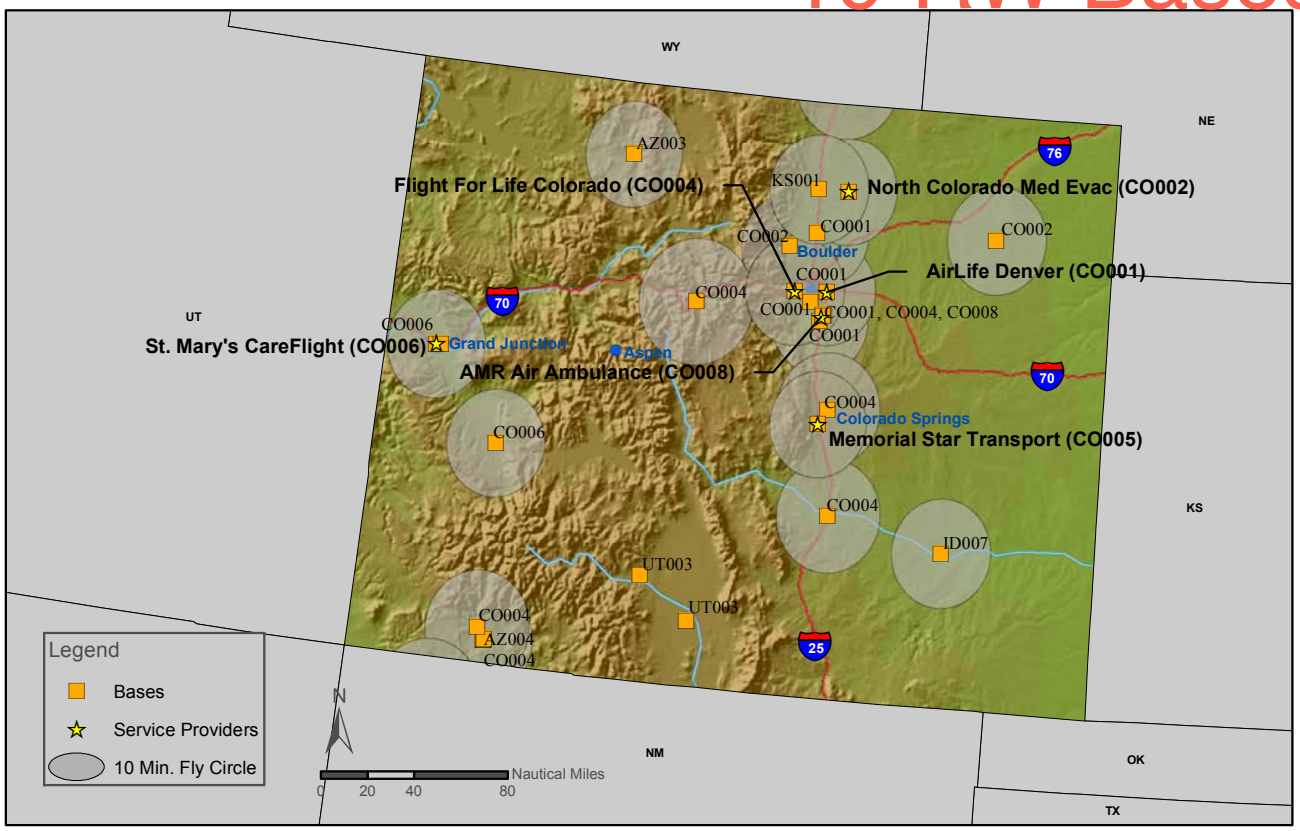
Wyoming 7 RW Bases

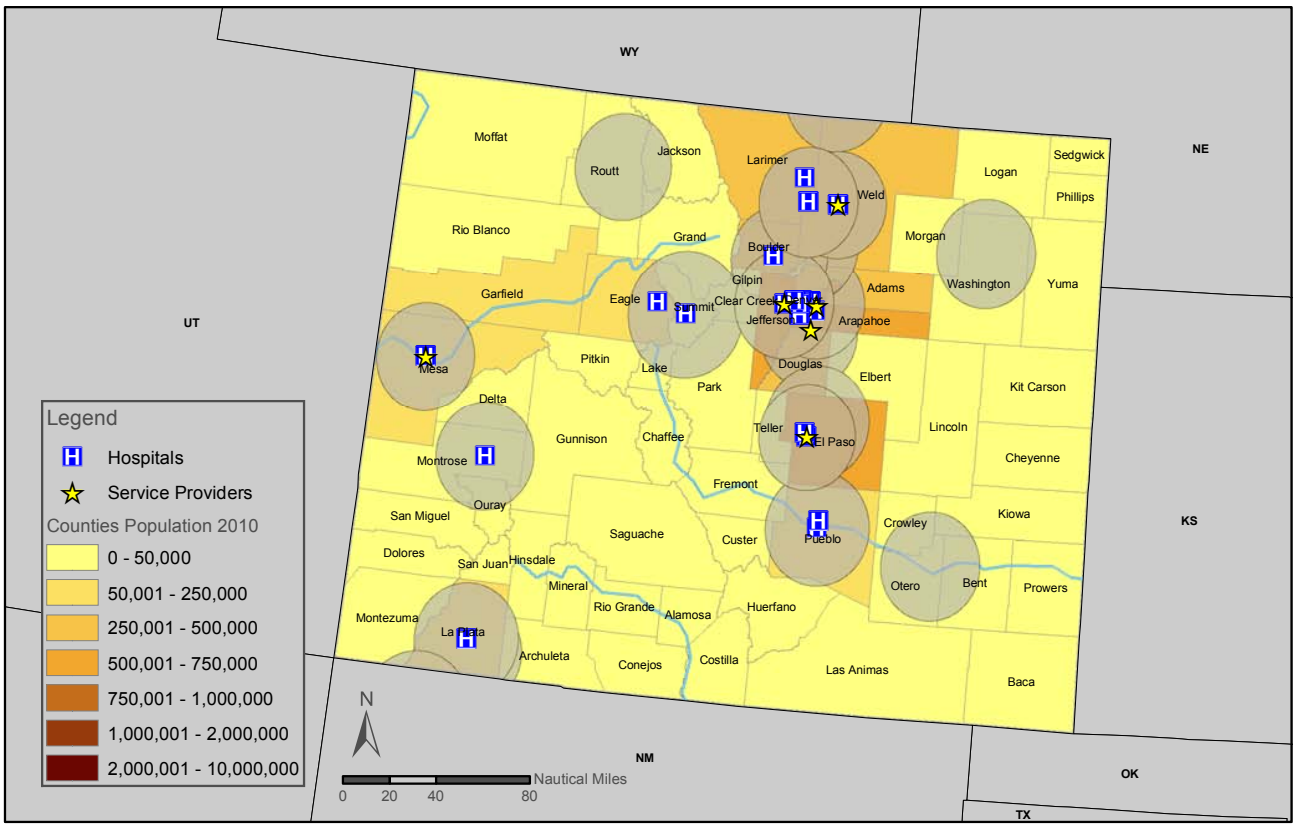




Colorado

19 RW Bases





Historic Montana Air Ambulance Claims

All Health Insurance Is Not Equal

Insurance Companies who do not burden their beneficiaries with large Balance Bills

1C-18282*02*000004-PM-15112-120*C04FICTTOPS
STD - EOB

UnitedHealthcare
A UnitedHealth Group Company

UnitedHealthcare Insurance Company
SPRINGFIELD SERVICE CENTER
P.O. BOX 30555
SALT LAKE CITY, UT 84130-0555
PHONE: 1-877-842-3210

DATE:	04/22/15
TIN:	26-4012800
NPI:	1770723272
GROUP NUMBER:	0717895
GROUP NAME:	DIMENSIONAL INVESTMENT LLC
CHECK NUMBER:	QC 09859768
CHECK AMOUNT:	$23,665.00

SUMMIT AIR AMBULANCE LLC
SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO TX 78265

PROVIDER EXPLANATION OF BENEFITS

[redacted]

MEMBER NAME: [redacted]
MEMBER ID: [redacted]
PRODUCT: CHOYC+
PATIENT ACCOUNT: 15-00628A

CONTROL NUMBER: 500802841701
DATE RECEIVED: 04/03/15
PROVIDER OF SERVICE: SUMMIT AIR AMBULANCE

DATE(S) OF SERVICE	DESCRIPTION OF SERVICES	AMOUNT CHARGED	NOT COVERED	PROV ADJ DISCOUNT	AMOUNT ALLOWED	DEDUCT	COPAY	PLAN CO	PAID TO PROVIDER	RMK CD	PATIENT RESP
03/18/15	AMBULANCE	$15,965.00			$15,965.00			100%	$15,965.00		
