Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the: Southern District of California (State)

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Blue Shield Promise Health Plan
   Name of the current creditor (the person or entity to be paid for this claim)
   Other names the creditor used with the debtor Care 1st Health Plan

2. **Has this claim been acquired from someone else?**
   ☑ No
   ☐ Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**
   Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

   Where should notices to the creditor be sent?
   Blue Shield Promise Health Plan
   601 Potreto Grande Drive
   Monterey Park, CA 91755

   Contact phone 916-350-6852
   Contact email amy.wylie@blueshieldca.com

   Where should payments to the creditor be sent? (if different)
   Blue Shield Promise Health Plan
   Attn: Cash Receiving
   P.O. Box 241012
   Lodi, CA 95241

   Contact phone 916-350-6852
   Contact email amy.wylie@blueshieldca.com

   (see summary page for notice party information)

   Uniform claim identifier for electronic payments in chapter 13 (if you use one):
   _____

4. **Does this claim amend one already filed?**
   ☑ No
   ☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**
   ☑ No
   ☐ Yes. Who made the earlier filing? _____

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Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**

☐ No

☑ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 0021

7. **How much is the claim?** $ 39179.06 . **Does this amount include interest or other charges?**

☑ No

☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**

Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.

Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

Limit disclosing information that is entitled to privacy, such as health care information.

Provider Recoupments / Medical Payment errors

9. **Is all or part of the claim secured?**

☑ No

☐ Yes. The claim is secured by a lien on property.

Nature or property:

☐ Real estate: If the claim is secured by the debtor's principle residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.

☐ Motor vehicle

☐ Other. Describe: _____

Basis for perfection: _____

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $_____

Amount of the claim that is secured: $_____

Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $_____

Annual Interest Rate (when case was filed)_____%

☐ Fixed

☐ Variable

10. **Is this claim based on a lease?**

☑ No

☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**

☑ No

☐ Yes. Identify the property: _____

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12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check all that apply:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐ Up to $3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐ Wages, salaries, or commissions (up to $15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☑ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.

☑ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 11/08/2022
MM / DD / YYYY

/s/Amy Wylie
Signature

Print the name of the person who is completing and signing this claim:

Name: Amy Wylie
First name Middle name Last name

Title: Custodian of Records/Paralegal

Company: Blue Shield Promise Health Plan
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address

Contact phone _____ Email _____

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KCC ePOC Electronic Claim Filing Summary

For phone assistance: Domestic (866) 967-0670 | International (310) 751-2670

Debtor:
22-02384 - Borrego Community Health Foundation
District:
Southern District of California, San Diego Division

Creditor:
Blue Shield Promise Health Plan
601 Potreto Grande Drive
Monterey Park, CA, 91755
Phone:
916-350-6852
Phone 2:
Fax:
Email:
amy.wylie@blueshieldca.com

Has Supporting Documentation:
Yes, supporting documentation successfully uploaded
Related Document Statement:

Has Related Claim:
No
Related Claim Filed By:

Filing Party:
Authorized agent

Disbursement/Notice Parties:

Blue Shield Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA, 95241
Phone:
916-350-6852
Phone 2:
Fax:
E-mail:
amy.wylie@blueshieldca.com
DISBURSEMENT ADDRESS

Snell and Wilmer
c/o Michael B. Reynolds and Andrew B. Still
Plaza Tower
600 Anton Boulevard - Suite 1400
Costa Mesa, CA, 92626-7689
Phone:
Phone 2:
Fax:
E-mail:
astill@swlaw.com

Other Names Used with Debtor:
Care 1st Health Plan

Amends Claim:
No
Acquired Claim:
No

Basis of Claim:
Provider Recoupments / Medical Payment errors

Last 4 Digits:
Yes - 0021

Uniform Claim Identifier:

Total Amount of Claim:
39179.06

Includes Interest or Charges:
No

Has Priority Claim:
No

Priority Under:

Has Secured Claim:
No
Amount of 503(b)(9):
No
Based on Lease:
No
Subject to Right of Setoff:
No

Nature of Secured Amount:
Value of Property:
Annual Interest Rate:
Arrearage Amount:
Basis for Perfection:
Amount Unsecured:

Submitted By:
Amy Wylie on 08-Nov-2022 12:55:38 p.m. Eastern Time
Title:
Custodian of Records/Paralegal
Company:
Blue Shield Promise Health Plan

VN: FBA18F4D7ED821B0950EF84B10C984E5

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2001151724222B	191513353300	PG0073150001	BORREGO MEDICAL CTR	105.65	0.00	105.65
AR20011609482985	190118251900	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	172.06	79.24	92.82
AR2008061312261B	190624171401	PG0073150001	BORREGO MEDICAL CLINIC	18.00	0.00	18.00
AR2008061327120B	200914324200	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061326448B	200831786700	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061326592B	200887491900	PG0010260010	CENTRO MEDICO EL CAJON	22.50	0.00	22.50
AR2008061327339B	200969385600	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061328023B	201060416100	PG0010260003	JULIAN MEDICAL CENTER	6.62	0.00	6.62
AR2008061330300B	201470377100	PG0010260003	JULIAN MEDICAL CENTER	9.88	0.00	9.88
AR2008061327119B	200914265100	PG0010260004	CENTRO MEDICO EL CAJON	177.60	0.00	177.60
AR2008061333363B	201877388900	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061333062B	201800226100	PG0010260003	JULIAN MEDICAL CENTER	36.60	0.00	36.60
AR2008061330252B	201459853900	PG0010260010	CENTRO MEDICO EL CAJON	14.55	0.00	14.55
AR2008061328301B	201154611100	PG0073150001	BORREGO MEDICAL CLINIC	6.62	0.00	6.62
AR2008061328162B	201113902200	PG0010260013	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061330306B	201470398700	PG0010260003	JULIAN MEDICAL CENTER	9.88	0.00	9.88
AR2008061328219B	201136246900	PG0010260008	BORREGO COMMUNITY HEALTH FOUNDATION	6.62	0.00	6.62
AR2008061330227B	201457065600	PG0010260003	JULIAN MEDICAL CENTER	9.88	0.00	9.88
AR2008061329243B	201340389800	PG0073150001	BORREGO MEDICAL CLINIC	6.62	0.00	6.62
AR2008061334293B	202020632400	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061329310B	201358039400	PG0010260008	BORREGO COMMUNITY HEALTH FOUNDATION	6.62	0.00	6.62
AR2008061329317B	201360514800	PG0073150001	BORREGO MEDICAL CLINIC	6.62	0.00	6.62
AR2008061331254B	201594220100	PG0010260011	CENTRO MEDICO EL CAJON	20.79	0.00	20.79
AR2008061331307B	201609854300	PG0010260011	CENTRO MEDICO EL CAJON	6.29	0.00	6.29
AR2008061330057B	201422994100	PG0073150001	BORREGO MEDICAL CLINIC	6.62	0.00	6.62
AR2008061330056B	201422602400	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061330058B	201423291900	PG0073150001	BORREGO MEDICAL CLINIC	6.62	0.00	6.62
AR2008061330166B	201443532300	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061331391B	201622677700	PG0010260011	CENTRO MEDICO EL CAJON	20.79	0.00	20.79
AR2008061330157B	201442821400	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061330164B	201443197000	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061330161B	201443005800	PG0043672004	CENTRO MEDICO CATHEDRAL CITY	6.62	0.00	6.62
AR2008061330470B	201493557500	PG0056208002	ANZA COMMUNITY HEALTH CENTER	6.62	0.00	6.62
AR2008061330413B	201476157800	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061330533B	201513592200	PG0083717003	CENTRO MEDICO ESCONDIDO	22.07	0.00	22.07
AR2008061330412B	201475531800	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061331049B	201548011600	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061331094B	201560999700	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061331087B	201560169200	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061331092B	201560499200	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061331532B	201648175100	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332082B	201703605800	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332149B	201715240500	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332151B	201715655200	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332462B	201765497900	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332463B	201765551900	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332461B	201765257100	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332542B	201776879200	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332543B	201776932100	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332597B	201790155000	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061332599B	201790723300	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2008061333076B	201801519800	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061333077B	201801646300	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061319159B	194840022400	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	6.60	0.00	6.60
AR2008061333243B	201851258000	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061333445B	201900904400	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061333438B	201899995100	PG0010260011	CENTRO MEDICO EL CAJON	18.00	0.00	18.00
AR2008061333439B	201900447400	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061333500B	201916754300	PG0010260011	CENTRO MEDICO EL CAJON	111.27	0.00	111.27
AR2008061333549B	201930071100	PG0010260011	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061334130B	201973957600	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061334133B	201974855500	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061334288B	202020240400	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061334503B	202073794300	PG0010260010	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061334430B	202057796100	PG0010260001	BORREGO MEDICAL CLINIC	6.62	0.00	6.62
AR2008061314062B	193615576800	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	6.60	0.00	6.60
AR2008061314582B	193807751600	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	6.60	0.00	6.60
AR2008061314253B	193693574800	PG0073150001	BORREGO MEDICAL CLINIC	6.62	0.00	6.62
AR2008061316242B	194074400000	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	6.60	0.00	6.60
AR2008061333296B	201866625200	PG0010260004	CENTRO MEDICO EL CAJON	10.91	0.00	10.91
AR2008061321505B	195533736000	PG0010260004	CENTRO MEDICO EL CAJON	6.62	0.00	6.62
AR2008061326199B	200757250000	PG0010260004	CENTRO MEDICO EL CAJON	9.88	0.00	9.88
AR2008061328460B	201206433000	PG0010260003	JULIAN MEDICAL CENTER	36.60	0.00	36.60
AR2008061328517B	201234282700	PG0010260010	CENTRO MEDICO EL CAJON	18.00	0.00	18.00
AR20081008493214	BULK RECOUP	PG0010260010	CENTRO MEDICO EL CAJON	72.82	0.00	72.82
AR2008131233296B	BULK RECOUP	PG0083717001	CENTRO MEDICO ESCONDIDO	640.69	0.00	640.69
AR20101608394320	201359002600	PG0083717003	CENTRO MEDICO ESCONDIDO	115.72	0.00	115.72
AR2010201309173B	201359028101	PG0010260001	BORREGO MEDICAL CLINIC	212.25	0.00	212.25
AR20102214594278	201359243900	PG0083717003	CENTRO MEDICO ESCONDIDO	24.08	0.00	24.08
AR2010281208375B	203531205000	PG0010260004	CENTRO MEDICO EL CAJON	40.50	0.00	40.50
AR2010281208391B	203315787900	PG0010260010	CENTRO MEDICO EL CAJON	29.71	0.00	29.71
AR2010301148589B	201359021700	PG0083717003	CENTRO MEDICO ESCONDIDO	171.59	0.00	171.59
AR2010301149247B	201340274300	PG0083717003	CENTRO MEDICO ESCONDIDO	21.17	0.00	21.17
AR2011021358369B	201182175100	PG0083717003	CENTRO MEDICO ESCONDIDO	24.08	0.00	24.08
AR2011031619392B	201340273600	PG0083717003	CENTRO MEDICO ESCONDIDO	24.08	0.00	24.08
AR2012191146093B	204181699900	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	538.84	0.00	538.84
AR2012191145583B	204165118800	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	539.27	0.00	539.27
AR2012191145587B	204182457400	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	539.27	0.00	539.27
AR2012191145586B	204164656500	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	538.84	0.00	538.84
AR2101201253493B	204494825800	PG0083717001	CENTRO MEDICO ESCONDIDO	9.62	0.00	9.62
AR21012208245411	204609164500	PG0083717001	CENTRO MEDICO ESCONDIDO	116.09	0.00	116.09
AR2102041308509B	201339747700	PG0083717001	CENTRO MEDICO ESCONDIDO	144.48	90.75	53.73
AR21061513524253	210666299600	PG0083717001	CENTRO MEDICO ESCONDIDO	61.82	0.00	61.82
AR21061512503887	210937723800	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR21061513201078	211919203300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR21061513283566	211919306700	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR21061512512970	211982667000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR21061512390458	203136467100	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR21061513090639	203616866200	PG0083717001	CENTRO MEDICO ESCONDIDO	61.82	0.00	61.82
AR21061513594576	204148342400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR21061513370057	204474834600	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR21061513140220	204886045900	PG0010260001	BORREGO MEDICAL CLINIC	23.88	0.00	23.88

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR21061513015550	205272996600	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR21061513005533	205502509900	PG0010260001	BORREGO MEDICAL CLINIC	19.55	0.00	19.55
AR21061513454513	205539672100	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR21061608511922	210156343300	PG0083717001	CENTRO MEDICO ESCONDIDO	559.39	465.42	93.97
AR2106241647298B	211852828000	PG0083717001	CENTRO MEDICO ESCONDIDO	471.70	0.00	471.70
AR21062808275333	202458093400	PG0083717001	CENTRO MEDICO ESCONDIDO	134.47	0.00	134.47
AR21070114403816	202753223200	PG0010260004	CENTRO MEDICO EL CAJON	23.76	0.00	23.76
AR21070113453917	211548604300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR21070113132355	203942624800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR21070211310916	210512394000	PG0010260001	BORREGO MEDICAL CLINIC	23.76	23.73	0.03
AR21070208482510	204419163900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107201608224B	210709891700	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2107201608236B	210881340000	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2107201608107B	201232400001	PG0010260013	CENTRO MEDICO EL CAJON	37.41	0.00	37.41
AR2107201608247B	211184893500	PG0010260010	CENTRO MEDICO EL CAJON	24.94	0.00	24.94
AR2107201608249B	211208566600	PG0010260010	CENTRO MEDICO EL CAJON	37.41	0.00	37.41
AR2107201608322B	212444218000	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2107201608334B	212503493000	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2107201608108B	202113694601	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2107201608350B	212704094600	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2107201608376B	212912942900	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2107201608109B	202358255801	PG0010260010	CENTRO MEDICO EL CAJON	24.94	0.00	24.94
AR2107201608358B	212769630900	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2107201608384B	213069203400	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2107201608131B	204101926200	PG0010260010	CENTRO MEDICO EL CAJON	8.92	0.00	8.92
AR2107201608136B	204210788600	PG0010260010	CENTRO MEDICO EL CAJON	24.94	0.00	24.94
AR2107201608208B	210244485900	PG0010260010	CENTRO MEDICO EL CAJON	24.94	0.00	24.94
AR2107201608137B	204299282800	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2107201608207B	210244459400	PG0010260010	CENTRO MEDICO EL CAJON	24.94	0.00	24.94
AR2107201608209B	210244643000	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2107201608180B	205316882600	PG0010260010	CENTRO MEDICO EL CAJON	37.41	0.00	37.41
AR2107201608201B	210109441100	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR21072311500064	205539505100	PG0010260003	JULIAN MEDICAL CENTER	37.13	0.00	37.13
AR2107271724039B	210539525500	PG0083717001	CENTRO MEDICO ESCONDIDO	93.10	0.00	93.10
AR2107271724306B	210559524300	PG0083717001	CENTRO MEDICO ESCONDIDO	58.27	0.00	58.27
AR2107271724247B	210727596600	PG0083717001	CENTRO MEDICO ESCONDIDO	37.94	0.00	37.94
AR2107271724365B	210776164200	PG0083717001	CENTRO MEDICO ESCONDIDO	99.04	0.00	99.04
AR2107271724257B	210938064100	PG0083717001	CENTRO MEDICO ESCONDIDO	61.51	0.00	61.51
AR2107271724041B	210959944300	PG0083717001	CENTRO MEDICO ESCONDIDO	99.04	0.00	99.04
AR2107271724424B	211325951200	PG0083717001	CENTRO MEDICO ESCONDIDO	61.51	0.00	61.51
AR2107271724210B	211326356200	PG0083717001	CENTRO MEDICO ESCONDIDO	99.04	0.00	99.04
AR2107271724364B	211672901100	PG0083717001	CENTRO MEDICO ESCONDIDO	37.94	0.00	37.94
AR2107271723550B	212029902800	PG0083717001	CENTRO MEDICO ESCONDIDO	99.04	0.00	99.04
AR2107271723545B	212134696100	PG0083717001	CENTRO MEDICO ESCONDIDO	99.04	0.00	99.04
AR2107271724042B	212134731200	PG0083717001	CENTRO MEDICO ESCONDIDO	99.04	0.00	99.04
AR2107271723549B	000390547400	PG0083717001	CENTRO MEDICO ESCONDIDO	93.71	0.00	93.71
AR2107271724259B	203190450500	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724367B	203616752000	PG0083717001	CENTRO MEDICO ESCONDIDO	54.19	0.00	54.19
AR2107271723552B	203616398300	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724545B	203696257900	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724258B	203768043000	PG0083717001	CENTRO MEDICO ESCONDIDO	84.11	0.00	84.11

