

# WHAT ENHANCEMENTS IS KAISER PERMANENTE MAKING TO THE EXPLANATION OF PAYMENT (EOP) FORM?



**Currently, Kaiser Permanente in California provides several types of remittance advices. These will be consolidated into one EOP type, used statewide.**

- The new EOP will contain a detailed explanation of payment, including:
  - Patient information – including benefit and member type information
  - Claim information – billed services
  - Basic payment information – pricing detail, member cost share, etc.
- When multiple claims are adjudicated for provider during a certain time frame, the EOP will consolidate all the claims payments onto one check.
- Based on the current process design, paper checks and EOPs will be included in the same mailing.

Please see the following pages  
which contain a sample EOP form based on a northern California claim.

Number refers to  
 "Understanding  
 Your EOP  
 Statement" page  
 containing  
 definitions of fields  
 used on your  
 statement.

Questions? Call Customer Service at (800) 390-3510  
 Weekdays Mon - Fri 9:00AM - 4:00PM PST  
 Weekends Sat - Sun 8:00AM - 6:00PM PST

- 1 Check / EFT #: 2000002368
- 2 Remittance Number: EOPVEN12518
- 3 Payment Date: 04/01/2016
- 4 Total Payment Amt: 70.85
- 5 Vendor Tax ID No: 94XXXXXXXX
- 6 Vendor ID No: 16XXXXXXXX
- 7 Vendor NPI No: 1XXXXXXXXXX

MEMORIAL HOSPITAL  
 1234 MAIN ST  
 SAN FRANCISCO, CA 94199

This Account Summary shows the current Provider account status with the KP region shown above, in this case Northern California

*** ACCOUNT SUMMARY ***								
	9 # of Claims	10 Billed Amount 11 Allowed Amount	12 Disallowed Amount/Discount	13 Not Cov'd Amount	14 Applied to Deductible	15 CoPay 16 Coins	17 Other Ins	18 Plan Pays
Claims Payment Total 8	1	72.12	1.45	0.00	0.00	0.00		70.67
		72.12				0.00		
Interest Amount 19								0.18
<b>Total Payment Amount 20</b>								<b>70.85</b>
Method of Payment: 21								
Check/EFT Amount 22								70.85
<b>Total Payment Amount 23</b>								<b>70.85</b>
Other / Claims Related Transactions 24								
								0.00

SECURITY NOTE: The face of this check is printed on a blue background. See reverse for additional security features.



California Claims Administration  
 NORTHERN CALIFORNIA  
 KAISER FOUNDATION HEALTHPLAN, INC  
 P.O. Box 12923  
 Oakland, CA 94604-2923

62-20 / 311  
 Citibank, N.A.  
 One Penn's Way  
 New Castle, DE 19720

Check No: 2000002368  
 Date: 04/01/2016



Non-Negotiable

Pay \* Seventy and 85/100 Dollars \*

\$ \*\*\*\*70.85\*\*\*\*

To the order of  
 MEMORIAL HOSPITAL  
 1234 MAIN ST  
 SAN FRANCISCO, CA 94199

VOID

Authorized Signature


MP

Endorse Here:

X

DO NOT WRITE, STAMP OR SIGN BELOW THIS LINE  
Reserved for financial institution use

*Original Document*

 The following security features (and others not listed) exceed industry standards:	
<u>Security Features</u>	<u>Document appearance if altered:</u>
Security Screen	• Absence or modification of "Original Document" screen on back of check
Microprint Signature Line	• Absence of tiny words or dotted line appear in signature line
Padlock Icon	• Absence of padlock icon
<small>© Padlock design is a certification mark of Check Payment Systems Association</small>	