03/18/15	AMBULANCE	$7,700.00			$7,700.00			100%	$7,700.00		
	CONTROL # 500802841701 SUBTOTAL	$23,665.00			$23,665.00				$23,665.00	#	$0.00
									TOTAL PAYABLE TO PROVIDER	$23,665.00		

Page 2 of 3

[redacted]

UHC Remittance Advice

Payer Information

UNITED HEALTHCARE INSURANCE COMPANY
9900 BREN ROAD
MINNETONKA, MN 553430000
Phone: 8778423210

Provider Information

ROCKY MOUNTAIN HOLDINGS LLC
PO BOX 713362
CINCINNATI, OH 452280000
Provider ID: 870533822
NPI: 1407855240
Provider Ref#: 870533822

Miscellaneous Information

Check / Eft Date: 8/19/2014
Check / Eft Amount: 714,331.90
Check #: 1QG52482890
Payer Cycle Date: 8/14/2014
Claim Received Date: 8/7/2014

Patient / Insured Information

Patient Name: [redacted]
Insured Name: [redacted]
Corrected Name: [redacted]
Rendering Prov:
Transfer Info:

Patient ID:
Insured ID: [redacted]
Corrected ID:
Rendering ID:
Transfer ID:

Patient Control #: [redacted]
ICN/Payer Control #: 3189720317 0024092562
Claim Status: 1
Bill Type: 42
MRN:

Claim Information

Claim Statement Date(s)	Submitted Charges	Paid Amount	Patient Responsibility	Reason Codes	Adjust Amount	Adjust Total	Remark Codes
06/06/14-06/06/14	48609.90	47157.33	1,452.57			0	