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2107271724234B	203769027300	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724170B	204038882500	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271723546B	203957979100	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724427B	203994799700	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724321B	204022265500	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724574B	204053844600	PG0083717001	CENTRO MEDICO ESCONDIDO	76.50	0.00	76.50
AR2107271724248B	204402978200	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271723548B	204262501700	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271723495B	204358410900	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271723553B	204377561600	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724426B	204448476700	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724366B	204497625100	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724423B	204561439300	PG0083717001	CENTRO MEDICO ESCONDIDO	245.66	0.00	245.66
AR2107271724040B	204679681900	PG0083717001	CENTRO MEDICO ESCONDIDO	147.73	0.00	147.73
AR2107271724425B	204760301500	PG0083717001	CENTRO MEDICO ESCONDIDO	320.60	0.00	320.60
AR2107271723551B	204800043900	PG0083717001	CENTRO MEDICO ESCONDIDO	54.19	0.00	54.19
AR2107271723547B	204845599100	PG0083717001	CENTRO MEDICO ESCONDIDO	52.56	0.00	52.56
AR2107271724194B	204970381100	PG0083717001	CENTRO MEDICO ESCONDIDO	54.19	0.00	54.19
AR2107271724038B	205502217400	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2107271724249B	205519338200	PG0083717001	CENTRO MEDICO ESCONDIDO	49.56	0.00	49.56
AR2107271724256B	210156224000	PG0083717001	CENTRO MEDICO ESCONDIDO	49.56	0.00	49.56
AR2107271719148B	210266521100	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271722317B	210207375500	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723137B	210207376400	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723152B	210267569100	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271722486B	210193920500	PG0010260001	BORREGO MEDICAL CLINIC	744.98	0.00	744.98
AR2107271719420B	210335208100	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271719373B	210367015400	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271720289B	210244470700	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271721436B	210391724100	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271723166B	210426665800	PG0083717001	CENTRO MEDICO ESCONDIDO	25.31	0.00	25.31
AR2107271721433B	210512162900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719150B	210512809400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719133B	210538696700	PG0083717001	CENTRO MEDICO ESCONDIDO	33.96	0.00	33.96
AR2107271720277B	210315458100	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723465B	210560264300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723115B	210560896500	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723097B	210539493100	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271720133B	210666738800	PG0010260004	CENTRO MEDICO EL CAJON	40.50	0.00	40.50
AR2107271720094B	210444629300	PG0010260001	BORREGO MEDICAL CLINIC	68.21	0.00	68.21
AR2107271719124B	210539344900	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271719461B	210813166300	PG0010260004	CENTRO MEDICO EL CAJON	37.22	0.00	37.22
AR2107271723114B	210445003000	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723278B	210667540800	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR2107271721361B	210559610200	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271719421B	210560892200	PG0083717001	CENTRO MEDICO ESCONDIDO	134.47	0.00	134.47
AR2107271722552B	210512540200	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723135B	211139993500	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271719460B	210683950500	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR2107271721428B	210513296200	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723155B	210896046800	PG0010260004	CENTRO MEDICO EL CAJON	28.80	0.00	28.80

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2107271720158B	210667089000	PG0083717001	CENTRO MEDICO ESCONDIDO	59.88	0.00	59.88
AR2107271721222B	210920021200	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723207B	210644177900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719474B	210667390600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	19.55	4.21
AR2107271719137B	210727593300	PG0010260001	BORREGO MEDICAL CLINIC	109.20	0.00	109.20
AR2107271720120B	210710660800	PG0010260001	BORREGO MEDICAL CLINIC	33.96	0.00	33.96
AR2107271720087B	210727632500	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271721219B	210776095200	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR2107271721425B	210775750700	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271720145B	210710297300	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723142B	210776143800	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723131B	210872099900	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271722491B	210792474700	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271720291B	210793787800	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR2107271723130B	210896880700	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271723126B	210897110500	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271722488B	210960053500	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723143B	211074436600	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR2107271721449B	210959661100	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271722313B	210960000000	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723160B	210897072900	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271719131B	210897077100	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723161B	210991722300	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271723124B	203768450300	PG0010260004	CENTRO MEDICO EL CAJON	105.14	0.00	105.14
AR2107271720273B	210939473300	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR2107271721430B	211072811100	PG0083717001	CENTRO MEDICO ESCONDIDO	28.69	0.00	28.69
AR2107271721450B	211385309200	PG0083717001	CENTRO MEDICO ESCONDIDO	434.94	0.00	434.94
AR2107271722316B	211041792400	PG0083717001	CENTRO MEDICO ESCONDIDO	59.88	0.00	59.88
AR2107271723466B	211042063700	PG0083717001	CENTRO MEDICO ESCONDIDO	36.39	0.00	36.39
AR2107271719437B	211185585800	PG0083717001	CENTRO MEDICO ESCONDIDO	39.57	0.00	39.57
AR2107271719455B	211283297500	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271723162B	211185253800	PG0083717001	CENTRO MEDICO ESCONDIDO	39.07	0.00	39.07
AR2107271723144B	211140778800	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271722012B	211208512500	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271723136B	211283791400	PG0010260001	BORREGO MEDICAL CLINIC	45.82	0.00	45.82
AR2107271721441B	211283809500	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271720095B	211140321900	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271721227B	211306206100	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271722015B	211326414800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720294B	211326021200	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR2107271723129B	211326432700	PG0083717001	CENTRO MEDICO ESCONDIDO	37.13	0.00	37.13
AR2107271722170B	211326467900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721226B	211363130900	PG0010260001	BORREGO MEDICAL CLINIC	65.41	0.00	65.41
AR2107271723111B	211389439400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721455B	211385205700	PG0083717001	CENTRO MEDICO ESCONDIDO	57.27	0.00	57.27
AR2107271723467B	211429288100	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723167B	203768008600	PG0010260004	CENTRO MEDICO EL CAJON	96.62	0.00	96.62
AR2107271721394B	211453390800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719438B	211453675100	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271721220B	211507613500	PG0083717001	CENTRO MEDICO ESCONDIDO	264.15	0.00	264.15
AR2107271721456B	211507706500	PG0083717001	CENTRO MEDICO ESCONDIDO	665.05	0.00	665.05

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2107271722071B	211548082300	PG0083717001	CENTRO MEDICO ESCONDIDO	61.66	0.00	61.66
AR2107271723123B	211548533000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720278B	211547853500	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271722495B	211654153100	PG0010260001	BORREGO MEDICAL CLINIC	59.40	0.00	59.40
AR2107271720160B	211609482700	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR2107271723146B	211610165500	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271719453B	211629703200	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271723128B	211694342800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720117B	211694572900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721442B	211694399100	PG0010260001	BORREGO MEDICAL CLINIC	61.66	0.00	61.66
AR2107271719135B	211728072600	PG0010260001	BORREGO MEDICAL CLINIC	61.66	0.00	61.66
AR2107271720135B	211805490500	PG0010260001	BORREGO MEDICAL CLINIC	61.66	0.00	61.66
AR2107271719465B	211852865300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723210B	211793495400	PG0010260001	BORREGO MEDICAL CLINIC	56.63	0.00	56.63
AR2107271720265B	211897985300	PG0010260001	BORREGO MEDICAL CLINIC	130.42	0.00	130.42
AR2107271719125B	211919743900	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271723307B	211920410300	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723168B	211920250100	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271719134B	211919706400	PG0010260001	BORREGO MEDICAL CLINIC	61.66	0.00	61.66
AR2107271721424B	211982607900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719141B	211981176000	PG0083717001	CENTRO MEDICO ESCONDIDO	36.69	0.00	36.69
AR2107271722487B	212012196700	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723153B	212030458600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723138B	212078742200	PG0083717001	CENTRO MEDICO ESCONDIDO	261.91	0.00	261.91
AR2107271720096B	212134420400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723147B	212134517300	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723116B	212205327200	PG0010260001	BORREGO MEDICAL CLINIC	45.82	0.00	45.82
AR2107271720098B	212179196100	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720116B	212237837200	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723148B	212259162300	PG0083717001	CENTRO MEDICO ESCONDIDO	17.92	0.00	17.92
AR2107271723109B	212260208700	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271721362B	212289102300	PG0010260001	BORREGO MEDICAL CLINIC	59.88	0.00	59.88
AR2107271720113B	212260530700	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271720576B	213049151800	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2107271723165B	203100917700	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720155B	203797106400	PG0010260004	CENTRO MEDICO EL CAJON	23.76	0.00	23.76
AR2107271722558B	203046797000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271722490B	203237583600	PG0083717001	CENTRO MEDICO ESCONDIDO	8.33	0.00	8.33
AR2107271721426B	203067101700	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271721448B	203190515700	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719443B	203085432000	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271720100B	203172255200	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720089B	203189740800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721223B	203237920200	PG0083717001	CENTRO MEDICO ESCONDIDO	126.99	0.00	126.99
AR2107271720282B	203190298300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723169B	203138240300	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR2107271720157B	203209483700	PG0083717001	CENTRO MEDICO ESCONDIDO	8.33	0.00	8.33
AR2107271723122B	203209487000	PG0083717001	CENTRO MEDICO ESCONDIDO	523.02	0.00	523.02
AR2107271723104B	203209645900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719428B	203209546600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721454B	203086010900	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2107271720085B	203064729900	PG0010260001	BORREGO MEDICAL CLINIC	65.41	0.00	65.41
AR2107271721224B	203258861600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720295B	203101185500	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271722013B	203101799900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719457B	203133505300	PG0010260001	BORREGO MEDICAL CLINIC	65.41	0.00	65.41
AR2107271723145B	203135480400	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271718527B	203278067000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723154B	203156151400	PG0083717001	CENTRO MEDICO ESCONDIDO	76.04	0.00	76.04
AR2107271722492B	203237459600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720115B	203278061900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723117B	203316032700	PG0010260004	CENTRO MEDICO EL CAJON	224.14	0.00	224.14
AR2107271719130B	203259133300	PG0083717001	CENTRO MEDICO ESCONDIDO	16.65	0.00	16.65
AR2107271720162B	203672671900	PG0010260004	CENTRO MEDICO EL CAJON	23.76	0.00	23.76
AR2107271721421B	203673509900	PG0010260004	CENTRO MEDICO EL CAJON	23.76	0.00	23.76
AR2107271720136B	203398371300	PG0083717001	CENTRO MEDICO ESCONDIDO	8.33	0.00	8.33
AR2107271719458B	203696660700	PG0083717001	CENTRO MEDICO ESCONDIDO	61.82	0.00	61.82
AR2107271720281B	203398476600	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271719378B	203530850900	PG0083717001	CENTRO MEDICO ESCONDIDO	59.88	0.00	59.88
AR2107271723209B	203616938800	PG0083717001	CENTRO MEDICO ESCONDIDO	8.33	0.00	8.33
AR2107271723164B	203616936200	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719377B	210512575500	PG0010260004	CENTRO MEDICO EL CAJON	56.63	0.00	56.63
AR2107271719138B	203634364300	PG0083717001	CENTRO MEDICO ESCONDIDO	105.46	0.00	105.46
AR2107271723150B	203472200800	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271723149B	203697469900	PG0010260004	CENTRO MEDICO EL CAJON	82.80	0.00	82.80
AR2107271723119B	203697199800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720161B	203673028900	PG0083717001	CENTRO MEDICO ESCONDIDO	134.47	0.00	134.47
AR2107271722355B	203673066400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719372B	203673566300	PG0010260004	CENTRO MEDICO EL CAJON	17.92	0.00	17.92
AR2107271723105B	203727311200	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721422B	203797107200	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271720137B	203771087200	PG0083717001	CENTRO MEDICO ESCONDIDO	61.82	0.00	61.82
AR2107271719435B	203771553500	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271722315B	203831787700	PG0083717001	CENTRO MEDICO ESCONDIDO	8.33	0.00	8.33
AR2107271720280B	203831310400	PG0044871001	WOMENS HEALTH AND WELLNESS CENTER	126.99	0.00	126.99
AR2107271723311B	203887277200	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271721443B	203905567900	PG0010260004	CENTRO MEDICO EL CAJON	25.92	0.00	25.92
AR2107271719122B	203906202600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723170B	203906248700	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271723158B	203942365800	PG0010260004	CENTRO MEDICO EL CAJON	56.63	0.00	56.63
AR2107271719433B	204022085600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723106B	204022948300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723312B	203924486500	PG0083717001	CENTRO MEDICO ESCONDIDO	34.34	0.00	34.34
AR2107271720091B	203991534600	PG0083717001	CENTRO MEDICO ESCONDIDO	362.95	0.00	362.95
AR2107271722016B	203903260100	PG0044871001	WOMENS HEALTH AND WELLNESS CENTER	65.41	0.00	65.41
AR2107271719158B	203956059100	PG0083717001	CENTRO MEDICO ESCONDIDO	506.04	0.00	506.04
AR2107271722494B	203957517200	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271721434B	204053917500	PG0010260004	CENTRO MEDICO EL CAJON	25.92	0.00	25.92
AR2107271721429B	203994471900	PG0083717001	CENTRO MEDICO ESCONDIDO	61.82	0.00	61.82
AR2107271719140B	203996132300	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271720293B	204022502800	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271723163B	204102750000	PG0083717001	CENTRO MEDICO ESCONDIDO	61.82	0.00	61.82

