

How to Read Your Explanation of Benefits



Know Your Benefits

Anthem Blue Cross (Anthem) provides you with an *Explanation of Benefits (EOB)* after every medical visit, whether or not payment is due. All member claims, including those of your dependents, that are processed on the same day will appear on a single EOB.

Below is a replica of the EOB you would receive. We have placed numbers next to the key areas of the EOB, with corresponding explanations.

1. Issue Date:

This shows the date your EOB was processed by Anthem.

2. Provider of Services:

The name of the provider and place where you received medical services is listed here.

3. Paid Amount:

Anthem paid this amount to the provider where you received medical services.

4. It is not your responsibility to pay:

This is the total amount you saved by using a participating provider.

5. It is your responsibility to pay:

The EOB is designed to provide you with at medical costs you will be responsible for and what costs will be taken care of by Anthem. It's our way of continuing to provide you with the quality customer service you have come to expect from Anthem.

6. Patient Savings:

This is the amount you saved by using a participating provider.

7. Member's Medical Deductible Applied to Date:

This is how much of your deductible has been paid up to the date shown.

8. Customer Service Information:

If you still have questions concerning your benefits, please contact a Customer Service representative at the toll-free number on your member ID card.

Anthem P.O. BOX 70000 VAN NUYS, CA 91408-0001

EXPLANATION OF BENEFITS 000058

1. ISSUE DATE: [] PAGE: []

Name Last/Name: []
123 Main Street
City, State, Zip Code

Subscriber's Name: []
Identification Number: []
Group Number: []
Group Name: []
Product: []

3. Patient's Name: [] Sequence Number: []
4. Claim Number: [] Provider of Service: []
5. Claim Processed Date: [] Place of Service: []
Patient Acct. Number: []

6. Paid Amount: [] To: []
It is your responsibility to pay: [] It is not your responsibility to pay: []

SERVICE (BILL#)	TYPE OF SERVICE	TOTAL BILLED	AMOUNT NOT ALLOWED	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE/CO-PAYMENT AMOUNT	CLAIMS PAYMENT
TOTAL THIS CLAIM					6.		

7. Member's Medical Deductible Applied to Date: []

DETAIL MESSAGE:
01 - This is the amount in excess of the allowed expense for a non-participating provider and is the member's responsibility to pay. Refer to your plan of coverage booklet for details regarding the schedule of benefits.
02 - This balance is the member's coinsurance responsibility.

HAVE QUESTIONS??
Check out our Website at WWW.ANTHM.COM/CA
Order I.D. Cards / Check Claims status / Review benefits /
Verify family members covered on your policy / Find a participating provider
OR call our CUSTOMER SERVICE DEPARTMENT AT: 1-XXX-XXX-XXXX

MAIL ALL INQUIRIES : ANTHEM BLUE CROSS
OR CLAIMS TO : P.O. BOX 68007
LOS ANGELES, CA 90068-0007

8. WE SUGGEST THAT YOU RETAIN THIS COPY FOR YOUR INCOME TAX RECORDS.

THIS IS NOT A BILL
SEE LAST PAGE FOR IMPORTANT INFORMATION