Service Line Information

Service Dates	Procedure	MOD	REV	APC	Units Paid	Units Orig	Charges	Allowed	Deductible	Coinsurance	Paid	CARC	Amount	Remark	Performing Physician
06/06/14 -06/06/14	HC A0431	IH			1		9,683.80	9,683.80	0.00	1,452.57	8,231.23	PR-2	1,452.57		
06/06/14 -06/06/14	HC A0431	IH			1		12,328.00	12,328.00	0.00	0.00	12,328.00				
06/06/14 -06/06/14	HC A0436	IH			95		26,598.10	26,598.10	0.00	0.00	26,598.10				
Line Totals							48,609.90	48,609.90	0.00	1,452.57	47,157.33		1,452.57		

Group, Reason and Remark Codes:

PR Patient Responsibility
2 Coinsurance Amount

AETNA
151 FARMINGTON AVENUE
HARTFORD, CT 06156

REMITTANCE
ADVICE
REPORT

SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO, TX 782658773

PROVIDER #:1770723272
Page #:0001
DATE: 9/22/2014
CHECK/EFT #:814259500000254

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME [redacted]			HIC		ACNT 1401385A			ICN E535GJZT10000		ASG Y MOA	
1770723272	0802	080214	42	A0436	IH	30600.00	30600.00	0.00	1878.75		28721.25
1770723272	0802	080214	42	A0431	IH	15500.00	15500.00	0.00	0.00		15500.00
PT RES 1878.75					CLAIM TOTALS	46100	46100.00	0.00	1878.75	0.00	44221.25
ADJ TO TOTALS: PREV PD 0.00					INTEREST 0.00		LATE FILING CHARGE		0.00	NET	44221.25

Status:Processed as primary

GLOSSARY: GROUP, REASON, MOA, REMARK AND REASON CODES
PR-2 Patient Responsibility-Coinsurance Amount

AETNA
151 FARMINGTON AVENUE
HARTFORD, CT 06156

REMITTANCE
ADVICE
REPORT

SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO, TX 782658773

PROVIDER #:1770723272
Page #:0001
DATE: 4/14/2015
CHECK/EFT #:815098490000935

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]				HIC		ACNT 1500520A		ICN E5TWK2MD50000		ASG Y MOA	
1770723272	0305	030515	42	A0436	HH	21350.00	17690.00	0.00	0.00	PI-45 3660.00	17690.00
1770723272	0305	030515	42	A0431	HH	15965.00	15870.00	0.00	0.00	PI-45 95.00	15870.00
PT RES	0.00				CLAIM TOTALS	37315	33560.00	0.00	0.00	3755.00	33560.00
ADJ TO TOTALS: PREV PD	0.00				INTEREST	0.00		LATE FILING CHARGE	0.00	NET	33560.00
Status:Processed as primary											

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	1	37315.00	33560.00	0.00	0.00	3755.00	33560.00	0.00	33560.00

GLOSSARY: GROUP, REASON, MOA, REMARK AND REASON CODES
PI Payor Initiated Reductions
PI-45 Payor Initiated Reductions-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

HEALTHPARTNERS
8170 33RD AVE S
PO BOX 1289
MINNEAPOLIS, MN 55440-1289
CONTACT: HEALTHPARTNERS MEDICAL
(952) 967-6633 OR 1-866-429-1474
PAYER ID: 1410797853
SUPPLEMENTAL ID: CLAIM

PAYEE: ROCKY MOUNTIAN HOLDINGS LLC
LIFENET-PHILADELPHIA
PO BOX 713362
CINCINATTI, OH 45271-3362
PAYEE TAX ID: 870533822
PAYEE NPI: 1407855240
PAYEE ID: V870533822103806

PROD DATE: 20140928
CHECK/EFT DT: 20141002
CHECK/EFT: 2000655437
PAYMENT: 39423.58
PAYMENT METHOD: ACH

PAT CTRL #: [redacted] CLM #: 2425119443 CLM STATUS: 4 DENIED CLM DT: 20140822-20140822 CLM CHG: 49999.00
PATIENT: [redacted] CLM PAYMENT: 0.00
PATIENT ID: [redacted] GRP: CLM FILING IND: HM PAT RESP: 49999.00 PRV LIAB: 0.00
REND PROV ID: 1407855240 CLM RECEIVED DT: 20140908 FACILITY TYPE: 42 FREQ: OTHER LIAB: 0.00 PRV TAX 0.00
COV EXP DT: 20130831 WITHHOLD: 0.00 COVERED: 0.00

LINE CTRL #	DOS	REV	ADJUDICATED PROD SRC MOD	SUBMITTED PROD SVC MOD	CHARGE/ ALLOWED	#	APC	ADJ AMT (GRP CD/CLM ADJ RSN CD)	REMARK CODES	REND PROV ID	PAYMENT
1	20140822-20140822		AC430 II		22085.67 0.00	0		22085.67(PR/31)			0.00
2	20140822-20140822		AC435 II		27913.33 0.00	0		27913.33(PR/31)			0.00

PAT CTRL #: 14110412 CLM #: 2422317810 CLM STATUS: 1 PAID PRIMARY CLM DT: 20140725-20140725 CLM CHG: 41050.44
PA[redacted] CLM PAYMENT: 39423.58
PATIENT ID: 30549559 GRP: 25274 CLM FILING IND: HM PAT RESP: 1626.86 PRV LIAB: 0.00
REND PROV ID: 1407855240 CLM RECEIVED DT: 20140811 FACILITY TYPE: 42 FREQ: OTHER LIAB: 0.00 PRV TAX 0.00
WITHHOLD: 0.00 COVERED: 41050.44