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2107271723159B	210093917500	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR2107271719365B	204019286300	PG0010260001	BORREGO MEDICAL CLINIC	60.95	0.00	60.95
AR2107271722493B	203992720100	PG0044871001	WOMENS HEALTH AND WELLNESS CENTER	65.41	0.00	65.41
AR2107271723110B	204054616200	PG0083717001	CENTRO MEDICO ESCONDIDO	8.33	0.00	8.33
AR2107271719441B	203990870500	PG0044871001	WOMENS HEALTH AND WELLNESS CENTER	61.82	0.00	61.82
AR2107271723156B	204055699200	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271723309B	204148347600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271718533B	204144938100	PG0083717001	CENTRO MEDICO ESCONDIDO	411.14	0.00	411.14
AR2107271719145B	204148460500	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721427B	204148669900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720297B	204184078200	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271719380B	204182441900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719479B	204261596600	PG0044871001	WOMENS HEALTH AND WELLNESS CENTER	88.67	0.00	88.67
AR2107271719475B	204359578100	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271723141B	204226509600	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271723276B	204240257700	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723107B	204262735200	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723468B	204278922600	PG0044871001	WOMENS HEALTH AND WELLNESS CENTER	97.07	0.00	97.07
AR2107271721229B	204300866300	PG0083717001	CENTRO MEDICO ESCONDIDO	22.08	0.00	22.08
AR2107271719470B	204339810000	PG0010260001	BORREGO MEDICAL CLINIC	65.41	0.00	65.41
AR2107271720156B	204359857300	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR2107271721445B	204376293000	PG0083717001	CENTRO MEDICO ESCONDIDO	349.40	0.00	349.40
AR2107271719456B	204492904500	PG0010260004	CENTRO MEDICO EL CAJON	79.89	0.00	79.89
AR2107271719445B	204358834200	PG0010260001	BORREGO MEDICAL CLINIC	63.47	0.00	63.47
AR2107271723140B	204376076400	PG0083717001	CENTRO MEDICO ESCONDIDO	71.47	0.00	71.47
AR2107271723102B	204585649100	PG0010260004	CENTRO MEDICO EL CAJON	54.91	0.00	54.91
AR2107271721221B	204377685800	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271720130B	204515025900	PG0010260004	CENTRO MEDICO EL CAJON	40.50	0.00	40.50
AR2107271720097B	204534424100	PG0083717001	CENTRO MEDICO ESCONDIDO	23.26	0.00	23.26
AR2107271720153B	204534856700	PG0083717001	CENTRO MEDICO ESCONDIDO	23.26	0.00	23.26
AR2107271722489B	210512219500	PG0010260004	CENTRO MEDICO EL CAJON	23.76	0.00	23.76
AR2107271723127B	204448816500	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723139B	210266347400	PG0010260003	JULIAN MEDICAL CENTER	17.92	0.00	17.92
AR2107271722312B	204449169900	PG0010260001	BORREGO MEDICAL CLINIC	23.26	0.00	23.26
AR2107271720118B	204514637100	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721452B	204534999900	PG0010260004	CENTRO MEDICO EL CAJON	25.92	0.00	25.92
AR2107271723108B	204534398000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720269B	204534502400	PG0083717001	CENTRO MEDICO ESCONDIDO	59.88	0.00	59.88
AR2107271722458B	204533965100	PG0083717001	CENTRO MEDICO ESCONDIDO	207.06	0.00	207.06
AR2107271722014B	204643519300	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271723305B	204680731000	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271719121B	204644860200	PG0010260004	CENTRO MEDICO EL CAJON	25.92	0.00	25.92
AR2107271720296B	204718692700	PG0010260001	BORREGO MEDICAL CLINIC	56.63	0.00	56.63
AR2107271719375B	204844523700	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271719473B	204627067400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723277B	204847114000	PG0010260004	CENTRO MEDICO EL CAJON	17.92	0.00	17.92
AR2107271720125B	204680787200	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR2107271718540B	204681590500	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271720119B	204680774800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720093B	204699066600	PG0083717001	CENTRO MEDICO ESCONDIDO	16.55	0.00	16.55
AR2107271719425B	204718082600	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2107271720105B	204760169600	PG0083717001	CENTRO MEDICO ESCONDIDO	77.69	0.00	77.69
AR2107271723118B	210513209300	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271720142B	204821201700	PG0083717001	CENTRO MEDICO ESCONDIDO	25.31	0.00	25.31
AR2107271720101B	204825449100	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271722496B	204825860200	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723157B	205036628000	PG0010260004	CENTRO MEDICO EL CAJON	50.68	0.00	50.68
AR2107271720275B	205041919700	PG0010260004	CENTRO MEDICO EL CAJON	23.30	0.00	23.30
AR2107271721225B	205042771000	PG0010260004	CENTRO MEDICO EL CAJON	25.97	0.00	25.97
AR2107271720127B	210512560500	PG0010260004	CENTRO MEDICO EL CAJON	37.13	0.00	37.13
AR2107271722069B	204950015600	PG0083717001	CENTRO MEDICO ESCONDIDO	8.33	0.00	8.33
AR2107271723464B	204932442700	PG0010260001	BORREGO MEDICAL CLINIC	16.74	0.00	16.74
AR2107271721360B	204970054000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720102B	204970634600	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723121B	205059213900	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271721432B	204986273900	PG0010260001	BORREGO MEDICAL CLINIC	17.97	0.00	17.97
AR2107271719136B	205029171800	PG0010260001	BORREGO MEDICAL CLINIC	61.88	0.00	61.88
AR2107271719478B	205083544700	PG0010260004	CENTRO MEDICO EL CAJON	25.92	0.00	25.92
AR2107271723120B	204970533300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721437B	204970317800	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271719477B	205039062700	PG0010260001	BORREGO MEDICAL CLINIC	17.93	0.00	17.93
AR2107271720121B	205059277900	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271720258B	205082464100	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271723125B	205132141700	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271720122B	205059218500	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721423B	205130561300	PG0010260001	BORREGO MEDICAL CLINIC	61.78	0.00	61.78
AR2107271719376B	205302192100	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271719436B	210155996800	PG0083717001	CENTRO MEDICO ESCONDIDO	25.92	0.00	25.92
AR2107271719467B	210109649600	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271721419B	205237324900	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723310B	210156208200	PG0083717001	CENTRO MEDICO ESCONDIDO	39.07	0.00	39.07
AR2107271720285B	205237820900	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271721358B	205273514000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723112B	205273622400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720140B	210110447800	PG0010260004	CENTRO MEDICO EL CAJON	17.92	0.00	17.92
AR2107271721439B	205362860700	PG0083717001	CENTRO MEDICO ESCONDIDO	315.06	0.00	315.06
AR2107271723151B	205539344400	PG0010260003	JULIAN MEDICAL CENTER	17.92	0.00	17.92
AR2107271721359B	205502225300	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271723132B	205418636500	PG0010260001	BORREGO MEDICAL CLINIC	65.41	0.00	65.41
AR2107271723134B	210207703900	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271720132B	205502287500	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271723133B	210110491900	PG0010260004	CENTRO MEDICO EL CAJON	23.76	0.00	23.76
AR2107271721440B	205519420600	PG0083717001	CENTRO MEDICO ESCONDIDO	25.31	0.00	25.31
AR2107271719459B	210156116500	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271723103B	210207656200	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271720138B	210207680700	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271723275B	205461884300	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271720099B	205519532000	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271723113B	205502132900	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271718554B	205502162100	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271721446B	205502429400	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271720141B	205518693500	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2107271721228B	205519018800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271722314B	205519820200	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271721447B	205520061000	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719480B	205519641800	PG0083717001	CENTRO MEDICO ESCONDIDO	23.76	0.00	23.76
AR2107271719440B	205519532900	PG0083717001	CENTRO MEDICO ESCONDIDO	19.55	0.00	19.55
AR2107271721438B	205539447400	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2107271720131B	210295191800	PG0083717001	CENTRO MEDICO ESCONDIDO	56.63	0.00	56.63
AR2107271720271B	210076310100	PG0083717001	CENTRO MEDICO ESCONDIDO	23.26	0.00	23.26
AR2107271720150B	210075601500	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2107271721420B	210156449900	PG0083717001	CENTRO MEDICO ESCONDIDO	61.82	0.00	61.82
AR2107271721451B	210334722400	PG0010260004	CENTRO MEDICO EL CAJON	23.26	0.00	23.26
AR2107271722011B	210076011000	PG0010260001	BORREGO MEDICAL CLINIC	23.76	0.00	23.76
AR2107271721453B	210088485600	PG0010260001	BORREGO MEDICAL CLINIC	17.92	0.00	17.92
AR2107271721444B	210367533000	PG0010260004	CENTRO MEDICO EL CAJON	40.50	0.00	40.50
AR2108031145150 7	203448866400	PG0010260001	BORREGO MEDICAL CLINIC	61.82	0.00	61.82
AR2108171045325 3	203832186500	PG0083717001	CENTRO MEDICO ESCONDIDO	54.19	0.00	54.19
AR2110251608060B	204533424500	PG0010260003	JULIAN MEDICAL CENTER	289.78	0.00	289.78
AR2110251608063B	204842895900	PG0010260003	JULIAN MEDICAL CENTER	252.59	0.00	252.59
AR2110261628295B	204472223300	PG0010260010	CENTRO MEDICO EL CAJON	97.41	0.00	97.41
AR2110261628184B	211793665800	PG0010260010	CENTRO MEDICO EL CAJON	46.61	0.00	46.61
AR2110281139048B	204740914900	PG0010260006	CENTRO MEDICO CATHEDRAL CITY	23.76	0.00	23.76
AR2111020837176B	212112113900	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2111020837205B	211727333700	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2111041038268B	213068709300	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2111041038198B	205131324400	PG0010260003	JULIAN MEDICAL CENTER	23.76	0.00	23.76
AR2111080948334B	211898118400	PG0010260010	CENTRO MEDICO EL CAJON	50.96	0.00	50.96
AR2111080948130B	211794667700	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2112151139088B	212984735800	PG0010260001	BORREGO MEDICAL CLINIC	29.71	0.00	29.71
AR2112171101241B	204376259200	PG0083717001	CENTRO MEDICO ESCONDIDO	81.11	0.00	81.11
AR2112171100534B	204886068800	PG0010260010	CENTRO MEDICO EL CAJON	19.17	0.00	19.17
AR2112291247066B	211016508100	PG0043890001	EASTSIDE HEALTH CENTER	34.82	0.00	34.82
AR2112291246229B	210292548700	PG0010260010	CENTRO MEDICO EL CAJON	23.49	0.00	23.49
AR2112291249233B	210644268800	PG0010260004	CENTRO MEDICO EL CAJON	62.04	0.00	62.04
AR2112291247348B	210665378700	PG0010260004	CENTRO MEDICO EL CAJON	377.61	0.00	377.61
AR2112291249263B	210709872400	PG0010260004	CENTRO MEDICO EL CAJON	481.34	0.00	481.34
AR2112291246246B	210709933700	PG0010260004	CENTRO MEDICO EL CAJON	377.61	0.00	377.61
AR2112291246526B	211080904100	PG0010260004	CENTRO MEDICO EL CAJON	305.89	0.00	305.89
AR2112291249070B	211115703200	PG0010260004	CENTRO MEDICO EL CAJON	58.92	0.00	58.92
AR2112291250053B	211792861600	PG0010260010	CENTRO MEDICO EL CAJON	21.00	0.00	21.00
AR2112291247076B	210959784200	PG0083717001	CENTRO MEDICO ESCONDIDO	57.80	0.00	57.80
AR2112291248013B	211547960900	PG0010260010	CENTRO MEDICO EL CAJON	334.68	0.00	334.68
AR2112291247205B	211608670800	PG0010260010	CENTRO MEDICO EL CAJON	112.34	0.00	112.34
AR2112291246375B	211580742800	PG0010260010	CENTRO MEDICO EL CAJON	65.57	0.00	65.57
AR2112291248401B	211039595900	PG0083717001	CENTRO MEDICO ESCONDIDO	36.54	0.00	36.54
AR2112291247206B	211727539200	PG0010260010	CENTRO MEDICO EL CAJON	502.84	0.00	502.84
AR2112291246310B	211239432200	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	381.14	0.00	381.14
AR2112291247179B	211548422400	PG0010260010	CENTRO MEDICO EL CAJON	111.88	0.00	111.88
AR2112291247242B	212501853500	PG0083717001	CENTRO MEDICO ESCONDIDO	282.05	0.00	282.05
AR2112291246091B	212501855700	PG0083717001	CENTRO MEDICO ESCONDIDO	282.05	0.00	282.05
AR2112291249546B	212158817900	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2112291250223B	214781725600	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2112291247021B	204928628600	PG0010260004	CENTRO MEDICO EL CAJON	253.84	0.00	253.84
AR2112291247082B	204926025200	PG0010260004	CENTRO MEDICO EL CAJON	364.62	0.00	364.62
AR2112291249515B	210266260300	PG0010260010	CENTRO MEDICO EL CAJON	165.63	0.00	165.63
AR2112291249223B	205393184100	PG0010260004	CENTRO MEDICO EL CAJON	296.15	0.00	296.15
AR2112291249091B	204926002801	PG0010260004	CENTRO MEDICO EL CAJON	32.67	0.00	32.67
AR2112291247515B	204922475000	PG0010260004	CENTRO MEDICO EL CAJON	490.14	0.00	490.14
AR2112291247364B	204820481100	PG0010260001	BORREGO MEDICAL CLINIC	56.30	0.00	56.30
AR2112291246513B	205336855400	PG0010260004	CENTRO MEDICO EL CAJON	44.37	0.00	44.37
AR2112291246231B	205336174800	PG0010260004	CENTRO MEDICO EL CAJON	73.56	0.00	73.56
AR2112291247526B	205296107500	PG0010260004	CENTRO MEDICO EL CAJON	62.69	0.00	62.69
AR2112291246280B	205336290600	PG0010260004	CENTRO MEDICO EL CAJON	441.44	0.00	441.44
AR2112291249474B	205036687400	PG0010260004	CENTRO MEDICO EL CAJON	69.32	0.00	69.32
AR2112291246249B	205393121600	PG0010260004	CENTRO MEDICO EL CAJON	441.44	0.00	441.44
AR2112291248378B	205060964600	PG0010260004	CENTRO MEDICO EL CAJON	41.04	0.00	41.04
AR2112291249229B	205083794900	PG0010260004	CENTRO MEDICO EL CAJON	23.28	0.00	23.28
AR2112291248456B	210244549800	PG0083717001	CENTRO MEDICO ESCONDIDO	179.02	0.00	179.02
AR2112291247089B	210244612600	PG0083717001	CENTRO MEDICO ESCONDIDO	42.05	0.00	42.05
AR2112291247519B	205362465000	PG0083717001	CENTRO MEDICO ESCONDIDO	93.71	0.00	93.71
AR2112291249224B	205518137300	PG0010260004	CENTRO MEDICO EL CAJON	45.28	0.00	45.28
AR2112291249093B	210206469300	PG0010260004	CENTRO MEDICO EL CAJON	42.60	0.00	42.60
AR2112291247135B	205518882800	PG0083717001	CENTRO MEDICO ESCONDIDO	39.00	0.00	39.00
AR2112291247122B	210075697201	PG0083717001	CENTRO MEDICO ESCONDIDO	250.67	0.00	250.67
AR2112291249512B	210366292500	PG0010260004	CENTRO MEDICO EL CAJON	354.35	0.00	354.35
AR2112291248194B	210365947100	PG0010260004	CENTRO MEDICO EL CAJON	62.69	0.00	62.69
AR2201111148101B	211016147900	PG0043890001	EASTSIDE HEALTH CENTER	293.59	0.00	293.59
AR2201111148307B	205097046500	PG0043890002	ARLANZA FAMILY HEALTH CENTER	491.61	0.00	491.61
AR2201111148090B	205192255500	PG0043890002	ARLANZA FAMILY HEALTH CENTER	62.33	0.00	62.33
AR2201111148359B	210578954800	PG0010260004	CENTRO MEDICO EL CAJON	481.34	0.00	481.34
AR2201111150371B	211547958100	PG0010260010	CENTRO MEDICO EL CAJON	46.98	0.00	46.98
AR2201111150061B	211016562100	PG0010260007	BORREGO COMMUNITY HEALTH FOUNDATION	340.29	0.00	340.29
AR2201111148405B	211547980300	PG0083717001	CENTRO MEDICO ESCONDIDO	491.04	0.00	491.04
AR2201111148393B	211694231600	PG0010260010	CENTRO MEDICO EL CAJON	24.04	0.00	24.04
AR2201111147280B	212204435600	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201111147402B	212112248000	PG0010260010	CENTRO MEDICO EL CAJON	21.00	0.00	21.00
AR2201111149444B	212134337400	PG0083717001	CENTRO MEDICO ESCONDIDO	328.24	0.00	328.24
AR2201111150074B	215423489800	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201111150073B	215423561500	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201111150071B	215268137300	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201111150052B	210244670500	PG0010260010	CENTRO MEDICO EL CAJON	68.85	0.00	68.85
AR2201111148243B	204926520400	PG0010260004	CENTRO MEDICO EL CAJON	62.69	0.00	62.69
AR2201111148533B	210244754700	PG0083717001	CENTRO MEDICO ESCONDIDO	48.61	0.00	48.61
AR2201111148308B	204985783600	PG0010260004	CENTRO MEDICO EL CAJON	141.55	0.00	141.55
AR2201111150053B	205037473600	PG0010260004	CENTRO MEDICO EL CAJON	42.70	0.00	42.70
AR2201111148086B	205097427900	PG0010260004	CENTRO MEDICO EL CAJON	23.27	0.00	23.27
AR2201111150358B	205518701000	PG0010260004	CENTRO MEDICO EL CAJON	62.33	0.00	62.33
AR2201111150051B	210207275500	PG0010260004	CENTRO MEDICO EL CAJON	328.94	0.00	328.94
AR2201210940597B	214497858700	PG0073150003	BORREGO MEDICAL CLINIC	15.00	0.00	15.00
AR2201210941047B	214057874100	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941067B	214026869500	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201210941059B	214347424000	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941054B	214347448200	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2201210941049B	214347945200	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2201210941058B	214026478200	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941052B	214434080600	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941069B	214104837600	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201210941060B	214188623100	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941057B	214188966300	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941065B	214189203100	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201210941063B	214189249600	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941050B	214242902500	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941062B	214504469700	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210940596B	214242304800	PG0010260001	BORREGO MEDICAL CLINIC	15.00	0.00	15.00
AR2201210941071B	214375660800	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201210941048B	214483018900	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941064B	215693438100	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941053B	214647543300	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941045B	214647962400	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941040B	214824326800	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941066B	214952649000	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201210941070B	214953926000	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201210941041B	215138564800	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941055B	215781400400	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210940599B	215241061400	PG0010260001	BORREGO MEDICAL CLINIC	36.80	0.00	36.80
AR2201210940598B	215241314000	PG0010260001	BORREGO MEDICAL CLINIC	15.00	0.00	15.00
AR2201210941044B	215794663600	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2201210941056B	215781325300	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941043B	215794235200	PG0010260010	CENTRO MEDICO EL CAJON	49.88	0.00	49.88
AR2201210941042B	215781386000	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941061B	215781507200	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941046B	215781330600	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201210941068B	215673980200	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201210940595B	215674532600	PG0010260001	BORREGO MEDICAL CLINIC	15.00	0.00	15.00
AR2201210941072B	215693633200	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2201311436497B	211530420500	PG0010260010	CENTRO MEDICO EL CAJON	362.97	0.00	362.97
AR2201311436507B	214347470900	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201311436595B	216057283000	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201311437141B	216056314900	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2201311437025B	216075709900	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201311437103B	216077214600	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201311437138B	216077587600	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2201311437112B	216185959000	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2202170900481B	220109361900	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2202170900480B	220141638000	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2202220942150B	215892092800	PG0010260010	CENTRO MEDICO EL CAJON	32.62	0.00	32.62
AR2202251013164B	220070781500	PG0010260010	CENTRO MEDICO EL CAJON	15.00	0.00	15.00
AR2202251013141B	216275769200	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2202251013136B	216314118600	PG0010260010	CENTRO MEDICO EL CAJON	12.47	0.00	12.47
AR2202251013188B	216362658400	PG0010260010	CENTRO MEDICO EL CAJON	37.41	0.00	37.41
AR2202251013159B	216313798900	PG0010260010	CENTRO MEDICO EL CAJON	37.41	0.00	37.41
AR2202251013143B	216421141100	PG0010260001	BORREGO MEDICAL CLINIC	15.00	0.00	15.00
AR2203111005265B	216475263800	PG0010260001	BORREGO MEDICAL CLINIC	15.00	0.00	15.00
AR2204181434229B	205500494200	PG0083717001	CENTRO MEDICO ESCONDIDO	66.02	0.00	66.02

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN OVERPAYMENTS MADE TO BORREGO COMMUNITY HEALTH FOUNDATION						
EIN XX-XXX0021 - PENDING RECOUPMENTS						
AR_NUMBER	CLAIM ID	PROVIDER ID	PROVIDER NAME	ORIGINAL OVERPAYMENT	CREDITED AMOUNT	BALANCE DUE FROM BORREGO
AR2205041127515B	220833165800	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2206141036108B	220705662400	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2206141036116B	220800100400	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2206141036119B	220832656500	PG0083717001	CENTRO MEDICO ESCONDIDO	15.00	0.00	15.00
AR2209011720008B	214743015700	PG0010260010	CENTRO MEDICO EL CAJON	168.00	0.00	168.00
AR2209011720041B	215153758000	PG0083717001	CENTRO MEDICO ESCONDIDO	18.00	0.00	18.00
				39,857.75	678.69	**39,179.06**

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

January 23, 2020

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369
Attn: Patient Accounts

A/R Number: AR2001151724222B
Amount Due: $105.65
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/07/2019
Patient Account Number: 5068637A 520714

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $105.65 has been made for a Medi-Cal Member on claim number 191513353300. This overpaid amount includes interest of $0.65. These services were provided to [redacted] on 03/04/2019 in the billed amount of $350.01.

