XYZ Medical Clinic
999 Nowhere St.
Nowhere, CA 99999

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
REMITTANCE ADVICE - PAID/DENIED
PAYEE: 000B Run Date: 05/01/2009 - Medi-Cal

Patient: John Doe Control #: 091050390115 ID: 0000000000 Acct: 999999999 Drg:

Serv	Date	Diag#	Proc#	Days/Cnt	Auth#	Charged	Allowed	Adj Rsn/Rmrk Codes	Denied	Ded&Co	Discount	Risk	TPP	Late Fee	Med Allow	Med Paid	Payment
0100	040209	94524	Z7502	1		1,886.03	49.10	45 N14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	49.10
0200	040209	94524	Z7610	1		1,183.11	21.30	45 N14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	21.30
				Sub-total		3,069.14	70.40		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	70.40
				TOTAL		3,069.14	70.40		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	70.40

Beginning negative balance:	0.00
Begining prepayment balance:	0.00
Total begining balance:	0.00
Claims paid this run	70.40
Adjustments not applied	0.00
Check Amount	70.40

Adjustment Reason/ RA Remark Codes	Description
45	Charges exceed our fee schedule or maximum allowable amount
N14	Pmnt based on contractual amt, fee schedule, or max. allowable amt

1ST LEVEL CLAIMS APPEAL - CLAIMS INQUIRY FORMS (CIFS)
Providers whose claims have been denied may seek an adjustment by submitting a Claim Inquiry Form (CIF) to the PHC Claims Department. The CIF should contain all additional information/corrections necessary for reconsideration, including a corrected claim. Providers have six months to CIF a claim from the original date of the denial on the PHC Remittance Advice. CIFS received after six months are subject to automatic denial. Upon receipt of the outcome of the CIF, providers have a one time window of 90 days from the date of the CIF denial to re-CIF their claim with additional corrections.

2ND LEVEL CLAIMS APPEAL - CLAIMS APPEAL
If the CIF is not approved and the claim denial is maintained, the provider may submit a claim appeal to the PHC Claims Department. Appeals must be submitted, in writing, within 90 days of the CIF denial, using the Medi-Cal Appeal form. Failure to submit an appeal within the 90 day time period will result in the appeal being denied.

3RD LEVEL CLAIMS APPEAL - PROVIDER GRIEVANCE PROCESS
Providers who are still not satisfied with the outcome of a Claim Appeal may file a Grievance with the PHC Provider Relations Department. Provider Grievances must be submitted, in writing, within 30 days of receipt of the claims appeal denial letter.

Send Claim Inquiry Forms and Appeals to:
Partnership HealthPlan of California
Attn: Claims Department
P.O. Box 1368
Suisun City, CA 94585-1368

Send Provider Grievances to:
Partnership HealthPlan of California
Attn: Provider Relations Director
360 Campus Lane, Suite 100
Fairfield, CA 94534