LINE CTRL #	DOS	REV	ADJUDICATED PROD SRC MOD	SUBMITTED PROD SVC MOD	CHARGE/ ALLOWED	#	APC	ADJ AMT (GRP CD/CLM ADJ RSN CD)	REMARK CODES	REND PROV ID	PAYMENT
1	20140725-20140725		AC431 IH		22011.80 22011.80	1		228.99(PR/1) 1397.87(PR/2)			20384.94
2	20140725-20140725		AC436 IH		19038.64 19038.64	68					19038.64

TOTAL PAYMENT AMT: 39423.58

GRP CD	GROUP CODE DESCRIPTION	ADJ RSN	ADJUSTMENT REASON DESCRIPTION	REMARK CODE	REMARK CODE DESCRIPTION
PR	PATIENT RESPONSIBILITY	1	DEDUCTIBLE AMOUNT		
		2	COINSURANCE AMOUNT		
		31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED		

835 Remittance Advice

Payer Information

SELECTHEALTH
PO BOX 30192
SALT LAKE CITY, UT 84130

Provider Information

ROCKY MOUNTAINS HOLDINGS
PO BOX 713362
CINCINNATI, OH 45271
Provider ID: 870533822
Provider Ref#:

Miscellaneous Information

Check / Eft Date: 2/12/2016
Check / Eft Amount: 10,469.64
Check #: 2221969
Payer Cycle Date: 2/18/2016
Claim Received Date:

Patient / Insured Information

Patient Name: [redacted]
Insured Name:
Corrected Name:
Rendering Prov:
Transfer Info:

Patient ID: [redacted]
Insured ID:
Corrected ID:
Rendering ID:
Transfer ID:

Patient Control #: [redacted]
ICN/Payer Control #: 169059240600
Claim Status: 1
Bill Type:
MRN:

Claim Information

Claim Statement Date(s)	Submitted Charges	Paid Amount	Patient Responsibility	Reason Codes	Adjust Amount	Adjust Total	Remark Codes
01/01/00-01/01/00	54443.32	54443.32	0.00			0	

Service Line Information

Service Dates	Procedure	MOD	REV	APC	Units Paid	Units Orig	Charges	Allowed	Deductible	Coinsurance	Paid	CARC	Amount	Remark	Performing Physician
07/23/15 -07/23/15	HC A0431	IH			1		24,653.22	24,653.22	0.00	0.00	24,653.22				
07/23/15 -07/23/15	HC A0436	IH			1		29,790.10	29,790.10	0.00	0.00	29,790.10				
Line Totals							54,443.32	54,443.32	0.00	0.00	54,443.32		0.00		

Group, Reason and Remark Codes:

835 Remittance Advice

Payer Information

PROVIDENCE HEALTH PLAN
UNKNOWN
UNKNOWN, UN 00000

Provider Information

ROCKY MOUNTAINS HOLDINGS
PO BOX 713362
CINCINNATI, OH 45271
Provider ID: 870533822
Provider Ref#:

Miscellaneous Information

Check / Eft Date: 12/20/2014
Check / Eft Amount: 40,770.46
Check #: 560700
Payer Cycle Date: 12/31/2014
Claim Received Date:

Patient / Insured Information

Patient Name: [redacted]
Insured Name:
Corrected Name:
Rendering Prov:
Transfer Info:

Patient ID: [redacted]
Insured ID:
Corrected ID:
Rendering ID:
Transfer ID:

Patient Control #: [redacted]
ICN/Payer Control #: 142870128700
Claim Status: 1
Bill Type:
MRN:

Claim Information

Claim Statement Date(s)	Submitted Charges	Paid Amount	Patient Responsibility	Reason Codes	Adjust Amount	Adjust Total	Remark Codes
01/01/00-01/01/00	40770.46	40770.46	0.00			0	

Service Line Information

Service Dates	Procedure	MOD	REV	APC	Units Paid	Units Orig	Charges	Allowed	Deductible	Coinsurance	Paid	CARC	Amount	Remark	Performing Physician
09/20/14 -09/20/14	HC A0431	IH			1		22,011.80	22,011.80	0.00	0.00	22,011.80				
09/20/14 -09/20/14	HC A0436	IH			1		18,758.66	18,758.66	0.00	0.00	18,758.66				
Line Totals							40,770.46	40,770.46	0.00	0.00	40,770.46		0.00		

Group, Reason and Remark Codes:

ALLSTATE FIRE CASUALTY INSURANCE COMPANY

PO BOX 2874
CLINTON IA 52733-2874

Allstate.
You're in good hands.

EXPLANATION OF MEDICAL BILL PAYMENT

Service Provided For:
[redacted]
10 W MAIN
FISHTAIL MO 59028

Date: 01/08/2015
Bill Received Date: 12/11/2014
Claim #: 0350895305-02
File Handler: 2R2
Invoice #: 14-02248A
Injured Person: [redacted]
Treatment Rendered By: SUMMIT AIR AMBULANCE LLC
Provider Specialty:
TIN: 26-4012800
NPI: 1770723272
CMS ID:

Diagnosis Codes/Present on Admission Indicator
850.5 Concussion with loss of consciousnes

Date Of Service(s) From	Thru	Procedure/Revenue/NDC Code/Modifier	Description	Units	Billed Amount	Covered Amount	Reason Code(s)
12/06/14	12/06/14	A0431-HH	Ambulance service, conve	1.00	$ 15500.00	$ 15500.00	
12/06/14	12/06/14	A0436-HH	Rotary wing air mileage,	39.00	$ 6630.00	$ 6630.00	
Total:					$ 22130.00	$ 22130.00	