FOR TEST PURPOSES



### Explanation of Payment

#	Service Dates	Service Code	Service Mod	Billed Amount	Disallowed Amount/Discount	Not Cov'd Amount	Applied to Deductible	CoPay	Other Ins	Plan Pays	Remark Code(s)
25	26	27	28	29	31	32	33	34	36	37	38
				30 Allowed Amount				35			
39	Patient Name: JADHA GIBENS			41 Provider: MEMORIAL HOSPITAL		43 POS:	45 TOB: 131	46 Patient Acct No (Provider):4001437040001B		48 Claim #: 54699	
40	Patient ID / MRN: 110003050958			42 Provider NPI: 1XXXXXXXXXX		44 LOB: SRA - SENIOR ADVANTAGE		47 Vendor TIN: 94XXXXXXX		49 Claim Remark Codes	
1	01/25/2016 01/25/2016	0250		0.72 0.72	0.01			0.00		0.71	45
2	01/25/2016 01/25/2016	0250		1.63 1.63	0.03			0.00		1.60	45
3	01/26/2016 01/26/2016	0250		3.26 3.26	0.07			0.00		3.19	45
4	01/26/2016 01/26/2016	0250		1.88 1.88	0.04			0.00		1.84	45
5	01/26/2016 01/26/2016	0270		12.42 12.42	0.25			0.00		12.17	45
6	01/25/2016 01/25/2016	0300		2.01 2.01	0.04			0.00		1.97	45
7	01/26/2016 01/26/2016	36415		0.46 0.46	0.01			0.00		0.45	45
8	01/25/2016 01/25/2016	71010		1.75 1.75	0.04			0.00		1.71	45
9	01/25/2016 01/25/2016	93041		1.58 1.58	0.03			0.00		1.55	45
10	01/25/2016 01/25/2016	93306		21.62 21.62	0.43			0.00		21.19	45
11	01/26/2016 01/26/2016	93308		8.93 8.93	0.18			0.00		8.75	45



### Explanation of Payment

#	Service Dates	Service Code	Service Mod	Billed Amount	Disallowed Amount/Discount	Not Cov'd Amount	Applied to Deductible	CoPay	Other Ins	Plan Pays	Remark Code(s)
				Allowed Amount				Coins			
<b>Patient Name:</b> JADHA GIBENS				<b>Provider:</b> MEMORIAL HOSPITAL		<b>POS:</b>	<b>TOB:</b> 131	<b>Patient Acct No (Provider):</b> 4001437040001B			<b>Claim #:</b> 54699
<b>Patient ID / MRN:</b> 110003050958				<b>Provider NPI:</b> 1XXXXXXXXXX		<b>LOB:</b> SRA - SENIOR ADVANTAGE		<b>Vendor TIN:</b> 9XXXXXXXXXX			<b>Auth #:</b> 50
12	01/25/2016	99285		15.86		0.32		0.00		15.54	45
	01/25/2016			15.86							
<b>Total 51</b>				<b>72.12</b>	<b>1.45</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>70.67</b>	
				<b>72.12</b>				<b>0.00</b>			
<b>Interest Amount 52</b>										<b>0.18</b>	
<b>Claim Payment Total 53</b>										<b>70.85</b>	
<b>Method of Payment: 54</b>											
<b>Check / EFT Amount 55</b>										<b>70.85</b>	
<b>Total Payment Amount 56</b>										<b>70.85</b>	