This payment has been identified as an incorrect payment due to the following reason(s): This claim has been processed in coordination with the primary carrier Medicare.

We would appreciate your refund of $105.65 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2001151724222B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 193220003745

Enclosure(s):
Appeals-Provider/Hospital

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

January 28, 2020

Borrego Community Health Foundation
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR20011609482985
Amount Due: $172.06
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/08/2019
Patient Account Number: 4535985A 424485

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medicare Member in error, which has resulted in an overpayment to you in the amount of $172.06 Due for services dated from 10/15/2018 to 10/15/2018. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services not paid according to Medicare allowable.

Check number 19380 dated on 02/01/2020 for the amount of $355.40 was sent to you.

Under existing regulations 42 CFR 405.374, you have 15 calendar days from the date of this demand letter to submit a statement and/or evidence stating why this recoupment should not take place. If we do not hear from you within 15 calendar days and have not received a refund from you in 30 calendar days, we will start recouping payments starting 03/01/2020.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_068_CR

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR#AR20011609482985.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after _insertdate_ will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 193650003712

Enclosure:

Appeals Provider /Hospital
Appeals Subscriber/Member
Explaination of Benefits

Prov_19_068_CR

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number: AR20011609482985
Claim Number: 190118251900

Amount Due: $172.06
Patient Name: [redacted]
Amount Paid: $
Date of Service: 10/15/2018 to 10/15/2018

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____
Date of Expiration: _____
Credit Card Number: _____
Phone Number: Day: _____
Evening: _____
Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

Prov_19_068_CR

PROVIDER DISPUTES OR APPEALS

MEDICARE NON-CONTRACTED PROVIDER DISPUTES:

Provider Disputes must be submitted to Blue Shield of California Promise Health Plan, at the address listed below, within 120 calendar days after receipt of the notice of the initial payment determination.

Items that may be filed as Provider Disputes include:

- Underpayment (the amount paid by Blue Shield of California Promise Health Plan for covered services is less than the amount that would have been paid under original Medicare); or
- Disagreement about Blue Shield of California Promise Health Plan's decision to make payment on a more appropriate code.

Denials of payments due to coverage and medical necessity determinations are not subject to the Provider Dispute Process. These items must be submitted as a Provider Appeal.

MEDICARE NON-CONTRACTED PROVIDER APPEALS:

Provider Appeals must be submitted to Blue Shield of California Promise Health Plan within 60 calendar days after receipt of the notice of the initial determination/decision.

Non-contracted providers must also submit a signed Waiver of Liability statement holding the member harmless regardless of the outcome of the appeal.

Copy of Waiver of Liability form can be found at: www.blueshieldca.com/promise/provider

Blue Shield of California Promise Health Plan
ATTN: Provider Dispute Dept.
P.O. Box 3829
Montebello, CA 90640

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR20080613122261B
Amount Due: $18.00
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 43833
Patient Account Number: 4903238A 1019616

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $18.00 has been made for a Medi-Cal Member on claim number 190624171401. These services were provided to [redacted] on 43489 to 43489 in the billed amount of $60.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $18.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061312261B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260027291

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061327120B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 02/28/2020
Patient Account Number: C0201OX7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 200914324200. These services were provided to [redacted] on 01/28/2020 to 01/28/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061327120B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270009243

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061326448B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 02/21/2020
Patient Account Number: C02018PS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 200831786700. These services were provided to [redacted] on 02/03/2020 to 02/03/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061326448B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190038092

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061326592B
Amount Due: $22.50
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 02/25/2020
Patient Account Number: C0201KBO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $22.50 has been made for a Medi-Cal Member on claim number 200887491900. These services were provided to [redacted] on 02/04/2020 to 02/04/2020 in the billed amount of $75.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $22.50 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061326592B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202240043817

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061327339B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 02/28/2020
Patient Account Number: C0201UVM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 200969385600. These services were provided to [redacted] on 02/11/2020 to 02/11/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061327339B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270014364

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/19/2020

JULIAN MEDICAL CENTER
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061328023B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 03/06/2020
Patient Account Number: C03003SO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201060416100. These services were provided to [redacted] on 02/17/2020 to 02/17/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061328023B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190038060

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/19/2020

JULIAN MEDICAL CENTER
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330300B
Amount Due: $9.88
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0301BKE

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $9.88 has been made for a Medi-Cal Member on claim number 201470377100. These services were provided to [redacted] on 02/17/2020 to 02/17/2020 in the billed amount of $122.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $9.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330300B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230018118

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061327119B
Amount Due: $177.60
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 02/28/2020
Patient Account Number: C0201OXD

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $177.60 has been made for a Medi-Cal Member on claim number 200914265100. These services were provided to [redacted] on 02/19/2020 to 02/19/2020 in the billed amount of $592.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $177.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061327119B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202240043612

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333363B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/08/2020
Patient Account Number: C050023L

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201877388900. These services were provided to [redacted] on 02/19/2020 to 02/19/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333363B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260039753

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/19/2020

JULIAN MEDICAL CENTER
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333062B
Amount Due: $36.60
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/30/2020
Patient Account Number: C0301CQG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $36.60 has been made for a Medi-Cal Member on claim number 201800226100. These services were provided to [redacted] on 02/21/2020 to 02/21/2020 in the billed amount of $122.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $36.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333062B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230018328

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330252B
Amount Due: $14.55
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302M35

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $14.55 has been made for a Medi-Cal Member on claim number 201459853900. These services were provided to [redacted] on 02/22/2020 to 02/22/2020 in the billed amount of $48.50.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $14.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330252B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270009309

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR20080613283O1B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 43907
Patient Account Number: C0300O0A

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201154611100. These services were provided to [redacted] on 43885 to 43885 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061328301B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260035457

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061328162B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 03/10/2020
Patient Account Number: C0300BGV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201113902200. These services were provided to [redacted] on 02/25/2020 to 02/25/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061328162B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270012686

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/19/2020

JULIAN MEDICAL CENTER
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330306B
Amount Due: $9.88
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0301BKI

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $9.88 has been made for a Medi-Cal Member on claim number 201470398700. These services were provided to [redacted] on 02/25/2020 to 02/25/2020 in the billed amount of $122.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $9.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330306B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230018200

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

BORREGO COMMUNITY HEALTH FOUNDATION
PO BOX 2369
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061328219B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 43900
Patient Account Number: C0300IR0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201136246900. These services were provided to [redacted] on 43888 to 43888 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061328219B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260005531

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/19/2020

JULIAN MEDICAL CENTER
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330227B
Amount Due: $9.88
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0301All

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $9.88 has been made for a Medi-Cal Member on claim number 201457065600. These services were provided to [redacted] on 02/27/2020 to 02/27/2020 in the billed amount of $122.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $9.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330227B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230018052

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061329243B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0301SDP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201340389800. These services were provided to [redacted] on 03/04/2020 to 03/04/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061329243B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270013850

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061334293B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/22/2020
Patient Account Number: C0500UOQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 202020632400. These services were provided to [redacted] on 03/04/2020 to 03/04/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061334293B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230025779

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO COMMUNITY HEALTH FOUNDATION
PO BOX 2369
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061329310B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0301Y1D

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201358039400. These services were provided to [redacted] on 03/06/2020 to 03/06/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061329310B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230014912

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061329317B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0301WXA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201360514800. These services were provided to [redacted] on 03/09/2020 to 03/09/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061329317B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270012562

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331254B
Amount Due: $20.79
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/10/2020
Patient Account Number: C0400BP3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $20.79 has been made for a Medi-Cal Member on claim number 201594220100. These services were provided to [redacted] on 03/09/2020 to 03/09/2020 in the billed amount of $69.29.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $20.79 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331254B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270010608

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331307B
Amount Due: $6.29
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/10/2020
Patient Account Number: C0400DUH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.29 has been made for a Medi-Cal Member on claim number 201609854300. These services were provided to [redacted] on 03/10/2020 to 03/10/2020 in the billed amount of $20.97.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.29 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331307B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260036313

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330057B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0302DBW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201422994100. These services were provided to [redacted] on 03/12/2020 to 03/12/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330057B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190038620

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330056B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 03/27/2020
Patient Account Number: C0302F6H

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201422602400. These services were provided to [redacted] on 03/13/2020 to 03/13/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330056B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202200012785

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330058B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0302F6J

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201423291900. These services were provided to [redacted] on 03/13/2020 to 03/13/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330058B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270012518

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330166B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302H8K

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201443532300. These services were provided to [redacted] on 03/16/2020 to 03/16/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330166B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202250038864

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331391B
Amount Due: $20.79
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/14/2020
Patient Account Number: C0400FUD

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $20.79 has been made for a Medi-Cal Member on claim number 201622677700. These services were provided to [redacted] on 03/16/2020 to 03/16/2020 in the billed amount of $69.29.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $20.79 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331391B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260008074

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330157B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302IHY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201442821400. These services were provided to [redacted] on 03/17/2020 to 03/17/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330157B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270010416

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330164B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302I9J

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201443197000. These services were provided to [redacted] on 03/17/2020 to 03/17/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330164B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202200035332

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO CATHEDRAL CITY
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330161B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302JM7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201443005800. These services were provided to [redacted] on 03/18/2020 to 03/18/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330161B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190038562

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

ANZA COMMUNITY HEALTH CENTER
PO BOX 2364
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061330470B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302SHW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201493557500. These services were provided to [redacted] on 03/20/2020 to 03/20/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330470B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230041176

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330413B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302RHD

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201476157800. These services were provided to [redacted] on 03/23/2020 to 03/23/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330413B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202250038879

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO ESCONDIDO
PO BOX 2369
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061330533B
Amount Due: $22.07
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C03031ID

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $22.07 has been made for a Medi-Cal Member on claim number 201513592200. These services were provided to [redacted] on 03/23/2020 to 03/23/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $22.07 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330533B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230008866

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061330412B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C0302TLH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201475531800. These services were provided to [redacted] on 03/24/2020 to 03/24/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061330412B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230028980

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331049B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C04001V9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201548011600. These services were provided to [redacted] on 03/26/2020 to 03/26/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331049B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270014649

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331094B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C040047K

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201560999700. These services were provided to [redacted] on 03/30/2020 to 03/30/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331094B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270012620

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331087B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C040047N

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201560169200. These services were provided to [redacted] on 03/31/2020 to 03/31/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331087B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202250040415

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331092B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/07/2020
Patient Account Number: C040047P

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201560499200. These services were provided to [redacted] on 03/31/2020 to 03/31/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331092B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270009993

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061331532B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/17/2020
Patient Account Number: C0400JOA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201648175100. These services were provided to [redacted] on 04/01/2020 to 04/01/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061331532B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202200012893

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332082B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/21/2020
Patient Account Number: C0400QJU

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201703605800. These services were provided to [redacted] on 04/07/2020 to 04/07/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332082B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260038979

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332149B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/21/2020
Patient Account Number: C0400VOM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201715240500. These services were provided to [redacted] on 04/08/2020 to 04/08/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332149B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260000434

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332151B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/21/2020
Patient Account Number: C0400VOJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201715655200. These services were provided to [redacted] on 04/09/2020 to 04/09/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332151B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260032809

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332462B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/24/2020
Patient Account Number: C0401462

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201765497900. These services were provided to [redacted] on 04/14/2020 to 04/14/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332462B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190038781

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332463B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/24/2020
Patient Account Number: C0401464

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201765551900. These services were provided to [redacted] on 04/14/2020 to 04/14/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332463B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270011851

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332461B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/24/2020
Patient Account Number: C04015TU

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201765257100. These services were provided to [redacted] on 04/15/2020 to 04/15/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332461B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202200000091

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332542B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/28/2020
Patient Account Number: C04017WB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201776879200. These services were provided to [redacted] on 04/16/2020 to 04/16/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332542B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230041179

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332543B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/28/2020
Patient Account Number: C04017WC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201776932100. These services were provided to [redacted] on 04/16/2020 to 04/16/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332543B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202240033751

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332597B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/28/2020
Patient Account Number: C0401AO6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201790155000. These services were provided to [redacted] on 04/16/2020 to 04/16/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332597B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260000438

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061332599B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/28/2020
Patient Account Number: C0401C4E

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201790723300. These services were provided to [redacted] on 04/17/2020 to 04/17/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061332599B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230029036

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333076B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/30/2020
Patient Account Number: C0401EYP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201801519800. These services were provided to [redacted] on 04/20/2020 to 04/20/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333076B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190038515

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333077B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 04/30/2020
Patient Account Number: C0401G9F

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201801646300. These services were provided to [redacted] on 04/21/2020 to 04/21/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333077B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270009546

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO COMMUNITY HEALTH FOUNDATION
PO BOX 2369
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061319159B
Amount Due: $6.60
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 11/01/2019
Patient Account Number: 5287644D 895858

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.60 has been made for a Medi-Cal Member on claim number 194840022400. These services were provided to [redacted] on 04/22/2019 to 04/22/2019 in the billed amount of $22.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061319159B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230041649

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333243B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/05/2020
Patient Account Number: C0401PBM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201851258000. These services were provided to [redacted] on 04/24/2020 to 04/24/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333243B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202200035343

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333445B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/08/2020
Patient Account Number: C05003OM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201900904400. These services were provided to [redacted] on 04/29/2020 to 04/29/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333445B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270012773

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333438B
Amount Due: $18.00
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/08/2020
Patient Account Number: C05004W0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $18.00 has been made for a Medi-Cal Member on claim number 201899995100. These services were provided to [redacted] on 04/30/2020 to 04/30/2020 in the billed amount of $60.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $18.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333438B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202240013069

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/25/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333439B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/08/2020
Patient Account Number: C0500580

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201900447400. These services were provided to [redacted] on 04/30/2020 to 04/30/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333439B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202310015256

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/25/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333500B
Amount Due: $111.27
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/08/2020
Patient Account Number: C05008TW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $111.27 has been made for a Medi-Cal Member on claim number 201916754300. These services were provided to [redacted] on 05/01/2020 to 05/01/2020 in the billed amount of $370.90.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $111.27 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333500B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202310015823

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333549B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/12/2020
Patient Account Number: C0500B3K

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201930071100. These services were provided to [redacted] on 05/04/2020 to 05/04/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333549B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190038235

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061334130B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/15/2020
Patient Account Number: C0500M9A

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201973957600. These services were provided to [redacted] on 05/05/2020 to 05/05/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061334130B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202240025161

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061334133B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/15/2020
Patient Account Number: C0500M97

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 201974855500. These services were provided to [redacted] on 05/05/2020 to 05/05/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061334133B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270013164

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061334288B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/19/2020
Patient Account Number: C0500UOU

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 202020240400. These services were provided to [redacted] on 05/06/2020 to 05/06/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061334288B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202260035360

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061334503B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/22/2020
Patient Account Number: C0501354

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 202073794300. These services were provided to [redacted] on 05/08/2020 to 05/08/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061334503B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202200035148

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061334430B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/22/2020
Patient Account Number: C050101A

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 202057796100. These services were provided to [redacted] on 05/13/2020 to 05/13/2020 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061334430B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202240025227

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO COMMUNITY HEALTH FOUNDATION
PO BOX 2369
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061314062B
Amount Due: $6.60
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 08/20/2019
Patient Account Number: 5677981C 1109752

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.60 has been made for a Medi-Cal Member on claim number 193615576800. These services were provided to [redacted] on 07/26/2019 to 07/26/2019 in the billed amount of $22.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061314062B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202240003148

