

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

7 **Benefits were payable to:**

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

PROVIDER OF MEDICAL CARE
ADDRESS
CITY, STATE ZIP CODE

8 **Claim Number: 919535695-00-00**


Services Provided By/ Date of Services		Services Provided	Amount Billed	TRICARE Approved	See Remarks
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	

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



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