Claim Remark Codes and Descriptions

Remark Codes 57

45 Chg exceeds fee sched/max allowbl or contractd/legislted fee,use only with Group Codes PR/CO

## UNDERSTANDING YOUR EXPLANATION OF PAYMENT (EOP) STATEMENT

\*\*\* Please retain for your records \*\*\*

- 25 **# [Line Number]** - The line number that coincides with the line number on the submitted claim.
- 9 **# of claims [Number of Claims]** - The total number of claims covered by this Explanation of Payment (EOP).
- 11 **Allowed Amount** - The total allowable amount as determined by contract, other provider agreement, or reasonable and customary payment guidelines.
- 30
- 14 **Applied to Deductible** - The amount of member's deductible applied to the claim.
- 33
- 50 **Auth # [Authorization Number]** - An assigned number that identifies the authorization for approved services identified on the claim.
- 10 **Billed Amount** - The amount billed by the provider for a specific service or set of services.
- 29
- 22 **Check/EFT Amount [Check/Electronic Funds Transfer Amount]** - The net amount of the check/EFT payment.
- 55
- 1 **Check/EFT No [Check/Electronic Funds Transfer Number]** - The payment instrument number issued on a check/EFT paid to the vendor or member/subscriber.
- 48 **Claim # [Claim Number]** - A number assigned by Kaiser Permanente to an individual claim.
- 51 **Claim Payment Amount** - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP).
- 8 **Claim Payment Total** - The total amount of the claim, interest, and penalty paid by the Health Plan.
- 53
- 16 **Colns [Coinsurance]** - A percentage of the payment amount the insured pays against a claim.
- 35
- 15 **CoPay** - A fixed amount the insured pays against a claim.
- 34
- 12 **Disallowed Amount/ Discount** - Reflects contractual allowances, usual and customary (U&C) charges, provider responsibility/not covered, and discounts.
- 31
- 19 **Interest Amount** - The interest penalty amount required under governing rules for the specific Line of Business.
- 52
- 44 **LOB [Line of Business]** - The relevant rules under which the patient is enrolled as Kaiser Foundation Health Plan member.
- 21 **Method of Payment** - Describes the method of payment for the Claim Payment Total or Total Payment Amount (e.g. check/EFT, recoupment, prepayment, etc., as applicable).
- 54
- 13 **Not Cov'd Amount [Not Covered Amount]** - Services not included under the terms of the insured's health care coverage.
- 32
- 24 **Other Claim Related Transactions** - Includes reversal claims, refunds received, recoupments applied, prepayments, write-ons and write-offs.
- 17 **Other Ins [Other Insurance]** - The amount paid by another financially responsible insurance carrier as primary on the claim, under Coordination of Benefits, Third Party Liability or Workers' Compensation.
- 36
- 46 **Patient Acct No (Provider) [Patient Account Number (Provider)]** - Your account number for the patient.
- 40 **Patient ID/MRN [Patient Identification Number/Medical Record Number]** - The Kaiser Permanente identification number or medical record number for the patient.
- 39 **Patient Name** - The name of the patient to whom the services were provided on this claim.
- Patient Out of Pocket** - Remaining cost share from the amount determined by primary coverage that the patient owes after additional payment by Kaiser Permanente on non-primary claims
- 3 **Payment Date** - The date that the claims represented on this Explanation of Payment (EOP) were paid.
- Penalty Amount** - A payment amount other than interest that may be required to pay the provider under governing rules for the specific Line of Business.
- 18 **Plan Pays** - The total amount paid by Kaiser Permanente for all payable services on the individual claim or total of all claims.
- 37
- 43 **POS [Place of Service]** - The location where the service was provided.
- Prepayments** - Funds paid to provider in advance of services used to satisfy liability of submitted claims consistent with the terms of the provider's contractual agreement.
- 41 **Provider** - The provider of services associated with the claim.
- 42 **Provider NPI [Provider National Provider Identification Number]** - A CMS number assigned to the vendor for billing and identification purposes.
- Recoupments** - Funds resulting from overpayments used to offset payment of claims.
- Refunds Received** - Funds received from the vendor for identified overpaid claims.
- 38 **Remark Code** - Codes describing how the claim was processed.
- 49
- 57
- 2 **Remittance Number** - A unique number identifying this Explanation of Payment (EOP).
- Reversal Claims** - Used to account for adjusted claims.
- 27 **Service Code** - A code used to describe the medical services and procedures provided.
- 26 **Service Dates** - The dates on which the services were provided.
- 28 **Service Mod [Service Modifier]** - An alpha and/or numeric code appended to a CPT/HCPCS procedure code to clarify the services or procedures being billed.
- 4 **Total Payment Amount** - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP). Total Payment Amount = Claims Payment Amount + Interest Amount + Penalty Amount.
- 20
- 23
- 56
- 45 **TOB [Type of Bill]** - A three digit code located on a claim form that describes the type of bill a provider is submitting.
- 6 **Vendor ID No [The Vendor Identification Number]** - The internal account number that Kaiser Permanente assigns each vendor.
- 7 **Vendor NPI No [Vendor National Provider Identification Number]** - A CMS number assigned to the vendor for billing and identification purposes.
- 5 **Vendor Tax ID No [Vendor Tax Identification Number/Vendor TIN]** - Federally issued tax identification number.
- 47
- Withheld Amount** - Payments made to 3rd parties/ lien holders on behalf of the vendor.
- Write Offs** - Vendor balance forgiven by Kaiser Permanente
- Write Ons** - Used to account for existing overpayment balances.

**This page is intentionally left blank.**

**This page of an actual EOP contains information related to provider dispute rights and mailing addresses for the Kaiser Permanente region issuing the EOP.**

# WHAT ENHANCEMENTS IS KAISER PERMANENTE MAKING TO THE EXPLANATION OF PAYMENT (EOP) FORM?



**Currently, Kaiser Permanente in California provides several types of remittance advices. These will be consolidated into one EOP type, used statewide.**

- The new EOP will contain a detailed explanation of payment, including:
  - Patient information – including benefit and member type information
  - Claim information – billed services
  - Basic payment information – pricing detail, member cost share, etc.
- When multiple claims are adjudicated for provider during a certain time frame, the EOP will consolidate all the claims payments onto one check.
- Based on the current process design, paper checks and EOPs will be included in the same mailing.