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO COMMUNITY HEALTH FOUNDATION
PO BOX 2369
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061314582B
Amount Due: $6.60
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 08/30/2019
Patient Account Number: 5716438A 434929

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.60 has been made for a Medi-Cal Member on claim number 193807751600. These services were provided to [redacted] [redacted] on 08/06/2019 to 08/06/2019 in the billed amount of $22.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061314582B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230041405

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO MEDICAL CLINIC
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061314253B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 08/23/2019
Patient Account Number: 5753286A 15228

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 193693574800. These services were provided to [redacted] on 08/14/2019 to 08/14/2019 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061314253B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202190035664

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

BORREGO COMMUNITY HEALTH FOUNDATION
PO BOX 2369
BORREGO SPRINGS CA 92004-2004

Attn: Patient Accounts

A/R Number: AR2008061316242B
Amount Due: $6.60
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 09/17/2019
Patient Account Number: 5791051D 1120518

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.60 has been made for a Medi-Cal Member on claim number 194074400000. These services were provided to [redacted] on 08/22/2019 to 08/22/2019 in the billed amount of $22.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061316242B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230025708

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061333296B
Amount Due: $10.91
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 05/08/2020
Patient Account Number: C0401SPS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $10.91 has been made for a Medi-Cal Member on claim number 201866625200. These services were provided to [redacted] on 09/14/2019 to 09/14/2019 in the billed amount of $48.50.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $10.91 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061333296B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270011070

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/22/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061321505B
Amount Due: $6.62
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 12/13/2019
Patient Account Number: C9B00GR3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $6.62 has been made for a Medi-Cal Member on claim number 195533736000. These services were provided to [redacted] on 10/17/2019 to 10/17/2019 in the billed amount of $22.07.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $6.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061321505B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202270012106

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061326199B
Amount Due: $9.88
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 02/21/2020
Patient Account Number: C0101D3U

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $9.88 has been made for a Medi-Cal Member on claim number 200757250000. These services were provided to [redacted] on 11/11/2019 to 11/11/2019 in the billed amount of $122.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $9.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061326199B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230041640

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/19/2020

JULIAN MEDICAL CENTER
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061328460B
Amount Due: $36.60
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 03/13/2020
Patient Account Number: C0101FDQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $36.60 has been made for a Medi-Cal Member on claim number 201206433000. These services were provided to [redacted] on 11/26/2019 to 11/26/2019 in the billed amount of $122.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $36.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061328460B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230017972

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

8/18/2020

CENTRO MEDICO EL CAJON
P O BOX 2369
BORREGO SPRINGS CA 92004-2369

Attn: Patient Accounts

A/R Number: AR2008061328517B
Amount Due: $18.00
Member Number: [redacted]
Member Name: [redacted]
Issue Date: 03/13/2020
Patient Account Number: C0301DDV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $18.00 has been made for a Medi-Cal Member on claim number 201234282700. These services were provided to [redacted] on 12/26/2019 to 12/26/2019 in the billed amount of $60.00.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $18.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2008061328517B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Enclosure(s):
Appeals-Provider/Hospital

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202230041172

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

August 10, 2020

Centro Medico El Cajon
P O Box 2369
Borrego Springs, CA 92004-2369
Attention: Patient Accounts

AR Number: AR20081008493214
AR Amount: $72.82

Dear Billing Department,

During the period of February 22, 2020 – February 28, 2020, Blue Shield processed claims, for multiple patients and later determined that the claims were paid by Blue Shield of California in error. This error has resulted in an overpayment of $72.82.

Attached is a spreadsheet which represents the subscriber and claims that were impacted.

Blue Shield of California is requesting a refund in the amount of $72.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of overpayments, you must file an appeal within 30 working days of your receipt of this letter.

Please remit payment to:

Blue Shield of California Promise Health Plan
Corporate Recovery Department
Attn: Cash Receiving
Po Box 241012
Lodi, CA 95241

Please be sure this letter and spreadsheet accompany your payment.

If you have further questions, please contact us at the address listed below or call toll free (800) 605-2556.
Sincerely,

Corporate Recovery
Inquiry Number: 202230005584

Enclosure(s): Appeals-Provider/Hospital
Claim Summary

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

September 9, 2020

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2008131233296B
Amount Due: $640.69

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $640.69 has been made for Medi-Cal Members on below claim summary.

This payment has been identified as an incorrect payment due to the following reason(s): 1 OR more billed CPT code are invalid or do not have an allowable resulting in non-covered benefit.

We would appreciate your refund of $640.69 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2008131233296B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Prov_19_071_CR

blue california | Promise Health Plan

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202390013571

Enclosure(s): Appeals-Provider/Hospital
Claims Summary

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

October 16, 2020

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number:AR20101608394320
Amount Due: $115.72
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/24/2020
Patient Account Number: C0301WXC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $115.72 has been made for a Medi-Cal Member on claim number 201359002600. These services were provided to [redacted] on 03/06/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s):

Retro contract change created a overpayment.

We would appreciate your refund of $115.72 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR20101608394320.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202530003308

Enclosure:
Appeals Provider /Hospital
Explaination of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

October 22, 2020

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369
Attn: Patient Accounts

A/R Number: AR2010201309173B
Amount Due: $212.25
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/15/2020
Patient Account Number: C0301YV8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $212.25 has been made for a Medi-Cal Member on claim number 201359028101. This overpaid amount includes interest of $0.14. These services were provided to [redacted] on 03/06/2020 in the billed amount of $1,478.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $212.25 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2010201309173B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202820004789

Enclosure(s):
Appeal - Provider / Hospital
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

October 26, 2020

Centro Medico Escondido
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2010221459427B
Amount Due: $24.08
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/24/2020
Patient Account Number: C03020E0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.08 has been made for a Medi-Cal Member on claim number 201359243900. These services were provided to [redacted] on 03/05/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $24.08 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2010221459427B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202530004097

Enclosure(s):
Appeal - Provider / Hospital
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

November 3, 2020

Centro Medico El Cajon
P O Box 2369
Borrego Springs, CA 92004-2369
Attn: Patient Accounts

A/R Number: AR2010281208375B
Amount Due: $40.50
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/01/2020
Patient Account Number: C0802NOX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $40.50 has been made for a Medi-Cal Member on claim number 203531205000. These services were provided to [redacted] on 08/11/2020 in the billed amount of $259.85.

This payment has been identified as an incorrect payment due to the following reason(s): Capitated hospital responsibility. Please bill capitated hospital.

We would appreciate your refund of $40.50 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2010281208375B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 203040016304

Enclosure(s):
Appeal - Provider / Hospital

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

November 3, 2020

Centro Medico EL Cajon
P O Box 2369
Borrego Springs, CA 92004-2369
Attn: Patient Accounts

A/R Number: AR2010281208391B
Amount Due: $29.71
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/18/2020
Patient Account Number: C0801CMJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $29.71 has been made for a Medi-Cal Member on claim number 203315787900. These services were provided to [redacted] on 08/12/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Capitated hospital responsibility. Please bill capitated hospital.

We would appreciate your refund of $29.71 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2010281208391B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 203040017190

Enclosure(s):
Appeal - Provider / Hospital

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

November 2, 2020

Centro Medico Escondido
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2010301148589B
Amount Due: $171.59
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/24/2020
Patient Account Number: C0301WX8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $171.59 has been made for a Medi-Cal Member on claim number 201359021700. These services were provided to [redacted] on 03/06/2020 in the billed amount of $201.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $171.59 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2010301148589B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202530003807

Enclosure(s):
Appeals-Provider/Hospitals
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

November 2, 2020

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2010301149247B
Amount Due: $21.17
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/24/2020
Patient Account Number: C0301U69

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $21.17 has been made for a Medi-Cal Member on claim number 201340274300. These services were provided to [redacted] on 03/09/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $21.17 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2010301149247B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202530002996

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

November 4, 2020

Centro Medico Escondido
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2011021358369B
Amount Due: $24.08
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 03/17/2020
Patient Account Number: C0300P2T

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.08 has been made for a Medi-Cal Member on claim number 201182175100. These services were provided to [redacted] on 02/25/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $24.08 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2011021358369B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202530001336

Enclosure(s):
Appeal - Provider / Hospital
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

November 9, 2020

Centro Medico Escondido
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts
REVISED LETTER

A/R Number: AR2011031619392B
Amount Due: $24.08
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/03/2020
Patient Account Number: C0301TCN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.08 has been made for a Medi-Cal Member on claim number 201340273600. These services were provided to [redacted] on 03/09/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $24.08 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2011031619392B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 202530002539

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

December 24, 2020

Borrego Community Health Foundation
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2012191146093B
Amount Due: $538.84
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 10/13/2020
Patient Account Number: C0A00VGR

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $538.84 has been made for a Medi-Cal Member on claim number 204181699900. These services were provided to [redacted] on 06/03/2020 in the billed amount of $2,337.08.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid to the wrong provider.

We would appreciate your refund of $538.84 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2012191146093B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 203420024964

Enclosure(s):
Appeals-Provider/Hospital

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

December 24, 2020

Borrego Community Health Foundation
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2012191145583B
Amount Due: $539.27
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/13/2020
Patient Account Number: C0A00UME

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $539.27 has been made for a Medi-Cal Member on claim number 204165118800. These services were provided to [redacted] on 06/05/2020 in the billed amount of $4,624.24.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid to the wrong provider.

We would appreciate your refund of $539.27 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2012191145583B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 203420024293

Enclosure(s):
Appeals-Provider/Hospital

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

December 24, 2020

Borrego Community Health Foundation
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2012191145587B
Amount Due: $539.27
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/13/2020
Patient Account Number: C0A00VGQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $539.27 has been made for a Medi-Cal Member on claim number 204182457400. These services were provided to [redacted] on 07/08/2020 in the billed amount of $4,624.24.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid to the wrong provider.

We would appreciate your refund of $539.27 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2012191145587B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 203420023396

Enclosure(s):
Appeals-Provider/Hospital

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

December 24, 2020

Borrego Community Health Foundation
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2012191145586B
Amount Due: $538.84
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/13/2020
Patient Account Number: C0A00UMD

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $538.84 has been made for a Medi-Cal Member on claim number 204164656500. These services were provided to [redacted] on 08/17/2020 in the billed amount of $2,337.08.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid to the wrong provider.

We would appreciate your refund of $538.84 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2012191145586B.

Prov_19_071_CR

blue california | Promise Health Plan

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 203420026735

Enclosure(s):
Appeals-Provider/Hospital

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

January 25, 2021

Centro Medico Escondido
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2101201253493B
Amount Due: $9.62
Member Number: 909759056
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/17/2020
Patient Account Number: C0A00LB9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $9.62 has been made for a Medi-Cal Member on claim number 204494825800. These services were provided to [redacted] on 09/28/2020 in the billed amount of $411.32.

This payment has been identified as an incorrect payment due to the following reason(s): it has been identified that these services were processed and paid to you previously on claim number 204126211400. with check number 2020100911101230. This duplicate payment was issued in error.

We would appreciate your refund of $9.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR# AR2101201253493B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 203570049120

Enclosure(s):
Appeal - Provider / Hospital
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

January 27, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number:AR21012208245411
Amount Due: $116.09
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/10/2020
Patient Account Number: C0B00E7W

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $116.09 has been made for a Medi-Cal Member on claim number 204609164500. These services were provided to [redacted] on 10/27/2020 in the billed amount of $429.65.

This payment has been identified as an incorrect payment due to the following reason(s):

Procedure to Procedure (PTP) IND1 Edit deny line one.

We would appreciate your refund of $116.09 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

blue california | Promise Health Plan

To avoid delay in processing, please submit your payment referencing AR#AR21012208245411 .

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 210120027776

Enclosure:

Appeals Provider /Hospital
Explanation of Benefits

Prov_19_071_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

February 5, 2021

Centro Medico Escondido
P O Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number: AR2102041308509B
Amount Due: $144.48
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 05/01/2020
Patient Account Number: C0301VQX

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medicare Member in error, which has resulted in an overpayment to you in the amount of $144.48 for services dated on 03/03/2020. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s): After additional review, it has been identified that there was an overpayment on claim 201339747700 due to an NCCI Procedure-To-Procedure Indicator Line 1 edit for billed code 99397. This claim is an overpayment for services rendered to the same member on the same date of service by the same rendering provider. Please see the enclosed corrected Explanation of Benefits (EOB) for the accurate processing of this claim line.

Check number 127706 dated on 05/01/2020 for the amount of $217.52 was sent to you.

Under existing regulations 42 CFR 405.374, you have 15 calendar days from the date of this demand letter to submit a statement and/or evidence stating why this recoupment should not take place. If we do not hear from you within 15 calendar days and have not received a refund from you in 30 calendar days, we will start recouping payments starting March 7, 2021.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012

Prov_19_068_CR

blue california | Promise Health Plan

Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2102041308509B.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after March 7, 2021 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 210120041523

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

Prov_19_068_CR

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number: AR2102041308509B
Claim Number: 201339747700

Amount Due: $144.48
Patient Name: [redacted]
Amount Paid:
Date of Service: 03/03/2020

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____
Date of Expiration: _____
Credit Card Number: _____
Phone Number: Day: _____
Evening: _____
Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

Prov_19_068_CR

PROVIDER DISPUTES OR APPEALS

MEDICARE NON-CONTRACTED PROVIDER DISPUTES:

Provider Disputes must be submitted to Blue Shield of California Promise Health Plan, at the address listed below, within 120 calendar days after receipt of the notice of the initial payment determination.

Items that may be filed as Provider Disputes include:

- Underpayment (the amount paid by Blue Shield of California Promise Health Plan for covered services is less than the amount that would have been paid under original Medicare); or
- Disagreement about Blue Shield of California Promise Health Plan's decision to make payment on a more appropriate code.

Denials of payments due to coverage and medical necessity determinations are not subject to the Provider Dispute Process. These items must be submitted as a Provider Appeal.

MEDICARE NON-CONTRACTED PROVIDER APPEALS:

Provider Appeals must be submitted to Blue Shield of California Promise Health Plan within 60 calendar days after receipt of the notice of the initial determination/decision.

Non-contracted providers must also submit a signed Waiver of Liability statement holding the member harmless regardless of the outcome of the appeal.

Copy of Waiver of Liability form can be found at: www.blueshieldca.com/promise/provider

Blue Shield of California Promise Health Plan
ATTN: Provider Dispute Dept.
P.O. Box 3829
Montebello, CA 90640

blue california
Promise Health Plan

June 15, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number: AR21061513524253
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C12007RF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 210666299600. These services were provided to [redacted] on 01/27/2021 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21061513524253.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019586

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369

Attn: Patient Accounts

A/R Number:AR21061512503887
Amount Due:$17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/02/2021
Patient Account Number:C1201SI3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210937723800. These services were provided to [redacted] on 02/19/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Enclosure:
Appeals Provider /Hospital

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21061512503887.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610016107

blue california
Promise Health Plan

June 15, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number: AR21061513201078
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/27/2021
Patient Account Number: C1400UXT

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211919203300. These services were provided to [redacted] on 04/12/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21061513201078.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016772

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number: AR21061513283566
Amount Due:$25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/27/2021
Patient Account Number: C1400UXY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 211919306700. These services were provided to [redacted] on 04/12/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21061513283566.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018244

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number: AR21061512512970
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/30/2021
Patient Account Number: C1400Z6Q

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211982667000. These services were provided to [redacted] on 04/19/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21061512512970.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620012598

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369

Attn: Patient Accounts

A/R Number:AR21061512390458
Amount Due:$61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/07/2020
Patient Account Number:C08005I6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203136467100. These services were provided to [redacted] on 07/28/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012

Prov_19_071_CR

Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR21061512390458.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610010206

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

June 15, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number: AR21061513090639
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/08/2020
Patient Account Number: C09008GM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203616866200. These services were provided to [redacted] on 08/21/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21061513090639.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620013737

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number: AR21061513594576
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/09/2020
Patient Account Number: C0A00NQ4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204148342400. These services were provided to [redacted] on 09/29/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21061513594576.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620020583

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number: AR21061513370057
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/30/2020
Patient Account Number: C0A02HKD

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 204474834600. These services were provided to [redacted] on 10/21/2020 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21061513370057.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018377

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369

Attn: Patient Accounts

A/R Number:AR21061513140220
Amount Due:$23.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number:C0B01V64

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.88 has been made for a Medi-Cal Member on claim number 204886045900. These services were provided to [redacted] on 11/03/2020 in the billed amount of $223.37.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.88 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21061513140220.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610025035

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

June 15, 2021

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369

Attn: Patient Accounts

A/R Number:AR21061513015550
Amount Due:$17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C00SC3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 205272996600. These services were provided to [redacted] on 12/03/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Enclosure:
Appeals Provider /Hospital

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21061513015550.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610020043

blue california
Promise Health Plan

June 15, 2021

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369

Attn: Patient Accounts

A/R Number: AR21061513005533
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01GOL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 205502509900. These services were provided to [redacted] on 12/11/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21061513005533.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620013097

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 15, 2021

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369

Attn: Patient Accounts

A/R Number: AR21061513454513
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01MR1

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 205539672100. These services were provided to [redacted] on 12/22/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21061513454513.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019106

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 16, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004

Attn: Patient Accounts

A/R Number:AR21061608511922
Amount Due:$599.39
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number:C1100E50

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $599.39 has been made for a Medi-Cal Member on claim number 210156343300. These services were provided to [redacted] on 12/11/2020 in the billed amount of $1,211.48.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $559.39 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21061608511922.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610018054

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

June 28, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2106241647298B
Amount Due: 471.70
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/23/2021
Patient Account Number: C1400P91

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $471.70 has been made for a Medi-Cal Member on claim number 211852828000. These services were provided to [redacted] on 04/08/2021 in the billed amount of $1,145.64.