Eligible Amount Based on 100% of Covered Amount $ 22130.00

Modifier Code(s):
HH Ambulance transport - Hospital to hospital

If you have any questions about this claim, please contact your file handler,
ROCKY E. GARRETT at (866) 575-4363 ext 9817576

Payment for $ 22130.00 was made on 01/08/2015 to:
SUMMIT AIR AMBULANCE LLC

Copy(s) of this Explanation of Benefits has been sent to:
[redacted]
SUMMIT AIR AMBULANCE LLC, PO BOX 47773 SAN ANTONIO, TX, 78265-8773

150108002024R0717 0004020
0002 0002

Batch: 8770 Seq: 3 Remittance #: Remittance Name: Check#: 73244066 Amount: $21,540.37 Image 1 of 3

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

LNM * 000046
Liberty Mutual Insurance
PO Box 5089
Portland, OR 97208-5089

Liberty Mutual. INSURANCE

Drawn on Bank of America, N.A.

73244066
64-1278
611

B.CODE
200

CLAIM NO.
WC 687-160424 REG

CHECK DATE
09/04/2015

$21540.37****

VOID IF NOT PRESENTED WITHIN SIX MONTHS OF ISSUE DATE OF CHECK

PAY TWENTY-ONE THOUSAND FIVE HUNDRED FORTY AND 37/100 DOLLARS**********

TO THE ORDER OF
SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO TX 78265-8773

NOT VALID IN EXCESS OF $150,000

⑈00732440668⑈ ⑆061112788⑆ 329 912 5494⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

Batch: 8770 Seq: 3 Remittance #: Remittance Name: Check#: 73244066 Amount: $21,540.37 Image 2 of 3

Liberty Mutual. INSURANCE

B.CODE	CHECK REFERENCE	CHECK DATE
200	73244066	09/04/2015
	CHECK AMOUNT	BLOCK NUMBER
	$21540.37****	076062

FOR REVIEW ONLY:
LIBERTY MUTUAL - WAUSAU
P.O. BOX 7070
LONDON, KY 40742

(800) 500-7044
SEND BILLS TO:
P.O. BOX 7204
LONDON, KY 40742

PAGE 1 OF 2

CLAIM NO: WC 687-160424 REG
CONTRACT NO: WC4-1NC-010990-014-93

INTERNAL BILL NO: 109052661 MBPS: N0171374
CUST/EXTERNAL BILL NO: 26151330737802

PAYEE: SUMMIT AIR AMBULANCE LLC

BILL PROV: SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO, TX 78265-8773

PATIENT ACCT. #: 1500134A
SSN: [redacted]
DOI:
PATIENT: [redacted]

TAX ID: XX-XXX2800
PROVIDER: ST PATRICK HOSPTIAL ER

EMPLOYER: [redacted]
DATES OF SERVICE: [redacted]

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
01/20/15	A0431		AMB. SERVICE, CAS, ONE WA	1.00	15965.00	15965.00	N/A	5167.61	10797.39	
01/20/15	A0436		ROTARY WING AIR MILEAGE P	76.00	13300.00	13300.00	N/A	2557.02	10742.98	

TOTAL CHARGES: 29265.00
TOTAL PREVIOUSLY PAID: 7724.63
TOTAL CURRENT PAYABLE: 21540.37
TOTAL WITHHOLDING - (FEDERAL AND STATE): 0.00

TOTAL AMOUNT PAID: 21540.37

EXPLANATION CODE DESCRIPTIONS:
Z146 IF YOU WOULD LIKE A REVIEW OF THE PAYMENT DECISION, PLEASE INCLUDE A COPY OF THE EOP, YOUR REASON FOR DISAGREEING WITH OUR DETERMINATION, AND ANY DOCUMENTATION YOU WOULD LIKE US TO REVIEW FOR RECONSIDERATION. FORWARD THIS INFORMATION TO THE "FOR REVIEW ONLY" ADDRESS LOCATED IN THE UPPER MOST LEFT CORNER OF THE EOP. (Z146)
Z989 THE AMOUNT PAID PREVIOUSLY WAS LESS THAN IS DUE. THE CURRENT RECOMMENDED AMOUNT IS THE RESULT OF SUPPLEMENTAL PAYMENT. (Z989)

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

LNCW31 V.0.02
08.24.10

Batch: 4911 Seq: 1 Remittance #: Remittance Name: Check#: 73232160 Amount: $7,724.63 Image 1 of 3

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

LNM * 000053
Liberty Mutual Insurance
PO Box 5089
Portland, OR 97208-5089

Liberty Mutual. INSURANCE

Drawn on Bank of America, N.A.

