NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT

PROVIDER, JOE
123 ANY STREET
ANY CITY, NC 12345

PROVIDER NUMBER 7700000 REPORT SEQ. NUMBER DATE 09/30/2004 PAGE

NAME RECIPIENT ID	SERVICE DATE FROM	SERVICE DATE TO	DAYS OR UNITS	PROCEDURE/ACCOMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES

Paid Claims

Mcare Primary

RECIPIENT *JOE A* **CO=92** **RCC=** **CLAIM NUMBER= 252002004250001NCXIX** **EST AMT DUE=**

900000000k **pat acct=123456789** **MED REC= 123456** **ATTN PROV= 7700000**

	09062004												
NCXIX	**09062004**	**1 B**	**E1390**	**OXYGEN CAPABL**	**CONCENTRATOR,**	**50000**	**00**	**50000**	**40000**	**7500**	**0**
			RR								

DEDUCTBLE= .00 PAT LIAB= .00 CO PAY= .00 TPL= 0 *50000 00 50000 40000 7500 0*

ORIGINAL BILLED AMOUNT= 100.00 ORIGINAL DETAIL COUNT = 1 TOTAL FINANCIAL PAYERS= 1