

How to Read an Explanation of Benefits

Explanation of Benefits (EOB)

Customer Service: 1-800-XXX-XXXX

Statement Date: MM/DD/YYYY
Document Number: XXXXXXXXXXXX
THIS IS NOT A BILL

Name:
Address:
City, State, Zip:



1 Subscriber Number: XXXXXXXX ID: XXXXXXXX Group: ABCDE Group Number: XXXXXXXX

Patient: Member Name Date Received: MM/DD/YY	Provider: Healthcare Provider Name	Claim Number: XXXXXXXX Date Paid: MM/DD/YYYY
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Claim Detail				What Your Provider Can Charge You		Your Responsibility			Total Claim Cost	
2	3		4	5	6	7	8		9	10
Dates of Service	Service Description	Claim Status	Amount Charged	Allowed Charges	Deductible	Co-Pay	Co-Insurance	Paid by Insurer	What You Owe	Remark Code
MM/DD/YY	Medicare	Paid	\$50	\$20	\$0	\$0	\$0	\$20	\$0	PDC
MM/DD/YY	Medicare	Paid	\$100	\$50	\$0	\$30	\$0	\$50	\$30	PDC
		Total	\$150	\$70	\$0	\$30	\$0	\$70	\$30	

1 Plan Information

Includes your name and details about your plan

2 Dates of Services

Lists the dates when you accessed the service

3 Service Description

Describes the type of service you received

4 Amount Charged

Amount that your health care provider billed for services

5 Amount Allowed

Amount that is covered by your Medicare plan

6 Deductible

Amount you need to pay before your insurance plan starts to pay

7 Copayment

Amount you may need to pay for covered services after you've paid your deductibles, usually a set amount

8 Coinsurance

Amount you may need to pay after you've paid your deductibles, usually a percentage of the service costs

9 What You Owe*

Specifies the total cost that you're responsible for after your benefits have paid. You may have already paid a portion of the amount or will receive a bill for this amount. **May go by different names*

10 Remark Code

Note from your plan provider that explains the costs and charges for services in more detail