

1 PGBA, LLC
TRICARE Claims Administrator For Your Region

TRICARE EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

2 **HUMANA MILITARY**
HEALTHCARE SERVICES
★ ★ ★ ★ ★

3 Date of Notice: August 02, 1999
4 Sponsor SSN: 000-00-0000
5 Sponsor Name: NAME OF SPONSOR
5 Beneficiary Name: NAME OF BENEFICIARY

6 PATIENT, PARENT/GUARDIAN
ADDRESS
CITY, STATE ZIP CODE

7 Benefits were payable to:
PROVIDER OF MEDICAL CARE
ADDRESS
CITY, STATE ZIP CODE

8 Claim Number: 919535695-00-00

Services Provided By/ Date of Services 9		Services Provided 10		Amount Billed 11	TRICARE Approved 12	See Remarks 13
PROVIDER OF MEDICAL CARE						
07/08/1999	1	Office/outpatient visit, est (99213)		\$45.00	\$38.92	1
07/08/1999	1	Comprehen metabolic panel (88054)		\$20.00	\$19.33	1
07/08/1999	1	Automated hemogram (85025)		\$12.00	\$12.00	1
Totals				\$77.00	\$70.25	

14 Claim
Summary

15 Beneficiary
Liability Summary


16 Benefit Period
Summary

Amount Billed:	77.00	Deductible:	0.00	Fiscal Year Beginning:	
TRICARE Approved:	70.25	Copayment:	0.00	October 1, 1998	
Non-Covered:	6.75	Cost Share:	17.56	Individual	Family
Paid by Beneficiary:	0.00			Deductible:	150.00 150.00
Other Insurance:	0.00			Catastrophic Cap:	856.32
Paid to Provider:	52.69			Enrollment Year Beginning:	
Paid to Beneficiary:	0.00			December 01, 1998	
Check Number:				Individual	Family
				POS Deductible:	300.00 600.00
				Prime Cap:	856.32

17 Remarks

1 – CHARGES ARE MORE THAN ALLOWABLE AMOUNT

18
1-800-XXX-XXXX
THIS IS NOT A BILL
If you have questions regarding this notice, please call or write us at the telephone number/address listed above.



Page 1 of 1