THE CENTER FOR
MINIMALLY INVASIVE
SURGERY

What is an Explanation of Benefits?

The EOB is the result of the claims process. Your provider submits their bills for services to your insurance company and your insurance reviews the claim to determine your benefits. If another insurance company is involved, the insurance companies coordinate benefits to determine which plan is responsible for the charges. Your health insurance administrator sends you and your provider an EOB, and, when appropriate, your provider also receives payment.

Your EOB may identify:

- The patient and the service provided.
- The amount charged by the provider.
- The amount of the charges that are covered and not covered under your plan.
- The amount paid to your provider.
- The amount you're responsible for.

Remember that the EOB is not a bill, but it explains what was covered by insurance. The provider may bill you separately for any charges you're still responsible for.

Sample Explanation of Benefits

Your Health Insurance
P.O. Box 1999
Anywhere, USA 12345
(20) Customer Service 800-555-1212

(1) Enrollee: John Doe
(2) Patient: Jane Doe
(3) Patient #: 123-45-6789

(4) Provider Name: Mark Smith, M.D.
(5) Claim #: 9999999999999
(6) Date Processed: 9/25/01

(7) Enrollee Address: 555 Main Street
Hometown, USA 54321

Dates Of Service (8)		Place of Service (9)	CPT Code (10)	Charge Amount (11)	Allowed Amount (12)	Not Covered (13)	Reason Code (14)	Deductible Amount (15)	Co-Pay (16)	Benefit Amount (17)	Due from Patient (18)	Payment Amount (19)
8/9/01	8/9/01	3	99201	80.00	80.00				15.00		15.00	
8/9/01	8/9/01	3	10121-22	150.00		150.00	55			0.00	0.00	0.00
8/9/01	8/9/01	3	36415	20.00	10.00	10.00	44			80%	2.00	8.00
8/9/01	8/9/01	3	80050	40.00	10.00	30.00	44			80%	2.00	8.00

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Legend

1. Enrollee Name: Identifies the policyholder. This is usually the name of the person who carries the insurance.
2. Patient: Identifies the patient.
3. Patient #: This serves as an identification number for the patient.
4. Provider Name: Identifies the name of the doctor or hospital that is billing for the services. Verify services were actually rendered by the provider listed.
5. Claim #: This is a number assigned to the claim by the insurance company to identify the claim in their computer system.
6. Date Processed: Indicates the date on which the claim is processed.
7. Enrollee Address: Indicates the address of the enrollee; this should be verified with each claim. Wrong addresses can cause problems in claims payment.
8. Dates of Service: Indicates the dates of service on which the service was rendered.
9. Place of Service: Indicates the location the service was rendered. This is important as some services are only covered in specific locations.
10. CPT Code: This identifies the service performed. This code is universal and dictates the payment allowances.
11. Charge Amount: Amount charged by provider of service.
12. Allowed Amount: Amount determined by a preset schedule of "usual and customary" (UCR) charges. Amount is usually determined by geographic location of provider.
13. Not Covered: Amount not included in the allowed amount; usually this is the amount deemed over the usual and customary allowance. In most incidences, the patient is responsible for the overage.
14. Reason Code: This is an explanation of why a service has been has denied, or why an amount is not covered.
15. Deductible: This reflects the amount the patient must pay prior to having benefits paid. Amounts that are not covered are not applied to the deductible. Generally, each patient will have his or her own deductible to meet. Deductibles may be required for both participating and not participating services; refer to the schedule of benefits.
16. Co-Pay: A minimal amount required from the patient when seeking services from a provider. Usually the patient is only responsible for copayments at a participating provider.
17. Benefit Amount: This is the percentage at which the amount covered will be paid. The percentage paid will be determined by the schedule of benefits. Generally, participating providers will be paid at a higher level; non-participating providers will be paid a lower level.
18. Due from Patient: This is the amount the patient is responsible for paying to the provider. This generally includes the co-insurance amount, deductible and may or may not include the amount over the UCR. If the amount over the UCR is not included, the patient needs to verify if the provider of service will write the amount off. If the provider of service will not write the amount off, the patient is responsible.
19. Payment Amount: The amount paid to the provider.
20. Customer Service: This is the number used to contact customer service.