

Descriptions

1. DATES OF SERVICE - The date the patient received services from the provider.
2. DESCRIPTION OF SERVICE - A brief description of the service provided.
3. BILLED AMOUNT - The amount the provider billed for the service.
4. PROVIDER DISCOUNT - The discount amount negotiated by the plan.
5. INELIGIBLE AMOUNT - Charges for which there are no insurance benefits.
6. MESSAGE CODE - This code will have the description or note listed in the message section.
7. COVERED BY PLAN - Charges that are covered under the plan.
- 8, 9 and 10. DEDUCTIBLE, COPAY AND COINSURANCE - These are the amounts for which the patient is responsible.
11. BALANCE AMOUNT - This is the amount remaining after any deductions. This amount is what is considered under the plan.
12. MESSAGE CODE/DESCRIPTION - These codes refer to the message code. The explanations are in the description listed by the code.
13. PLAN DETAILS - Total amount of deductible, out of pocket, etc. you have paid out for the year listed.
14. PAYMENT DETAILS - If a check has been issued on this Explanation of Benefits, this section will note who the check was made to and for what amount.