73232160
64-1278
611

B.CODE
200

CLAIM NO.
WC 687-160424 REG

CHECK DATE
05/22/2015

$7724.63*****

VOID IF NOT PRESENTED WITHIN SIX MONTHS OF ISSUE DATE OF CHECK

PAY SEVEN THOUSAND SEVEN HUNDRED TWENTY-FOUR AND 63/100 DOLLARS**********

TO THE ORDER OF
SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO TX 78265-8773

NOT VALID IN EXCESS OF $150,000

⑈007323216O⑈ ⑆O611127BB⑆ 329 912 5494⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

Batch: 4911 Seq: 1 Remittance #: Remittance Name: Check#: 73232160 Amount: $7,724.63 Image 2 of 3

Liberty Mutual. INSURANCE

B.CODE	CHECK REFERENCE	CHECK DATE
200	73232160	05/22/2015
	CHECK AMOUNT	BLOCK NUMBER
	$7724.63*****	050793

FOR REVIEW ONLY:
LIBERTY MUTUAL - WAUSAU
P.O. BOX 7070
LONDON, KY 40742

(800) 500-7044
SEND BILLS TO:
P.O. BOX 7204
LONDON, KY 40742

PAGE 1 OF 2

CLAIM NO: WC 687-160424 REG
CONTRACT NO: WC4-1NC-010990-014-93

INTERNAL BILL NO: 109052661 MBPS: N0238317
CUST/EXTERNAL BILL NO: 26151330737800

PAYEE: SUMMIT AIR AMBULANCE LLC

BILL PROV: SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO, TX 78265-8773

PATIENT ACCT. #: 1500134A
SSN: [redacted]
DOI: [redacted]
PATIENT: [redacted]

TAX ID: XX-XXX2800
PROVIDER: ST PATRICK HOSPTIAL ER

EMPLOYER: [redacted]
DATES OF SERVICE: [redacted]

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
01/20/15	A0431		AMB. SERVICE, CAS, ONE WA	1.00	15965.00	5167.61	N/A	0.00	5167.61	P300 ZC93
01/20/15	A0436		ROTARY WING AIR MILEAGE P	76.00	13300.00	2557.02	N/A	0.00	2557.02	P300 ZC93

TOTAL CHARGES: 29265.00
TOTAL PREVIOUSLY PAID: 0.00
TOTAL CURRENT PAYABLE: 7724.63
TOTAL WITHHOLDING - (FEDERAL AND STATE): 0.00

TOTAL AMOUNT PAID: 7724.63

EXPLANATION CODE DESCRIPTIONS:
P300 THE AMOUNT PAID REFLECTS A FEE SCHEDULE REDUCTION. (P300)
ZC93 THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (ZC93)
Z146 IF YOU WOULD LIKE A REVIEW OF THE PAYMENT DECISION, PLEASE INCLUDE A COPY OF THE EOP, YOUR REASON FOR DISAGREEING WITH OUR DETERMINATION, AND ANY DOCUMENTATION YOU WOULD LIKE US TO REVIEW FOR RECONSIDERATION. FORWARD THIS INFORMATION TO THE "FOR REVIEW ONLY" ADDRESS LOCATED IN THE UPPER MOST LEFT CORNER OF THE EOP. (Z146)

ASSURANT Health

TIME INSURANCE COMPANY
P O BOX 2806
CLINTON, IA 527332806

ROCKY MOUNTAIN HOLDINGS LLC
PO BOX 713362
CINCINNATI, OH 45271-3362

DATE : December 5, 2014
PAYMENT NUMBER : 223903672
AMOUNT PAID : $20,082.00
PAYEE NPI : 1407855240
PAYEE TIN : 870533822

If you have questions, Customer Service is available Monday to Friday, between the hours of 7:00 am - 6:00 pm, Central Time at (800) 553-7654

Remittance Advice

19267711

Details - Claims and Services

Claim Control #	223903672				Provider Name	ROCKY MOUNTAIN HOLDINGS L					
Claim Identifier #	TI-62073711-001-1-01-10-0002				Provider NPI	1407855240					
Patient Name	[redacted]				Insured Name	[redacted]					
Patient Account #	[redacted]				Policy	062073711			Certificate	000001	
Service Date(s)	Service Code	Charged Amount	Allowed Amount	Deductible Amount	Copay Amount	Coinsurance Amount	Discount Amount	Ineligible/Not Covered	Reason Codes	Remarks	Amount Paid
08/17/2014-08/17/2014	A0436	$17,918.72	$17,560.35	$0.00	$0.00	$2,149.85	$358.37	$358.37	131, 2		$15,410.50
08/17/2014-08/17/2014	A0431	$22,011.80	$21,571.65	$6,000.00	$0.00	$10,900.15	$440.15	$440.15	131, 2		$4,671.50
Patient Responsibility								$19,050.00			
Totals		$39,930.52	$39,132.00	$6,000.00	$0.00	$13,050.00	$798.52	$798.52			$20,082.00

Summary - Claims and Services

Statement Totals

	Reason Codes	Payment Amount
Claim Totals		$20,082.00
Totals		$20,082.00
	Remittance Total :	$20,082.00

Reason Codes	Reasons
131	Claim specific negotiated discount.
2	Coinsurance Amount
1	Deductible Amount

Assurant Health markets products underwritten by Time Insurance Company

00812 3592513 002436 004871 0002/0003 k000812

SUMMARY OF HEALTH PLAN PAYMENTS

[redacted]

MASSACHUSETTS

What is this?
This summary shows the amount covered by Blue Cross Blue Shield of Massachusetts ("Blue Cross") for the claim(s) below, and the amount that is your financial responsibility. **This is not a bill**, your health care provider(s) will bill you directly for the amount you owe.

Summary Date: 9/24/15

Member information
Service for: [redacted]
Member ID number: [redacted]
Group Plan Number: 4957246 0085
Plan name: Blue Care Elect PPO

Individual deductible: $500
Family deductible: $1,500

Claim no.: 27152171477902

PAYMENT OVERVIEW

Adjusted amount charged
The amount charged by your health care provider(s) based on Blue Cross' contract rates. **$40,959.38**

Amount covered
Benefits provided by Blue Cross for your medical services. **$38,755.96**

What you owe
The amount not covered by your Blue Cross health plan. This includes copayments, co-insurance, and deductible.