This payment has been identified as an incorrect payment due to the following reason(s): services were rendered on or after the cancellation date of 2020-12-31. Please verify with the member if they have other coverage and bill other insurance for payment..

We would appreciate your refund of $471.70 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2106241647298B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211680011633

blue california
Promise Health Plan

June 28, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number:AR21062808275333
Amount Due:$134.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/23/2020
Patient Account Number:C0601IYF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of 134.47 has been made for a Medi-Cal Member on claim number 202458093400 . These services were provided to [redacted] on 05/29/2020 in the billed amount of $135.83.

This payment has been identified as an incorrect payment due to the following reason(s)

Services not paid according to Medi-cal allowable.

We would appreciate your refund of $134.47 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR#AR21062808275333.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211670026970

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

July 1, 2021

Centro Medico El Cajon
P O Box 2369
Borrego Springs, CA 92004-2369
Attn: Patient Accounts

A/R Number:AR21070114403816
Amount Due:$23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 07/10/2020
Patient Account Number:C0700KUS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 202753223200. These services were provided to [redacted] on 03/10/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s):

This claim was reimbursed at an incorrect negotiated contract rate.

We would appreciate your refund of $23.76 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21070114403816.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620003164

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

July 1, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number:AR21070113453917
Amount Due:$23.76
Member Number: [redacted]
Member Name:
Patient Name: [redacted]
Issue Date: 04/06/2021
Patient Account Number:C14000GV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211548604300. These services were provided to [redacted] on 03/25/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s):

This claim was reimbursed at an incorrect negotiated contract rate.

We would appreciate your refund of $23.76 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21070113453917.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000705

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

July 1, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number:AR21070113132355
Amount Due:$23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/29/2020
Patient Account Number:C09026IC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203942624800. These services were provided to [redacted] on 09/14/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s):

This claim was reimbursed at an incorrect negotiated contract rate.

We would appreciate your refund of $23.76 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Enclosure:
Appeals Provider /Hospital

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21070113132355.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000656

blue california
Promise Health Plan

July 2, 2021

Borrego Medical Clinic
P O Box 2369
Borrego Springs, CA 92004-2369
Attn: Patient Accounts

A/R Number:AR21070211310916
Amount Due:$23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number:C11017QG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210512394000. These services were provided to [redacted] on 01/21/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s):

This claim was reimbursed at an incorrect negotiated contract rate.

We would appreciate your refund of $23.746 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR21070211310916.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022118

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

July 2, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number:AR21070208482510
Amount Due:$23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/27/2020
Patient Account Number:C0A0272W

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204419163900. These services were provided to [redacted] on 09/30/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s):

This claim was reimbursed at an incorrect negotiated contract rate.

We would appreciate your refund of $23.76 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR#AR21070208482510.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014146

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

July 23, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608224B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/16/2021
Patient Account Number: C1200G1P

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $12.47 has been made for a Medi-Cal Member on claim number 210709891700. These services were provided to [redacted] on 02/01/2021 in the billed amount of $1,033.13.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $12.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608224B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800037947

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 27, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608236B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/26/2021
Patient Account Number: C12018MT

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $12.47 has been made for a Medi-Cal Member on claim number 210881340000. These services were provided to [redacted] on 02/08/2021 in the billed amount of $534.43.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $12.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608236B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800041870

Enclosure(s):
Appeals-Provider/Hospitals
Explanation of Benefits

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608107B
Amount Due: $37.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C03019IV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.41 has been made for a Medi-Cal Member on claim number 201232400001. These services were provided to [redacted] on 02/13/2020 in the billed amount of $1,309.40.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $37.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608107B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800039161

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 27, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608247B
Amount Due: $24.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300KEC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.94 has been made for a Medi-Cal Member on claim number 211184893500. These services were provided to [redacted] on 03/01/2021 in the billed amount of $1,157.77.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $24.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608247B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800042608

Enclosure(s):
Appeals-Provider/Hospitals
Explanation of Benefits

blue california
Promise Health Plan

July 27, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608249B
Amount Due: $37.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300MQW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.41 has been made for a Medi-Cal Member on claim number 211208566600. These services were provided to [redacted] on 03/03/2021 in the billed amount of $982.90.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $37.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608249B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800040769

Enclosure(s):
Appeals-Provider/Hospitals
Explanation of Benefits

blue california
Promise Health Plan

July 27, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608322B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/21/2021
Patient Account Number: C1500QCQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 212444218000. These services were provided to [redacted] on 04/07/2021 in the billed amount of $243.29.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608322B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820044894

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 27, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608334B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/28/2021
Patient Account Number: C1500TE7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 212503493000. These services were provided to [redacted] on 04/21/2021 in the billed amount of $285.08.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608334B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820044276

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608108B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0501EDV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $12.47 has been made for a Medi-Cal Member on claim number 202113694601. These services were provided to [redacted] on 05/13/2020 in the billed amount of $493.73.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $12.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608108B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800039223

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 27, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608350B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/08/2021
Patient Account Number: C16008PL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 212704094600. These services were provided to [redacted] on 05/17/2021 in the billed amount of $481.57.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608350B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820025164

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 27, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107201608376B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/18/2021
Patient Account Number: C1600S3E

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 212912942900. These services were provided to [redacted] on 05/19/2021 in the billed amount of $1,238.26.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608376B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820044261

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608109B
Amount Due: $24.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 07/28/2020
Patient Account Number: C0600SF4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.94 has been made for a Medi-Cal Member on claim number 202358255801. These services were provided to [redacted] on 05/21/2020 in the billed amount of $1,244.66.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $24.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608109B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820044844

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 27, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107201608358B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/11/2021
Patient Account Number: C1600EX0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 212769630900. These services were provided to [redacted] on 05/26/2021 in the billed amount of $285.29.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608358B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800024412

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 27, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107201608384B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/29/2021
Patient Account Number: C1601B05

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 213069203400. These services were provided to [redacted] on 06/10/2021 in the billed amount of $285.29.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608384B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820042560

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 22, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608131B
Amount Due: $8.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/09/2020
Patient Account Number: C0A00AMF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.92 has been made for a Medi-Cal Member on claim number 204101926200. These services were provided to [redacted] on 09/23/2020 in the billed amount of $868.08.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $8.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608131B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800017224

Enclosure(s):
Appeals-Provider/Hospitals
Explanation of Benefits

blue california
Promise Health Plan

July 22, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608136B
Amount Due: $24.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/16/2020
Patient Account Number: C0A0103M

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.94 has been made for a Medi-Cal Member on claim number 204210788600. These services were provided to [redacted] on 10/02/2020 in the billed amount of $967.23.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $24.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608136B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800039330

Enclosure(s):
Appeals-Provider/Hospitals
Explanation of Benefits

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608208B
Amount Due: $24.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100NL5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.94 has been made for a Medi-Cal Member on claim number 210244485900. These services were provided to [redacted] on 10/09/2020 in the billed amount of $1,225.64.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $24.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608208B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820045254

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 22, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608137B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01HRE

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $12.47 has been made for a Medi-Cal Member on claim number 204299282800. These services were provided to [redacted] on 10/12/2020 in the billed amount of $609.59.

This payment has been identified as an incorrect payment due to the following reason(s): the submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $12.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608137B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800010525

Enclosure(s):
Appeals-Provider/Hospitals
Explanation of Benefits

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608207B
Amount Due: $24.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100NL6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $24.94 has been made for a Medi-Cal Member on claim number 210244459400. These services were provided to [redacted] on 11/23/2020 in the billed amount of $1,195.64.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $24.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608207B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820045421

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608209B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100NL7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $12.47 has been made for a Medi-Cal Member on claim number 210244643000. These services were provided to [redacted] on 12/03/2020 in the billed amount of $534.43.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $12.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608209B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800039515

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608180B
Amount Due: $37.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/05/2021
Patient Account Number: C0C00YP2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.41 has been made for a Medi-Cal Member on claim number 205316882600. These services were provided to [redacted] on 12/10/2020 in the billed amount of $1,201.08.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $37.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608180B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800040078

Enclosure(s):
Appeal - Provider / Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107201608201B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100A5D

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $12.47 has been made for a Medi-Cal Member on claim number 210109441100. These services were provided to [redacted] on 12/30/2020 in the billed amount of $428.60.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $12.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107201608201B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211800038708

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 23, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR21072311500064
Amount Due: $37.13
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01N5H

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.13 has been made for a Medi-Cal Member on claim number 205539505100. These services were provided to [redacted] on 12/28/2020 in the billed amount of $259.85.

This payment has been identified as an incorrect payment due to the following reason(s): This claim was reimbursed at an incorrect negotiated contract rate.

We would appreciate your refund of $37.13 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR21072311500064.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003548

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724039B
Amount Due: $93.10
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12002I7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $93.10 has been made for a Medi-Cal Member on claim number 210539525500. These services were provided to [redacted] on 01/18/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $93.10 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724039B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530022837

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724306B
Amount Due: $58.27
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/09/2021
Patient Account Number: C12003OA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $58.27 has been made for a Medi-Cal Member on claim number 210559524300. These services were provided to [redacted] on 01/25/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $58.27 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724306B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530023188

Enclosure(s)
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724247B
Amount Due: $37.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C1200HO7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.94 has been made for a Medi-Cal Member on claim number 210727596600. These services were provided to [redacted] on 02/01/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $37.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724247B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530023396

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724365B
Amount Due: $99.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C1200Z3U

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $99.04 has been made for a Medi-Cal Member on claim number 210776164200. These services were provided to [redacted] on 02/04/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $99.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724365B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530024236

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724257B
Amount Due: $61.51
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/02/2021
Patient Account Number: C1201SDF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.51 has been made for a Medi-Cal Member on claim number 210938064100. These services were provided to [redacted] on 02/10/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.51 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724257B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530025187

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724041B
Amount Due: $99.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/05/2021
Patient Account Number: C1201TOY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $99.04 has been made for a Medi-Cal Member on claim number 210959944300. These services were provided to [redacted] on 02/11/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $99.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724041B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530026038

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724424B
Amount Due: $61.51
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/26/2021
Patient Account Number: C1300XGO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.51 has been made for a Medi-Cal Member on claim number 211325951200. These services were provided to [redacted] on 03/11/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.51 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724424B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530022378

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724210B
Amount Due: $99.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/26/2021
Patient Account Number: C1300YIW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $99.04 has been made for a Medi-Cal Member on claim number 211326356200. These services were provided to [redacted] on 03/11/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $99.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724210B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530021396

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724364B
Amount Due: $37.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/13/2021
Patient Account Number: C1400AWW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.94 has been made for a Medi-Cal Member on claim number 211672901100. These services were provided to [redacted] on 04/01/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $37.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724364B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530021700

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723550B
Amount Due: $99.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/04/2021
Patient Account Number: C140143P

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $99.04 has been made for a Medi-Cal Member on claim number 212029902800. These services were provided to [redacted] on 04/21/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $99.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723550B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530026085

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723545B
Amount Due: $99.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/11/2021
Patient Account Number: C15002WA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $99.04 has been made for a Medi-Cal Member on claim number 212134696100. These services were provided to [redacted] on 04/26/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $99.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723545B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530022497

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724042B
Amount Due: $99.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/11/2021
Patient Account Number: C15002W9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $99.04 has been made for a Medi-Cal Member on claim number 212134731200. These services were provided to [redacted] on 04/26/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $99.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724042B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530026428

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723549B
Amount Due: $93.71
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/21/2020
Patient Account Number: C06012IB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $93.71 has been made for a Medi-Cal Member on claim number 000390547400. These services were provided to [redacted] on 06/08/2020 in the billed amount of $263.37.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $93.71 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723549B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530026004

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724259B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/11/2020
Patient Account Number: C0800G3G

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 203190450500. These services were provided to [redacted] on 07/13/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724259B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530027386

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724367B
Amount Due: $54.19
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/08/2020
Patient Account Number: C0900C92

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $54.19 has been made for a Medi-Cal Member on claim number 203616752000. These services were provided to [redacted] on 08/10/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $54.19 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724367B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530027654

Enclosure(s)
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723552B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0900C91

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 203616398300. These services were provided to [redacted] on 08/10/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723552B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530030864

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724545B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0900MMN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 203696257900. These services were provided to [redacted] on 08/20/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724545B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530025795

Enclosure(s)
Appeals-Provider/Hospita

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724258B
Amount Due: $84.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/25/2020
Patient Account Number: C0901212

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $84.11 has been made for a Medi-Cal Member on claim number 203768043000. These services were provided to [redacted] on 08/31/2020 in the billed amount of $223.37.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $84.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724258B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530026075

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724234B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0901211

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 203769027300. These services were provided to [redacted] on 08/31/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724234B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530021044

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724170B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/06/2020
Patient Account Number: C0902S4L

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204038882500. These services were provided to [redacted] on 09/14/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724170B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530025610

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723546B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/30/2020
Patient Account Number: C0902DVS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 203957979100. These services were provided to [redacted] on 09/16/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723546B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530023308

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724427B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0902H2C

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 203994799700. These services were provided to [redacted] on 09/17/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724427B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530025093

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724321B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0902O95

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204022265500. These services were provided to [redacted] on 09/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724321B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530025331

Enclosure(s)
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724574B
Amount Due: $76.50
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/06/2020
Patient Account Number: C0902U8K

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $76.50 has been made for a Medi-Cal Member on claim number 204053844600. These services were provided to [redacted] on 09/22/2020 in the billed amount of $180.22.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $76.50 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724574B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530026152

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724248B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/27/2020
Patient Account Number: C0A0224L

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204402978200. These services were provided to [redacted] on 10/05/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724248B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530024646

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723548B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/20/2020
Patient Account Number: C0A017DY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204262501700. These services were provided to [redacted] on 10/08/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723548B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530024011

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723495B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/27/2020
Patient Account Number: C0A01RIY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204358410900. These services were provided to [redacted] on 10/12/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723495B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530024441

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723553B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/27/2020
Patient Account Number: C0A01V8S

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204377561600. These services were provided to [redacted] on 10/12/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723553B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530031399

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724426B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/30/2020
Patient Account Number: C0A0297N

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204448476700. These services were provided to [redacted] on 10/19/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724426B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530024844

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724366B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02K57

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 204497625100. These services were provided to [redacted] on 10/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724366B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530025042

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724423B
Amount Due: $245.66
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/06/2020
Patient Account Number: C0B000YS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $245.66 has been made for a Medi-Cal Member on claim number 204561439300. These services were provided to [redacted] on 10/26/2020 in the billed amount of $368.00.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $245.66 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724423B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530021994

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724040B
Amount Due: $147.73
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00NOP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $147.73 has been made for a Medi-Cal Member on claim number 204679681900. These services were provided to [redacted] on 11/03/2020 in the billed amount of $350.01.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $147.73 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724040B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530023233

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724425B
Amount Due: $320.60
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/20/2020
Patient Account Number: C0B0137F

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $320.60 has been made for a Medi-Cal Member on claim number 204760301500. These services were provided to [redacted] on 11/04/2020 in the billed amount of $520.50.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $320.60 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724425B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530023488

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723551B
Amount Due: $54.19
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B015KF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $54.19 has been made for a Medi-Cal Member on claim number 204800043900. These services were provided to [redacted] on 11/09/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $54.19 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723551B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530028238

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723547B
Amount Due: $52.56
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B01K0G

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $52.56 has been made for a Medi-Cal Member on claim number 204845599100. These services were provided to [redacted] on 11/12/2020 in the billed amount of $184.39.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $52.56 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723547B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530023890

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724194B
Amount Due: $54.19
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B027TW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $54.19 has been made for a Medi-Cal Member on claim number 204970381100. These services were provided to [redacted] on 11/19/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $54.19 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724194B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530024342

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724038B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C01GGR

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $81.11 has been made for a Medi-Cal Member on claim number 205502217400. These services were provided to [redacted] on 12/14/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724038B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530021479

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724249B
Amount Due: $49.56
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C01JWX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $49.56 has been made for a Medi-Cal Member on claim number 205519338200. These services were provided to [redacted] on 12/17/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $49.56 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724249B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530028601

