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**BAY MEDICAL GROUP**

BCBS  
PO Box 60007  
Los Angeles CA 90060-0007

Wednesday, August 09, 2006

**Patient:** LANG, MARY A      **Insured ID:** XDP318A51715  
**Account Number:** 26213914      **Provider Tax ID:** 680273974  
**Date(s) of Service:** 06/01/2006      **Claim Number:** 06158624649  
**Payment Date:** 06/10/2006      **Provider:** KAREN NISH, MD

According to the explanation of benefits, your company appears to have reduced payment as a result of downcoding, fee schedule application or other contractual adjustment. Please accept this letter as a formal appeal of this benefit reduction.

The California Health Disclosure Act of 1974 stipulates that any reductions or limitations to benefits must be clearly and unambiguously disclosed in the insurance benefit documents. Specifically, CA. Insurance. Code § 10604 states the following information, in concise and specific terms, is required in the following insurance policies:

(a) The applicable category or categories of coverage provided by the policy, from among the following: (1) Basic hospital expense coverage. (2) Basic medical-surgical expense coverage. (3) Hospital confinement coverage. (4) Major medical expense coverage. (5) Disability income protection coverage. (6) ... (8) Such other categories as the insurer of any right to change ...  
(h) A statement that the disclosure form is a summary only, and does not constitute a contract, and that the policy and contract determine governing contractual provisions.

It is our position that the above referenced claim was correctly coded and that additional benefits are due. If benefits remain denied, please provide a detailed explanation of how the reimbursement was determined and where in the contract such exceptions, reductions and limitations were explained. If additional information is required from this office, please submit a written request.

Place of Service	Procedure	Modifier	Units	Charge	Paid Amount	Allowed Amount	Contracted Amount	Balance Due
11	11101		1	\$88.00	\$0.00	\$0.00	\$75.99	\$75.99

Please remit a corrected payment of \$75.99 with appropriate interest.

If you have any questions regarding this request, please contact our office directly. Thank you for your prompt attention to this matter.

Sincerely,  
  
Rose Laur  
Reimbursement Analyst  
(916) 231-0400

**Remittance Address:**  
BAY MEDICAL GROUP  
123 J Street STE 200  
SACRAMENTO CA 95814

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