Copayments	$0.00
Deductible	$0.00
Co-insurance	$2,203.42
Not Covered	$0.00
	$2,203.42

Adjusted amount charged

Amount your health care provider charged	Blue Cross discount	Adjusted amount
$40,959.38	$0.00	**$40,959.38**

Glossary

Blue Cross discount
Your savings from the discounted rate Blue Cross negotiated with your health care provider. The discount only applies to health care providers that are in our network.

Copayments
A fixed dollar amount, typically collected at your medical appointment, at a doctor's office or other medical facility.

Deductible
The amount you pay for specific services each coverage year before Blue Cross starts paying.

Co-insurance
The amount you pay for specific health care services, calculated as a percentage.

Out-of-pocket maximum
The most you'll pay annually for your share of the cost of covered services. These may include copayments, co-insurance, and deductibles.

Health care provider
A doctor, hospital, health care professional,or health care facility.

Keep for your records

690173664 700/700

(For a detailed breakdown of your payments, please see next page)

BCBS Remittance Advice

Payer Information

BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.
P.O. BOX 13466
PHOENIX, AZ 850023466

Provider Information

NATIVE AMERICAN AIR ROCKY MOUNTIAN HOLDINGS,
PO BOX 713362
CINCINNATI, OH 452713362
Provider ID: 870533822
NPI: 1407855240
Provider Ref#: 870533822

Miscellaneous Information

Check / Eft Date: 10/6/2014
Check / Eft Amount: 272,885.57
Check #: 865412361
Payer Cycle Date: 10/6/2014
Claim Received Date: 9/30/2014

Patient / Insured Information

Patient Name: [redacted]
Insured Name: [redacted]
Corrected Name: [redacted]
Rendering Prov:
Transfer Info:

Patient ID: [redacted]
Insured ID: [redacted]
Corrected ID:
Rendering ID:
Transfer ID:

Patient Control #: [redacted]
ICN/Payer Control #: 530142731058800
Claim Status: 1
Bill Type:
MRN:

Claim Information

Claim Statement Date(s)	Submitted Charges	Paid Amount	Patient Responsibility	Reason Codes	Adjust Amount	Adjust Total	Remark Codes
01/01/00-01/01/00	40210.50	34178.93	0.00			0	

Service Line Information

Service Dates	Procedure	MOD	REV	APC	Units Paid	Units Orig	Charges	Allowed	Deductible	Coinsurance	Paid	CARC	Amount	Remark	Performing Physician
08/06/14 -08/06/14	HC A0431	IH			1		22,011.80	18,710.03	0.00	0.00	18,710.03	CO-45	3,301.77		
08/06/14 -08/06/14	HC A0436	IH			65		18,198.70	15,468.90	0.00	0.00	15,468.90	CO-45	2,729.80		
Line Totals							40,210.50	34,178.93	0.00	0.00	34,178.93		6,031.57		

Group, Reason and Remark Codes:

CO Contractual Obligations

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reduct

Historic BCBS MT Claims

What Changed?

BlueCross BlueShield of Montana
P.O.Box 7982
Helena, Montana 59604-7982
(800) 447-7828

PROVIDER CLAIM SUMMARY

DATE: 09/23/14
PROVIDER NUMBER: 1770723272
CHECK NUMBER: 30128080
TAX IDENTIFICATION NUMBER: 264012800

Visit *www.bcbsmt.com/provider,*
for the latest news and updates on matters that impact you

SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO TX 78265-8773

Online Pre-authorization Coming Soon -- Keep your eye out for 'iExchange' ... details will be published in the Providers' Announcements page at bcbsmt.com.

ANY MESSAGES WILL BEGIN ON PAGE 2

#2
14-01485

PATIENT: [redacted]
PERF PRV: [redacted]
CLAIM NO: [redacted]

IDENTIFICATION NO: [redacted]
PATIENT NO: 1401485A

FROM / TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
08/16-08/16/14	05	NOP	A0431	15,500.00	15,500.00	0.00	0.00	15,500.00
08/16-08/16/14	05	NOP	A0436	22,780.00	22,780.00	0.00	0.00	22,780.00
				38,280.00	38,280.00	0.00	0.00	38,280.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $38,280.00

TOTAL SERVICES NOT COVERED: 0.00
PATIENT'S SHARE: $0.00

[redacted]

IDENTIFICATION NO: [redacted]
PATIENT NO: [redacted]

FROM / TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
07/16-07/16/14	05	NOP	A0431	15,500.00	15,500.00	0.00	0.00	15,500.00
07/16-07/16/14	05	NOP	A0436	10,540.00	10,540.00	0.00	0.00	10,540.00
				26,040.00	26,040.00	0.00	0.00	26,040.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $26,040.00

TOTAL SERVICES NOT COVERED: 0.00
PATIENT'S SHARE: $0.00

BlueCross BlueShield of Montana
P.O.Box 7982
Helena, Montana 59604-7982
(800) 447-7828

PROVIDER CLAIM SUMMARY

DATE: 09/30/14
PROVIDER NUMBER: 1770723272
CHECK NUMBER: 30131588
TAX IDENTIFICATION NUMBER: 264012800

Visit www.bcbsmt.com/provider, for the latest news and updates on matters that impact you

SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO TX 78265-8773

Online Pre-authorization Coming Soon -- Keep your eye out for 'iExchange' ... details will be published in the Providers' Announcements page at bcbsmt.com.