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271724256B
Amount Due: $49.56
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100FCG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $49.56 has been made for a Medi-Cal Member on claim number 210156224000. These services were provided to [redacted] on 12/31/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $49.56 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271724256B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530022259

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 29, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719148B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100P3N

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210266521100. These services were provided to [redacted] on 01/04/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719148B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650030345

Enclosure(s):

Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722317B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100HI7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210207375500. These services were provided to [redacted] on 01/05/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722317B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021944

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723137B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100HY3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210207376400. These services were provided to [redacted] on 01/06/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723137B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019556

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723152B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100P3O

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210267569100. These services were provided to [redacted] on 01/06/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723152B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000081

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722486B
Amount Due: $744.98
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100IDW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $744.98 has been made for a Medi-Cal Member on claim number 210193920500. These services were provided to [redacted] on 01/06/2021 in the billed amount of $1,173.99.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $744.98 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722486B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610010406

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719420B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100UT3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 210335208100. These services were provided to [redacted] on 01/07/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719420B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610027470

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719373B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100W1T

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210367015400. These services were provided to [redacted] on 01/07/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719373B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610019376

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720289B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100LHQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210244470700. These services were provided to [redacted] on 01/08/2021 in the billed amount of $189.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720289B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620013578

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721436B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100Z5W

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210391724100. These services were provided to [redacted] on 01/08/2021 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721436B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002927

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723166B
Amount Due: $25.31
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C11010T8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.31 has been made for a Medi-Cal Member on claim number 210426665800. These services were provided to [redacted] on 01/08/2021 in the billed amount of $342.62.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.31 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723166B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000059

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721433B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12000JJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210512162900. These services were provided to [redacted] on 01/11/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721433B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000144

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719150B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12000JK

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210512809400. These services were provided to [redacted] on 01/11/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719150B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211660001497

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719133B
Amount Due: $33.96
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12002NA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $33.96 has been made for a Medi-Cal Member on claim number 210538696700. These services were provided to [redacted] on 01/11/2021 in the billed amount of $233.83.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $33.96 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719133B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003527

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720277B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100TCZ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210315458100. These services were provided to [redacted] on 01/12/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720277B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610024497

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723465B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12004L8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210560264300. These services were provided to [redacted] on 01/13/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723465B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000681

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723115B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12004L9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210560896500. These services were provided to [redacted] on 01/13/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723115B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000014

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723097B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12002N6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210539493100. These services were provided to [redacted] on 01/14/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723097B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610018709

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271720133B
Amount Due: $40.50
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C1200BEE

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $40.50 has been made for a Medi-Cal Member on claim number 210666738800. These services were provided to [redacted] on 01/15/2021 in the billed amount of $259.85.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $40.50 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720133B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022326

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720094B
Amount Due: $68.21
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C11013BF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $68.21 has been made for a Medi-Cal Member on claim number 210444629300. These services were provided to [redacted] on 01/18/2021 in the billed amount of $1,211.45.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $68.21 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR#AR2107271720094B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610019379

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719124B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12001VR

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210539344900. These services were provided to [redacted] on 01/18/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719124B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000133

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271719461B
Amount Due: $37.22
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/26/2021
Patient Account Number: C12011VW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.22 has been made for a Medi-Cal Member on claim number 210813166300. These services were provided to [redacted] on 01/18/2021 in the billed amount of $115.00.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $37.22 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719461B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002953

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723114B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C11014H2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210445003000. These services were provided to [redacted] on 01/19/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723114B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000010

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723278B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C1200CDC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210667540800. These services were provided to [redacted] on 01/19/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723278B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620025154

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721361B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12004KY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210559610200. These services were provided to [redacted] on 01/20/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721361B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017130

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719421B
Amount Due: $134.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/09/2021
Patient Account Number: C12003RN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $134.47 has been made for a Medi-Cal Member on claim number 210560892200. These services were provided to [redacted] on 01/21/2021 in the billed amount of $135.83.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $134.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719421B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610029737

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722552B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C11017QH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210512540200. These services were provided to [redacted] on 01/22/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services not paid according to Medi-cal allowable.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722552B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000401

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego, CA 92004-2369

A/R Number: AR2107271723135B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/12/2021
Patient Account Number: C1300FV8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 211139993500. These services were provided to [redacted] on 01/22/2021 in the billed amount of $449.99.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723135B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018950

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719460B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C1200F99

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210683950500. These services were provided to [redacted] on 01/25/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719460B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002916

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721428B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12001AX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210513296200. These services were provided to [redacted] on 01/26/2021 in the billed amount of $189.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721428B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022610

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271723155B
Amount Due: $28.80
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/05/2021
Patient Account Number: C1201LKL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $28.80 has been made for a Medi-Cal Member on claim number 210896046800. These services were provided to [redacted] on 01/26/2021 in the billed amount of $311.13.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $28.80 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723155B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000221

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720158B
Amount Due: $59.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C12007RG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $59.88 has been made for a Medi-Cal Member on claim number 210667089000. These services were provided to [redacted] on 01/27/2021 in the billed amount of $60.48.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $59.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720158B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650011534

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721222B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/02/2021
Patient Account Number: C1201PV7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210920021200. These services were provided to [redacted] on 01/27/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721222B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000687

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723207B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C12009UX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210644177900. These services were provided to [redacted] on 01/28/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723207B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620009598

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P OBox 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719474B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C1200BBW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210667390600. These services were provided to [redacted] on 01/28/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719474B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000160

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719137B
Amount Due: $109.20
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C1200HXM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $109.20 has been made for a Medi-Cal Member on claim number 210727593300. These services were provided to [redacted] on 02/01/2021 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $109.20 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719137B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004132

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720120B
Amount Due: $33.96
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/16/2021
Patient Account Number: C1200GYH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $33.96 has been made for a Medi-Cal Member on claim number 210710660800. These services were provided to [redacted] on 02/02/2021 in the billed amount of $233.83.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $33.96 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720120B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014178

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720087B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C1200HXN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210727632500. These services were provided to [redacted] on 02/02/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720087B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610012177

Enclosure(s)
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721219B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C1200YPE

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210776095200. These services were provided to [redacted] on 02/03/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721219B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610010316

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721425B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C1200Z4L

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 210775750700. These services were provided to [redacted] on 02/04/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721425B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018509

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720145B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/16/2021
Patient Account Number: C1200GXM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210710297300. These services were provided to [redacted] on 02/05/2021 in the billed amount of $201.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720145B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003018

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723142B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C1200ZGO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210776143800. These services were provided to [redacted] on 02/05/2021 in the billed amount of $189.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723142B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022322

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723131B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/26/2021
Patient Account Number: C1201JAW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210872099900. These services were provided to [redacted] on 02/08/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723131B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017423

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722491B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C120103B

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210792474700. These services were provided to [redacted] on 02/09/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722491B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019927

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720291B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/19/2021
Patient Account Number: C120103A

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210793787800. These services were provided to [redacted] on 02/09/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720291B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014841

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723130B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/26/2021
Patient Account Number: C1201MGP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 210896880700. These services were provided to [redacted] on 02/09/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723130B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016865

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723126B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/26/2021
Patient Account Number: C1201MGN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 210897110500. These services were provided to [redacted] on 02/09/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723126B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620012949

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722488B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/02/2021
Patient Account Number: C1201TQM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210960053500. These services were provided to [redacted] on 02/11/2021 in the billed amount of $201.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722488B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610029727

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723143B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/09/2021
Patient Account Number: C130081J

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 211074436600. These services were provided to [redacted] on 02/14/2021 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723143B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022529

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721449B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/02/2021
Patient Account Number: C1201V3Z

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210959661100. These services were provided to [redacted] on 02/15/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721449B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000183

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722313B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/02/2021
Patient Account Number: C1201V41

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 210960000000. These services were provided to [redacted] on 02/16/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722313B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610019659

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723160B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/26/2021
Patient Account Number: C1201N82

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210897072900. These services were provided to [redacted] on 02/17/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723160B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003116

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719131B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/26/2021
Patient Account Number: C1201MYJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210897077100. These services were provided to [redacted] on 02/17/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719131B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002988

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723161B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/05/2021
Patient Account Number: C13000IK

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210991722300. These services were provided to [redacted] on 02/18/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723161B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003236

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723124B
Amount Due: $105.14
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/18/2020
Patient Account Number: C090125W

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $105.14 has been made for a Medi-Cal Member on claim number 203768450300. These services were provided to [redacted] on 02/19/2020 in the billed amount of $565.61.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $105.14 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723124B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620011799

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720273B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/02/2021
Patient Account Number: C1201SI4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210939473300. These services were provided to [redacted] on 02/19/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720273B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610020865

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721430B
Amount Due: $28.69
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/09/2021
Patient Account Number: C1300B9S

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $28.69 has been made for a Medi-Cal Member on claim number 211072811100. These services were provided to [redacted] on 02/23/2021 in the billed amount of $225.61.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $28.69 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721430B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620026254

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721450B
Amount Due: $434.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/30/2021
Patient Account Number: C13012IR

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $434.94 has been made for a Medi-Cal Member on claim number 211385309200. These services were provided to [redacted] on 02/23/2021 in the billed amount of $1,213.18.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $434.94 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721450B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000199

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722316B
Amount Due: $59.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/05/2021
Patient Account Number: C13006O7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $59.88 has been made for a Medi-Cal Member on claim number 211041792400. These services were provided to [redacted] on 02/24/2021 in the billed amount of $60.48.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $59.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722316B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017140

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723466B
Amount Due: $36.39
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/09/2021
Patient Account Number: C13006O8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $36.39 has been made for a Medi-Cal Member on claim number 211042063700. These services were provided to [redacted] on 02/24/2021 in the billed amount of $187.71.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $36.39 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723466B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014939

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719437B
Amount Due: $39.57
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/16/2021
Patient Account Number: C1300K75

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $39.57 has been made for a Medi-Cal Member on claim number 211185585800. These services were provided to [redacted] on 03/02/2021 in the billed amount of $281.06.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $39.57 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719437B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016711

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719455B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/19/2021
Patient Account Number: C1300S1L

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 211283297500. These services were provided to [redacted] on 03/02/2021 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719455B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000120

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723162B
Amount Due: $39.07
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300K73

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $39.07 has been made for a Medi-Cal Member on claim number 211185253800. These services were provided to [redacted] on 03/02/2021 in the billed amount of $198.16.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $39.07 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723162B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003263

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723144B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/12/2021
Patient Account Number: C1300G5Q

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211140778800. These services were provided to [redacted] on 03/03/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723144B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022533

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722012B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/16/2021
Patient Account Number: C1300M6O

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 211208512500. These services were provided to [redacted] on 03/03/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722012B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610019721

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723136B
Amount Due: $45.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/19/2021
Patient Account Number: C1300TOD

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $45.82 has been made for a Medi-Cal Member on claim number 211283791400. These services were provided to [redacted] on 03/04/2021 in the billed amount of $189.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $45.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723136B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018954

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721441B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/19/2021
Patient Account Number: C1300TOC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211283809500. These services were provided to [redacted] on 03/04/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721441B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003167

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720095B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/12/2021
Patient Account Number: C1300G5R

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211140321900. These services were provided to [redacted] on 03/05/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720095B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610019971

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721227B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300V2N

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 211306206100. These services were provided to [redacted] on 03/08/2021 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721227B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003969

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722015B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300XIO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211326414800. These services were provided to [redacted] on 03/10/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722015B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017681

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720294B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300YJW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 211326021200. These services were provided to [redacted] on 03/11/2021 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720294B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017168

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723129B
Amount Due: $37.13
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300YJX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.13 has been made for a Medi-Cal Member on claim number 211326432700. These services were provided to [redacted] on 03/11/2021 in the billed amount of $259.85.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $37.13 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723129B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016549

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722170B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/23/2021
Patient Account Number: C1300XIP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211326467900. These services were provided to [redacted] on 03/11/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722170B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000699

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721226B
Amount Due: $65.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/26/2021
Patient Account Number: C130112X

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $65.41 has been made for a Medi-Cal Member on claim number 211363130900. These services were provided to [redacted] on 03/15/2021 in the billed amount of $108.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $65.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721226B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000199

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723111B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/26/2021
Patient Account Number: C13012IP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211389439400. These services were provided to [redacted] on 03/15/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723111B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610029912

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721455B
Amount Due: $57.27
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/30/2021
Patient Account Number: C13013AC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $57.27 has been made for a Medi-Cal Member on claim number 211385205700. These services were provided to [redacted] on 03/15/2021 in the billed amount of $452.28.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $57.27 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721455B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650014178

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723467B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/30/2021
Patient Account Number: C13017DB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 211429288100. These services were provided to [redacted] on 03/16/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723467B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018551

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271723167B
Amount Due: $96.62
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/18/2020
Patient Account Number: C090125Y

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $96.62 has been made for a Medi-Cal Member on claim number 203768008600. These services were provided to [redacted] on 03/18/2020 in the billed amount of $491.04.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $96.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723167B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000180

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721394B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/30/2021
Patient Account Number: C1301AWK

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211453390800. These services were provided to [redacted] on 03/18/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721394B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000249

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719438B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/30/2021
Patient Account Number: C1301AWG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 211453675100. These services were provided to [redacted] on 03/18/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719438B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017801

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721220B
Amount Due: $264.15
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/02/2021
Patient Account Number: C1301EIR

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $264.15 has been made for a Medi-Cal Member on claim number 211507613500. These services were provided to [redacted] on 03/22/2021 in the billed amount of $825.71.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $264.15 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721220B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610020014

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721456B
Amount Due: $665.05
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/02/2021
Patient Account Number: C1301EIQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $665.05 has been made for a Medi-Cal Member on claim number 211507706500. These services were provided to [redacted] on 03/22/2021 in the billed amount of $1,586.47.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $665.05 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721456B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650015710

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722071B
Amount Due: $61.66
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/06/2021
Patient Account Number: C1301HM8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.66 has been made for a Medi-Cal Member on claim number 211548082300. These services were provided to [redacted] on 03/24/2021 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.66 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722071B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016212

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723123B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/06/2021
Patient Account Number: C1301HM7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211548533000. These services were provided to [redacted] on 03/24/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723123B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620010994

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720278B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/06/2021
Patient Account Number: C14001JI

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211547853500. These services were provided to [redacted] on 03/25/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720278B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610030608

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722495B
Amount Due: $59.40
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/09/2021
Patient Account Number: C14009OO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $59.40 has been made for a Medi-Cal Member on claim number 211654153100. These services were provided to [redacted] on 03/26/2021 in the billed amount of $350.84.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $59.40 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722495B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650002523

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720160B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/09/2021
Patient Account Number: C14005M7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 211609482700. These services were provided to [redacted] on 03/31/2021 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720160B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650017154

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723146B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/09/2021
Patient Account Number: C14005M5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 211610165500. These services were provided to [redacted] on 03/31/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723146B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620026550

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719453B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/09/2021
Patient Account Number: C14007UT

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211629703200. These services were provided to [redacted] on 03/31/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719453B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000100

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723128B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/13/2021
Patient Account Number: C1400CB0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211694342800. These services were provided to [redacted] on 04/01/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723128B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016114

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720117B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/13/2021
Patient Account Number: C1400CB2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211694572900. These services were provided to [redacted] on 04/01/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720117B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620012005

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721442B
Amount Due: $61.66
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/13/2021
Patient Account Number: C1400D5Y

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.66 has been made for a Medi-Cal Member on claim number 211694399100. These services were provided to [redacted] on 04/02/2021 in the billed amount of $130.43.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.66 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721442B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003213

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719135B
Amount Due: $61.66
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/16/2021
Patient Account Number: C1400EPA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.66 has been made for a Medi-Cal Member on claim number 211728072600. These services were provided to [redacted] on 04/06/2021 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.66 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719135B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003923

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720135B
Amount Due: $61.66
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/20/2021
Patient Account Number: C1400HRT

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.66 has been made for a Medi-Cal Member on claim number 211805490500. These services were provided to [redacted] on 04/07/2021 in the billed amount of $130.43.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.66 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720135B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620023360

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719465B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/23/2021
Patient Account Number: C1400P94

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211852865300. These services were provided to [redacted] on 04/08/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719465B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003385

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723210B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/20/2021
Patient Account Number: C1400KZV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 211793495400. These services were provided to [redacted] on 04/09/2021 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723210B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000171

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720265B
Amount Due: $130.42
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/23/2021
Patient Account Number: C1400TKJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $130.42 has been made for a Medi-Cal Member on claim number 211897985300. These services were provided to [redacted] on 04/12/2021 in the billed amount of $174.19.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $130.42 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720265B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610012828

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719125B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/27/2021
Patient Account Number: C1400VYC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 211919743900. These services were provided to [redacted] on 04/12/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719125B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000135

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723307B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/27/2021
Patient Account Number: C1400VYD

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 211920410300. These services were provided to [redacted] on 04/12/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723307B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610030689

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723168B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/27/2021
Patient Account Number: C1400VYF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 211920250100. These services were provided to [redacted] on 04/13/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723168B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000253

