** Professional Remittance Advice **

Zip 97000

③ **RA#** 986719557

Provider Name/Number: ① **Name, Provider, MD ######** Date: ② **4/27/05** ④ **Page 1**

⑤ Recipient Name	⑥ Recipient ID	⑦ ICN	⑧ Patient Account	⑨ Service Dates From	Thru	⑩ TOS/Proc Code	⑪ Qty	⑫ Billed Amount	⑬ TPL Cred Applied	⑭ Payment Amount	⑮ **Messages**
Doe, John	XX#####X	###########	#######	04-02-05	04-02-05	1-99212	1	35.00	00	26.21	093
Doe, Jane	XX#####X	###########	#######	04-04-05	04-04-05	1-98213	1	40.00	00	36.59	093
				⑯		Provider Totals		75.00	00	62.80	

⑰

******* Provider Earnings Information *******

	- Current-	-Year to Date-
Total Claims	2	10
Total Amount Billed	75.00	
Gross Reimbursement Authorized	62.80	350.00
+ Additional Payment Included	.00	.00
- Recoupment Amount Withheld	.00	.00
Payment Amount	62.80	350.00
Refunds Credited to Earnings	.00	.00

⑱

******* Claims Message Codes *******

093 Payment at maximum allowable rate.