

Sample Provider Explanation of Payment (EPP)

AmeriHealth Inc
 1901 Market Street
 Philadelphia, PA 19103-1480



PROVIDER NAME
 1234 12 STREET
 PHILADELPHIA PA 19050

Your name, **PROVIDER NAME**, and Tax ID have been verified by the IRS.

Visit us at our website: www.amerihealth.com

Tax ID: 555555555 EPC Draft #: **1** 5555555555 Payment Week: **2** 5 Payment Date: **3** 01/01/2024 Page 1 of 34

| Service Date | Proc/Rev Code (Modifiers) | Units | Explanation Code(s) | Total Charge | Allowed Amount | Contractual Adjustment | Other Coverage | Other Adjustment | Patient Obligation | | | | Net Payment Amount |
|--------------------------------|---------------------------|-------|---------------------|--------------|----------------------------------|------------------------|----------------|------------------|--------------------|---------------------------------|------------|---------|--------------------|
| | | | | | | | | | Co-Ins | Co-Pay | Deductible | Non-Cov | |
| Claim Number: 5555555555555555 | | | | | Patient Name: JANE DOE | | | | | Payment Reference Number: 55555 | | | |
| NPI: 5555555555 | | | | | Patient Acct #: 5555555555555555 | | | | | Subscriber Name: Jane Doe | | | |
| Provider: Provider Name | | | | | | | | | | Member ID: 55555555555555 | | | |

| Statement Summary | | Total Charge | Allowed Amount | Contractual Adjustment | Other Coverage | Other Adjustment | Patient Obligation | | | | Net Payment Amount |
|-------------------|--|--------------|----------------|------------------------|----------------|------------------|--------------------|-------------|-------------|------------|--------------------|
| Administered By | | | | | | | Co-Ins | Co-Pay | Deductible | Non-Cov | |
| AmeriHealth Inc | | \$300,000.00 | \$100,000.00 | \$200,000.00 | \$0.00 | \$100,000.00 | \$100.00 | \$10,000.00 | \$20,000.00 | \$1,000.00 | \$100,100.00 |

| Payment Adjustments | | |
|---------------------|--------------------|-------------------|
| Reference ID | Adjustment Type | Adjustment Amount |
| | Forwarding Balance | \$100.00 |
| TOTAL: | | \$100.00 |

| Document Total | |
|----------------------|--------------|
| Total Amount Paid: | \$100,100.00 |
| Payment Adjustments: | \$100.00 |
| Total Payment: | \$100,000.00 |

- 1** A number represents a payment, 0 = no payment issued
- 2** Week of the year payment was processed
- 3** The date payment generated by ECHO Health
- 4** Shows applicable provider reimbursement
- 5** Shows a summary of member responsibility within each service date / date of service
- 6** Payor check number
- 7** The summary now appears at the end of the EPP instead of the cover page
- 8** Shows forwarding balance, interest owed, etc.