Please see the following pages  
which contain a sample EOP form based on a Southern California claim.





California Claims Administration  
SOUTHERN CALIFORNIA  
KAISER FOUNDATION HEALTHPLAN, INC  
P.O. Box 7004  
Downey, CA 90242-7004

Questions? Call Customer Service at (800) 390-3510  
Weekdays Mon - Fri 8:00AM - 5:00PM PST  
Weekends Sat - Sun 8:00AM - 6:00PM PST

Check / EFT #: 800000XXXX  
Remittance Number: EOPVENXXX  
Payment Date: 06/23/2016  
Total Payment Amt: 110.00  
Vendor Tax ID No: 13XXXXXXXX  
Vendor ID No: 1XXXXXXXXXX  
Vendor NPI No: 1XXXXXXXXXX

SAMPLE PROVIDER  
1234 MAIN STREET  
LOS ANGELES, CA 99999-9999

*** ACCOUNT SUMMARY ***								
	# of Claims	Billed Amount Allowed Amount	Disallowed Amount/Discount	Not Cov'd Amount	Applied to Deductible	CoPay Colns	Other Ins	Plan Pays
Claims Payment Total	2	180.00 180.00	0.00	0.00	0.00	70.00 0.00		110.00
<b>Total Payment Amount</b>								<b>110.00</b>
<b>Method of Payment:</b>								
Check/EFT Amount								110.00
<b>Total Payment Amount</b>								<b>110.00</b>
<b>Other / Claims Related Transactions</b>								0.00

SECURITY NOTE: The face of this check is printed on a blue background. See reverse for additional security features.



California Claims Administration  
SOUTHERN CALIFORNIA  
KAISER FOUNDATION HEALTHPLAN, INC  
P.O. Box 7004  
Downey, CA 90242-7004

62-XX / XXX  
Citibank, N.A.  
One Penn's Way  
New Castle, DE 19720

Check No: 800000XXXX  
Date: 06/23/2016



Non-Negotiable

\$ \*\*\*\* 110.00 \*\*\*\*

Pay \* One Hundred Ten Dollars \*

To the order of  
SAMPLE PROVIDER  
1234 MAIN STREET  
LOS ANGELES, CA 99999-9999

VOID

Authorized Signature

MP

Endorse Here

X

DO NOT WRITE, STAMP OR SIGN BELOW THIS LINE  
Reserved for financial institution use

*Original Document*

 The following security features (and others not listed) exceed industry standards:

- Security Features**
- Document appearance if altered:
  - Absence or modification of "Original Document" screen on back of check
  - Absence of tiny words or dotted line appear in signature line
  - Absence of padlock icon
- Microprint Signature Line**
- Padlock Icon**
- © Padlock design is a certification mark of Check Payment Systems Association

FOR TEST

## Explanation of Payment

#	Service Dates	Service Code	Service Mod	Billed Amount	Disallowed Amount/Discount	Not Cov'd Amount	Applied to Deductible	CoPay	Other Ins	Plan Pays	Remark Code(s)
				Allowed Amount				Colns			
<b>Patient Name: TEST PATIENT 1</b>				<b>Provider: SAMPLE PROVIDER</b>		<b>POS: 11</b>	<b>TOB:</b>	<b>Patient Acct No (Provider):0000XXXXXXXX</b>			<b>Claim #: 8XX</b>
<b>Patient ID / MRN: 00000XXXXXXXX</b>				<b>Provider NPI: 1XXXXXXXXXX</b>		<b>LOB: HMO - HMO COMMERCIAL</b>		<b>Vendor TIN: 1XXXXXXXXXX</b>			<b>Auth #: 22XXXXXXXXXX</b>
1	06/13/2016	90837		90.00	0.00		0.00	20.00		70.00	3
	06/13/2016			90.00				0.00			
<b>Total</b>				<b>90.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>20.00</b>	<b>0.00</b>	<b>70.00</b>	
				<b>90.00</b>				<b>0.00</b>			
<b>Claim Payment Total</b>										<b>70.00</b>	
<b>Method of Payment:</b>											
<b>Check / EFT Amount</b>										<b>70.00</b>	
<b>Total Payment Amount</b>										<b>70.00</b>	
<b>Patient Name: TEST PATIENT 2</b>				<b>Provider: SAMPLE PROVIDER</b>		<b>POS: 11</b>	<b>TOB:</b>	<b>Patient Acct No (Provider):0000XXXXXXXX</b>			<b>Claim #: 8XX</b>
<b>Patient ID / MRN: 0000XXXXXXXX</b>				<b>Provider NPI: 1XXXXXXXXXX</b>		<b>LOB: HMO - HMO COMMERCIAL</b>		<b>Vendor TIN: 1XXXXXXXXXX</b>			<b>Auth #: 22XXXXXXXXXX</b>
1	06/13/2016	90837		90.00	0.00		0.00	50.00		40.00	3
	06/13/2016			90.00				0.00			
<b>Total</b>				<b>90.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>50.00</b>	<b>0.00</b>	<b>40.00</b>	
				<b>90.00</b>				<b>0.00</b>			
<b>Claim Payment Total</b>										<b>40.00</b>	
<b>Method of Payment:</b>											
<b>Check / EFT Amount</b>										<b>40.00</b>	
<b>Total Payment Amount</b>										<b>40.00</b>	