ANY MESSAGES WILL BEGIN ON PAGE 2

#3
14-01507

PATIENT: [redacted]
PERF PRV: [redacted]
CLAIM NO: [redacted]
IDENTIFICATION NO: [redacted]
PATIENT NO: 1401507A

FROM / TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
08/18-08/18/14	05	NOP	A0431	15,500.00	15,500.00	0.00	0.00	15,500.00
08/18-08/18/14	05	NOP	A0436	21,080.00	21,080.00	0.00	0.00	21,080.00
				36,580.00	36,580.00	0.00	0.00	36,580.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $36,580.00

TOTAL SERVICES NOT COVERED: 0.00
PATIENT'S SHARE: $0.00

PATIENT: [redacted]
PERF PRV: [redacted]
CLAIM NO: [redacted]
IDENTIFICATION NO: [redacted]
PATIENT NO: [redacted]

FROM / TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
08/22-08/22/14	05	NOP	A0430	12,500.00	12,500.00	0.00	0.00	12,500.00
08/22-08/22/14	05	NOP	A0435	22,610.00	22,610.00	0.00	0.00	22,610.00
				35,110.00	35,110.00	0.00	0.00	35,110.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $35,110.00

TOTAL SERVICES NOT COVERED: 0.00
PATIENT'S SHARE: $0.00

BlueCross BlueShield of Montana
P.O.Box 7982
Helena, Montana 59604-7982
(800) 447-7828

PROVIDER CLAIM SUMMARY

DATE: 11/18/14
PROVIDER NUMBER: [redacted]
CHECK NUMBER: 30157638
TAX IDENTIFICATION NUMBER: 264012800

Visit *www.bcbsmt.com/provider,*
for the latest news and updates on matters that impact you

SUMMIT AIR AMBULANCE LLC
PO BOX 47773
SAN ANTONIO TX 78265-8773

Electronic Preauthorization Tool Now Available
iExchange is here! For webinar dates & more, watch the Providers' Announcements page at bcbsmt.com.

ANY MESSAGES WILL BEGIN ON PAGE 2

PATIENT: [redacted]
PERF PRV: [redacted] IDENTIFICATION NO: [redacted]
CLAIM NO: [redacted] PATIENT NO: [redacted]

FROM / TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
10/16-10/16/14	05	NOP	A0430	12,500.00	12,500.00	0.00	0.00	12,500.00
10/16-10/16/14	05	NOP	A0435	25,670.00	25,670.00	0.00	0.00	25,670.00
				38,170.00	38,170.00	0.00	0.00	38,170.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $38,170.00

TOTAL SERVICES NOT COVERED: 0.00
PATIENT'S SHARE: $0.00

#4
14-01728

PATIENT: [redacted]
PERF PRV: [redacted]
CLAIM NO: [redacted] IDENTIFICATION NO: [redacted]
PATIENT NO: 1401728A

FROM / TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
09/21-09/21/14	05	NOP	A0431	15,500.00	15,500.00	0.00	0.00	15,500.00
09/21-09/21/14	05	NOP	A0436	20,910.00	20,910.00	0.00	0.00	20,910.00
				36,410.00	36,410.00	0.00	0.00	36,410.00

AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $36,410.00

TOTAL SERVICES NOT COVERED: 0.00
PATIENT'S SHARE: $0.00

Batch: 6940 Seq: 1 Remittance #: GROUP 2 Remittance Name: GROUP 2 Check#: 5184 Amount: $42,700.00 Image 1 of 3

[redacted]

5184
93-7686/2929

9/25 20 14

Pay to the Order of Summit Air Ambulance BR22 $ 150.00

One hundred fifty and no/100 Dollars

Security features are included. Details on back

VALLEY FEDERAL CREDIT UNION
OF MONTANA
BILLINGS, MT 59104

Acct 14-01394
claim # 02014230070194ZCC (BC/BS)
For [redacted]

MP

[redacted]

5184

SERENE

Batch: 6940 Seq: 1 Remittance #: GROUP 2 Remittance Name: GROUP 2 Check#: 5184 Amount: $42,700.00 Image 2 of 3

DB365 Rev. 9/03

BlueCross BlueShield of Montana
An Independent Licensee of the Blue Cross Blue Shield Association
P.O. Box 7982
Helena, Montana 59604

192381673

0037996

FEDERAL EMPLOYEES PROGRAM

The Northern Trust Company
Chicago, IL
Payable Through
Oakbrook Terrace, IL

70-2382
719

I.D. NUMBER: R58456542
CLAIM NUMBER: 751-1423007019420C
BATCH NUMBER: 26146

MO.	DAY	YR.
09	16	14

AMOUNT

EXACTLY ****42,550 DOLLARS AND 00 CENTS

$****42,550 | 00

PAY TO THE ORDER OF

[redacted]

PLEASE NEGOTIATE PROMPTLY. THIS CHECK IS VOID 1 YEAR AFTER DATE OF ISSUE.

AUTHORIZED SIGNATURE

⑈0037996⑈ ⑆071923828⑆ 00325954000⑈

#1

14-01394

No EOB, paid to patient and they only sent the check.