You are logged in as DAVID A DUVALL

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Claim Details

Learn More About Your Claim Details

Member: DAVID (You)
Date(s) of Service: 07/09/2013
Type: Medical
Status: Completed

Total Amount billed by Health Care Professional:	**$700.00**
Your plan pays:	**$291.23**
Amount you can expect to pay out of pocket:	**$72.80**

Claim Summary

Claim ID#: PSYZ6JMTQ **Payment:** Made on 07/30/2013 to Provider
Status: Completed **EFT Number:** 813205560001540

Health Care Professional: Van Wagner

	Amount	Your Plan Pays	You Pay
Bill received by Aetna on 07/24/2013	$700.00		
Your Aetna member rate	$364.03	$291.23	

SERVICES IN THIS CLAIM: Close All

OFFICE VISIT Hide Details

Service provided 07/09/2013

	Amount	Your Plan Pays	You Pay
Bill received by Aetna on 07/24/2013	$100.00		
Your Aetna Member Rate	$59.96	$47.97	
Not paid (excluded by plan)			$0.00
Amount paid toward meeting your deductible			$0.00
Amount paid toward your remaining coinsurance			$11.99
Your copay amount			$0.00

FLUOROSCOPIC GUIDANCE Hide Details

Service provided 07/09/2013

	Amount	Your Plan Pays	You Pay
Bill received by Aetna on 07/24/2013	$125.00		
Your Aetna Member Rate	$69.56	$55.65	
Not paid (excluded by plan)			$0.00
Amount paid toward meeting your deductible			$0.00
Amount paid toward your remaining coinsurance			$13.91
Your copay amount			$0.00

CONTRAST XRAY UPPER GI TRACT Hide Details

Service provided 07/09/2013

	Amount	Your Plan Pays	You Pay
Bill received by Aetna on 07/24/2013	$175.00		
Your Aetna Member Rate	$110.75	$88.60	
Not paid (excluded by plan)			$0.00
Amount paid toward meeting your deductible			$0.00
Amount paid toward your remaining coinsurance			$22.15
Your copay amount			$0.00

ADJUSTMENT GASTRIC BAND Hide Details

Service provided 07/09/2013

Take Action

- Print this claim
- Coordinate benefits
- Contact Member Services
- Ask a question

	Amount	Your Plan Pays	You Pay
Bill received by Aetna on 07/24/2013	$300.00		
Your Aetna Member Rate	$123.76	$99.01	
Not paid (excluded by plan)			$0.00
Amount paid toward meeting your deductible			$0.00
Amount paid toward your remaining coinsurance			$24.75
Your copay amount			$0.00

Not paid (excluded by plan)	$0.00
Amount paid toward meeting your deductible	$0.00
Amount paid toward your remaining coinsurance	$72.80
Your copay amount	$0.00
Your total responsibility:	$72.80
Total amount you can expect to pay out of pocket :	$72.80