**Remark Codes**

3      Co-payment Amount

## UNDERSTANDING YOUR EXPLANATION OF PAYMENT (EOP) STATEMENT

\*\*\* Please retain for your records \*\*\*

**# [Line Number]** - The line number that coincides with the line number on the submitted claim.

**# of claims [Number of Claims]** - The total number of claims covered by this Explanation of Payment (EOP).

**Allowed Amount** - The total allowable amount as determined by contract, other provider agreement, or reasonable and customary payment guidelines.

**Applied to Deductible** - The amount of member's deductible applied to the claim.

**Auth # [Authorization Number]** - An assigned number that identifies the authorization for approved services identified on the claim.

**Billed Amount** - The amount billed by the provider for a specific service or set of services.

**Check/EFT Amount [Check/Electronic Funds Transfer Amount]** - The net amount of the check/EFT payment.

**Check/EFT No [Check/Electronic Funds Transfer Number]** - The payment instrument number issued on a check/EFT paid to the vendor or member/subscriber.

**Claim # [Claim Number]** - A number assigned by Kaiser Permanente to an individual claim.

**Claim Payment Amount** - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP).

**Claim Payment Total** - The total amount of the claim, interest, and penalty paid by the Health Plan.

**Coins [Coinsurance]** - A percentage of the payment amount the insured pays against a claim.

**CoPay** - A fixed amount the insured pays against a claim.

**Disallowed Amount/ Discount** - Reflects contractual allowances, usual and customary (U&C) charges, provider responsibility/not covered, and discounts.

**Interest Amount** - The interest penalty amount required under governing rules for the specific Line of Business.

**LOB [Line of Business]** - The relevant rules under which the patient is enrolled as Kaiser Foundation Health Plan member.

**Method of Payment** - Describes the method of payment for the Claim Payment Total or Total Payment Amount (e.g. check/EFT, recoupment, prepayment, etc., as applicable) .

**Not Cov'd Amount [Not Covered Amount]** - Services not included under the terms of the insured's health care coverage.

**Other Claim Related Transactions** - Includes reversal claims, refunds received, recoupments applied, prepayments, write-ons and write-offs.

**Other Ins [Other Insurance]** - The amount paid by another financially responsible insurance carrier as primary on the claim, under Coordination of Benefits, Third Party Liability or Workers' Compensation.

**Patient Acct No (Provider) [Patient Account Number (Provider)]** - Your account number for the patient.

**Patient ID/MRN [Patient Identification Number/Medical Record Number]** - The Kaiser Permanente identification number or medical record number for the patient.

**Patient Name** - The name of the patient to whom the services were provided on this claim.

**Patient Out of Pocket** - Remaining cost share from the amount determined by primary coverage that the patient owes after additional payment by Kaiser Permanente on non-primary claims

**Payment Date** - The date that the claims represented on this Explanation of Payment (EOP) were paid.

**Penalty Amount** - A payment amount other than interest that may be required to pay the provider under governing rules for the specific Line of Business.

**Plan Pays** - The total amount paid by Kaiser Permanente for all payable services on the individual claim or total of all claims.

**POS [Place of Service]** - The location where the service was provided.

**Prepayments** - Funds paid to provider in advance of services used to satisfy liability of submitted claims consistent with the terms of the provider's contractual agreement.

**Provider** - The provider of services associated with the claim.

**Provider NPI [Provider National Provider Identification Number]** - A CMS number assigned to the vendor for billing and identification purposes.

**Recoupments** - Funds resulting from overpayments used to offset payment of claims.

**Refunds Received** - Funds received from the vendor for identified overpaid claims.

**Remark Code** - Codes describing how the claim was processed.

**Remittance Number** - A unique number identifying this Explanation of Payment (EOP).

**Reversal Claims** - Used to account for adjusted claims.

**Service Code** - A code used to describe the medical services and procedures provided.

**Service Dates** - The dates on which the services were provided.

**Service Mod [Service Modifier]** - An alpha and/or numeric code appended to a CPT/HCPCS procedure code to clarify the services or procedures being billed.

**Total Payment Amount** - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP). Total Payment Amount = Claims Payment Amount + Interest Amount + Penalty Amount.

**TOB [Type of Bill]** - A three digit code located on a claim form that describes the type of bill a provider is submitting.

**Vendor ID No [The Vendor Identification Number]** - The internal account number that Kaiser Permanente assigns each vendor.

**Vendor NPI No [Vendor National Provider Identification Number]** - A CMS number assigned to the vendor for billing and identification purposes.

**Vendor Tax ID No [Vendor Tax Identification Number/Vendor TIN]** - Federally issued tax identification number.

**Withheld Amount** - Payments made to 3rd parties/ lien holders on behalf of the vendor.

**Write Offs** - Vendor balance forgiven by Kaiser Permanente

**Write Ons** - Used to account for existing overpayment balances.

## **IMPORTANT INFORMATION ABOUT YOUR RIGHTS TO DISPUTE OUR DETERMINATION ON THIS CLAIM**

For information generally about a paid claim, please call: (800) 390-3910. If you wish to dispute our action or decision, you must submit your dispute in writing to one of the following addresses:

**Please make a note of this address to use for all future correspondence with us regarding our provider dispute resolution process.**

Kaiser Foundation Health Plan, Inc.  
California Claims Administration  
Post Office Box 7006  
Downey, CA 90242-7006

You must include the following minimum information with your written dispute or it will be returned to you:

- Provider tax identification number (TIN)
- Kaiser Permanente initial claim number
- Patient's Kaiser Permanente medical record number
- Date(s) of service
- A clear explanation of the basis for your belief that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action on the claim is incorrect.

### **Time Period for Submission of Provider Payment Disputes**

Subject to any other period specifically permitted under your agreement or required under applicable law, provider payment disputes must be received by KP within 365 days from our most recent action or inaction that led to the dispute.

**If you would like to receive a Kaiser Permanente Provider Payment Dispute Resolution Form, please contact our Call Center at 1-800-390-3510.**

If all necessary information has been included in your written dispute, your dispute will be acknowledged within 15 working days of our receiving it. We will promptly consider your issue(s) and inform you of our decision within 45 working days of the date we received your dispute. If we require more information which you have not previously provided, or which we have previously returned to you, we will notify you shortly after receiving your dispute of the specific information that we need. We must receive this information within 30 working days of our request, or our initial determination will be automatically upheld. Your dispute will be promptly considered once we receive the requested information. We will communicate our final decision, including the specific reason for any denial of your request, to you in writing. **If you choose to take advantage of our provider dispute resolution process, we strongly urge you not to bill the patient during the dispute resolution period.**

### **Regarding the Practice of Balance Billing**

Kaiser Permanente enrollees are financially responsible for their contractual cost share amounts, e.g., copayments, coinsurance, deductibles, etc. **California regulations prohibit balance billing of HMO members by contracted providers and providers of emergency services**

**(professional and institutional) for amounts in excess of these cost shares.** Please refer to the applicable state rules prior to billing Kaiser Permanente enrollees. Follow the included provider payment dispute guidelines to resolve non-cost share related payment issues.

Please remember, if you are a provider of services to a Medi-Cal No-Share-of-Cost patient, you are precluded by regulation from seeking reimbursement from our member for any item(s) or service(s) that have been denied unless he/she was previously informed that he/she may be financially responsible. **If that notification was not given, the member is not responsible for payment of this claim and you may not balance bill this member.**

Please also note, if you are a Medicare participating provider, you are precluded from balance billing beneficiaries enrolled in Medicare because you have agreed to accept the Medicare allowed amount as payment in full.

Sincerely,

Kaiser Foundation Health Plan, Inc.