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719134B
Amount Due: $61.66
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/27/2021
Patient Account Number: C1400VAI

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.66 has been made for a Medi-Cal Member on claim number 211919706400. These services were provided to [redacted] on 04/14/2021 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.66 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719134B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003664

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721424B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/30/2021
Patient Account Number: C1400Z6U

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 211982607900. These services were provided to [redacted] on 04/15/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721424B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018461

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719141B
Amount Due: $36.69
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/30/2021
Patient Account Number: C14010DC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $36.69 has been made for a Medi-Cal Member on claim number 211981176000. These services were provided to [redacted] on 04/16/2021 in the billed amount of $400.29.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $36.69 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719141B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000107

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722487B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/30/2021
Patient Account Number: C14010U7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 212012196700. These services were provided to [redacted] on 04/19/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722487B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610020638

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723153B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/30/2021
Patient Account Number: C140144Y

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 212030458600. These services were provided to [redacted] on 04/21/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723153B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000156

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723138B
Amount Due: $261.91
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/07/2021
Patient Account Number: C14017ML

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $261.91 has been made for a Medi-Cal Member on claim number 212078742200. These services were provided to [redacted] on 04/22/2021 in the billed amount of $486.73.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $261.91 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723138B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620020240

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720096B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/07/2021
Patient Account Number: C15002YI

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 212134420400. These services were provided to [redacted] on 04/26/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720096B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610020434

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723147B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/07/2021
Patient Account Number: C15002YO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 212134517300. These services were provided to [redacted] on 04/27/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723147B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620026686

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723116B
Amount Due: $45.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/11/2021
Patient Account Number: C1500BCS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $45.82 has been made for a Medi-Cal Member on claim number 212205327200. These services were provided to [redacted] on 04/27/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $45.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723116B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620002112

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720098B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/11/2021
Patient Account Number: C15007Z9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 212179196100. These services were provided to [redacted] on 04/29/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720098B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610020986

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720116B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/14/2021
Patient Account Number: C1500CAQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 212237837200. These services were provided to [redacted] on 04/30/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720116B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620011617

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723148B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/14/2021
Patient Account Number: C1500CVN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 212259162300. These services were provided to [redacted] on 05/03/2021 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723148B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620026843

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723109B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/14/2021
Patient Account Number: C1500CX7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 212260208700. These services were provided to [redacted] on 05/03/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723109B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610025508

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721362B
Amount Due: $59.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/14/2021
Patient Account Number: C1500GG7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $59.88 has been made for a Medi-Cal Member on claim number 212289102300. These services were provided to [redacted] on 05/04/2021 in the billed amount of $60.48.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $59.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721362B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021910

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720113B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/14/2021
Patient Account Number: C1500CX8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 212260530700. These services were provided to [redacted] on 05/05/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720113B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620004962

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720576B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/25/2021
Patient Account Number: C16018ZN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 213049151800. These services were provided to [redacted] on 06/08/2021 in the billed amount of $318.96.

This payment has been identified as an incorrect payment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107271720576B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211820044219

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723165B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/07/2020
Patient Account Number: C060189Q

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203100917700. These services were provided to [redacted] on 06/10/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723165B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000044

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720155B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/18/2020
Patient Account Number: C09015BF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203797106400. These services were provided to [redacted] on 06/17/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720155B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000342

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722558B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/04/2020
Patient Account Number: C0702F3D

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203046797000. These services were provided to [redacted] on 07/01/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722558B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000106

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722490B
Amount Due: $8.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 08/14/2020
Patient Account Number: C0800S64

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.33 has been made for a Medi-Cal Member on claim number 203237583600. These services were provided to [redacted] on 07/10/2020 in the billed amount of $8.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $8.33 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722490B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620013509

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721426B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 07/31/2020
Patient Account Number: C0702K9J

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203067101700. These services were provided to [redacted] on 07/13/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721426B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019048

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721448B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/11/2020
Patient Account Number: C0800G45

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203190515700. These services were provided to [redacted] on 07/13/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721448B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000123

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719443B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/04/2020
Patient Account Number: C0702M4J

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203085432000. These services were provided to [redacted] on 07/16/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719443B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019241

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720100B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/11/2020
Patient Account Number: C0800C6C

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203172255200. These services were provided to [redacted] on 07/16/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720100B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610021684

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720089B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/11/2020
Patient Account Number: C0800HQI

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203189740800. These services were provided to [redacted] on 07/16/2020 in the billed amount of $223.37.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720089B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610014407

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721223B
Amount Due: $126.99
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800UK2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $126.99 has been made for a Medi-Cal Member on claim number 203237920200. These services were provided to [redacted] on 07/16/2020 in the billed amount of $196.26.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $126.99 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721223B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620011079

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720282B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/11/2020
Patient Account Number: C0800IQ8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203190298300. These services were provided to [redacted] on 07/20/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720282B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000646

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723169B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/07/2020
Patient Account Number: C08005CT

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 203138240300. These services were provided to [redacted] on 07/21/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723169B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000302

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720157B
Amount Due: $8.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800M3M

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.33 has been made for a Medi-Cal Member on claim number 203209483700. These services were provided to [redacted] on 07/21/2020 in the billed amount of $8.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $8.33 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720157B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650004831

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723122B
Amount Due: $523.02
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800KHI

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $523.02 has been made for a Medi-Cal Member on claim number 203209487000. These services were provided to [redacted] on 07/21/2020 in the billed amount of $1,023.77.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $523.02 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723122B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620010013

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723104B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800M3L

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203209645900. These services were provided to [redacted] on 07/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723104B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610022710

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719428B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800OYU

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203209546600. These services were provided to [redacted] on 07/22/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719428B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620006369

Enclosure(s):

Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721454B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/04/2020
Patient Account Number: C0702O0V

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203086010900. These services were provided to [redacted] on 07/23/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721454B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650013668

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720085B
Amount Due: $65.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 07/31/2020
Patient Account Number: C0702IQZ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $65.41 has been made for a Medi-Cal Member on claim number 203064729900. These services were provided to [redacted] on 07/24/2020 in the billed amount of $108.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $65.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720085B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610000566

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721224B
Amount Due:$23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800VRL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203258861600. These services were provided to [redacted] on 07/27/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721224B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019567

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720295B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/04/2020
Patient Account Number: C0702PX2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203101185500. These services were provided to [redacted] on 07/28/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720295B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017614

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722013B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/07/2020
Patient Account Number: C0702PPF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203101799900. These services were provided to [redacted] on 07/28/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722013B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000013

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719457B
Amount Due: $65.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/07/2020
Patient Account Number: C08005I7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $65.41 has been made for a Medi-Cal Member on claim number 203133505300. These services were provided to [redacted] on 07/28/2020 in the billed amount of $108.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $65.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719457B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000193

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723145B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/07/2020
Patient Account Number: C08002MZ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 203135480400. These services were provided to [redacted] on 07/29/2020 in the billed amount of $223.37.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723145B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620023654

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271718527B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/18/2020
Patient Account Number: C080132J

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203278067000. These services were provided to [redacted] on 07/29/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271718527B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610023034

Enclosure(s)
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723154B
Amount Due: $76.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/07/2020
Patient Account Number: C08007F5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $76.04 has been made for a Medi-Cal Member on claim number 203156151400. These services were provided to [redacted] on 07/30/2020 in the billed amount of $358.23.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $76.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723154B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000175

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722492B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800PX1

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203237459600. These services were provided to [redacted] on 07/30/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722492B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620023841

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720115B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/18/2020
Patient Account Number: C080132M

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203278061900. These services were provided to [redacted] on 07/30/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720115B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620006792

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723117B
Amount Due: $224.14
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/21/2020
Patient Account Number: C0801CLS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $224.14 has been made for a Medi-Cal Member on claim number 203316032700. These services were provided to [redacted] on 07/31/2020 in the billed amount of $432.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $224.14 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723117B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620003218

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719130B
Amount Due: $16.65
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/14/2020
Patient Account Number: C0800YBW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $16.65 has been made for a Medi-Cal Member on claim number 203259133300. These services were provided to [redacted] on 08/03/2020 in the billed amount of $16.82.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $16.65 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719130B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002875

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720162B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0900KT8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203672671900. These services were provided to [redacted] on 08/03/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720162B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650022182

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721421B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0900KT9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203673509900. These services were provided to [redacted] on 08/03/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721421B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620003323

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720136B
Amount Due: $8.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/25/2020
Patient Account Number: C0801VZM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.33 has been made for a Medi-Cal Member on claim number 203398371300. These services were provided to [redacted] on 08/05/2020 in the billed amount of $8.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $8.33 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720136B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620024010

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719458B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/15/2020
Patient Account Number: C0900QPA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203696660700. These services were provided to [redacted] on 08/06/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719458B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000216

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720281B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/25/2020
Patient Account Number: C0801W81

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203398476600. These services were provided to [redacted] on 08/07/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Duplicate payment services previously paid.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720281B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000204

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719378B
Amount Due: $59.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/04/2020
Patient Account Number: C0802LPG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $59.88 has been made for a Medi-Cal Member on claim number 203530850900. These services were provided to [redacted] on 08/07/2020 in the billed amount of $104.55.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $59.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719378B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610022413

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723209B
Amount Due: $8.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/08/2020
Patient Account Number: C0900CCN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.33 has been made for a Medi-Cal Member on claim number 203616938800. These services were provided to [redacted] on 08/10/2020 in the billed amount of $8.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $8.33 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723209B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021301

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723164B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/08/2020
Patient Account Number: C0900CCG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203616936200. These services were provided to [redacted] on 08/11/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723164B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000017

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271719377B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12000L0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 210512575500. These services were provided to [redacted] on 08/12/2020 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719377B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610022099

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719138B
Amount Due: $105.46
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0900EXJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $105.46 has been made for a Medi-Cal Member on claim number 203634364300. These services were provided to [redacted] on 08/17/2020 in the billed amount of $326.17.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $105.46 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719138B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004136

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723150B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 08/28/2020
Patient Account Number: C08029IV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203472200800. These services were provided to [redacted] on 08/18/2020 in the billed amount of $130.43.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723150B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000050

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271723149B
Amount Due: $82.80
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/15/2020
Patient Account Number: C0900MQL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $82.80 has been made for a Medi-Cal Member on claim number 203697469900. These services were provided to [redacted] on 08/18/2020 in the billed amount of $269.01.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $82.80 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723149B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620027185

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723119B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/15/2020
Patient Account Number: C0900MPL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203697199800. These services were provided to [redacted] on 08/20/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723119B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620003928

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720161B
Amount Due: $134.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0900KS5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $134.47 has been made for a Medi-Cal Member on claim number 203673028900. These services were provided to [redacted] on 08/24/2020 in the billed amount of $135.83.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $134.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720161B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650019386

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722355B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0900KRZ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203673066400. These services were provided to [redacted] on 08/24/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722355B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004068

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271719372B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/11/2020
Patient Account Number: C0900KTB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 203673566300. These services were provided to [redacted] on 08/24/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719372B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610019074

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723105B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/18/2020
Patient Account Number: C0900VVF

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203727311200. These services were provided to [redacted] on 08/24/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723105B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610023297

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721422B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 09/18/2020
Patient Account Number: C09017ZB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203797107200. These services were provided to [redacted] on 08/27/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721422B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016099

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720137B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/18/2020
Patient Account Number: C0900ZBU

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203771087200. These services were provided to [redacted] on 08/28/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720137B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620024230

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719435B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/18/2020
Patient Account Number: C090122T

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203771553500. These services were provided to [redacted] on 08/31/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719435B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620013953

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722315B
Amount Due: $8.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/22/2020
Patient Account Number: C0901HMK

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.33 has been made for a Medi-Cal Member on claim number 203831787700. These services were provided to [redacted] on 09/02/2020 in the billed amount of $8.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $8.33 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722315B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620011057

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Womens Health And Wellness Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720280B
Amount Due: $126.99
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/22/2020
Patient Account Number: C0901FDW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $126.99 has been made for a Medi-Cal Member on claim number 203831310400. These services were provided to [redacted] on 09/03/2020 in the billed amount of $196.26.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $126.99 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720280B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000077

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723311B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/25/2020
Patient Account Number: C0901Q4W

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 203887277200. These services were provided to [redacted] on 09/08/2020 in the billed amount of $223.37.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723311B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620024482

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721443B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/25/2020
Patient Account Number: C0901SHB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 203905567900. These services were provided to [redacted] on 09/08/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721443B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003421

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719122B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/25/2020
Patient Account Number: C0901TYJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 203906202600. These services were provided to [redacted] on 09/09/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719122B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000122

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723170B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/25/2020
Patient Account Number: C0901V5U

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 203906248700. These services were provided to [redacted] on 09/09/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723170B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211660001660

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271723158B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/29/2020
Patient Account Number: C09028A8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 203942365800. These services were provided to [redacted] on 09/10/2020 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723158B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002823

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719433B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0902LX8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204022085600. These services were provided to [redacted] on 09/10/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719433B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620011647

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723106B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0902LX5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204022948300. These services were provided to [redacted] on 09/10/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723106B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610023530

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723312B
Amount Due: $34.34
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/25/2020
Patient Account Number: C09021RH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $34.34 has been made for a Medi-Cal Member on claim number 203924486500. These services were provided to [redacted] on 09/11/2020 in the billed amount of $167.17.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $34.34 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723312B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000223

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720091B
Amount Due: $362.95
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/30/2020
Patient Account Number: C0902H5P

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $362.95 has been made for a Medi-Cal Member on claim number 203991534600. These services were provided to [redacted] on 09/14/2020 in the billed amount of $1,319.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $362.95 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720091B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610015389

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Womens Health And Wellness Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722016B
Amount Due: $65.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/25/2020
Patient Account Number: C0901U7W

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $65.41 has been made for a Medi-Cal Member on claim number 203903260100. These services were provided to [redacted] on 09/15/2020 in the billed amount of $108.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $65.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722016B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620024813

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719158B
Amount Due: $506.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/29/2020
Patient Account Number: C0902B0O

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $506.04 has been made for a Medi-Cal Member on claim number 203956059100. These services were provided to [redacted] on 09/15/2020 in the billed amount of $1,145.64

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $506.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719158B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211670028237

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722494B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/29/2020
Patient Account Number: C0902CN1

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 203957517200. These services were provided to [redacted] on 09/16/2020 in the billed amount of $223.37.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722494B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004117

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721434B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/06/2020
Patient Account Number: C0A001CZ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 204053917500. These services were provided to [redacted] on 09/16/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721434B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000154

Enclosure(s):
Appeals-Provider/Hospital

MEDI-CAL PROVIDER DISPUTE RESOLUTION:

If you disagree with this payment/denial decision, you may file a formal dispute in writing to Blue Shield of California Promise Health Plan, at the address listed below, within 365 calendar days of the last payment/denial decision.

Blue Shield of California Promise Health Plan
ATTN: Provider Dispute Dept.
P.O. Box 3829
Montebello, CA 90640

If you have questions about your claim, you should contact Provider Customer Care by calling (800) 468-9935.

Prov_19_071_CR

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721429B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/30/2020
Patient Account Number: C0902H5S

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203994471900. These services were provided to [redacted] on 09/17/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721429B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022853

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719140B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/30/2020
Patient Account Number: C0902H5R

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 203996132300. These services were provided to [redacted] on 09/17/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719140B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000027

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720293B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0902KZ4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204022502800. These services were provided to [redacted] on 09/17/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720293B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620016586

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723163B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/09/2020
Patient Account Number: C0A00D8Q

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 204102750000. These services were provided to [redacted] on 09/18/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723163B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004009

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723159B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 01/12/2021
Patient Account Number: C11006QX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 210093917500. These services were provided to [redacted] on 09/21/2020 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723159B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003114

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719365B
Amount Due: $60.95
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/02/2020
Patient Account Number: C0902KCB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $60.95 has been made for a Medi-Cal Member on claim number 204019286300. These services were provided to [redacted] on 09/21/2020 in the billed amount of $309.87.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $60.95 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719365B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610010663

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Womens Health and Wellness Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722493B
Amount Due: $65.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/30/2020
Patient Account Number: C0902HZL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $65.41 has been made for a Medi-Cal Member on claim number 203992720100. These services were provided to [redacted] on 09/22/2020 in the billed amount of $108.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $65.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722493B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000206

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723110B
Amount Due: $8.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/06/2020
Patient Account Number: C0A001BV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.33 has been made for a Medi-Cal Member on claim number 204054616200. These services were provided to [redacted] on 09/22/2020 in the billed amount of $8.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $8.33 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723110B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610029408

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Womens Health and Wellness Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719441B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/30/2020
Patient Account Number: C0902HZP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 203990870500. These services were provided to [redacted] on 09/23/2020 in the billed amount of $130.43.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719441B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018407

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723156B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/06/2020
Patient Account Number: C0A001BX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 204055699200. These services were provided to [redacted] on 09/23/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723156B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000232

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723309B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/09/2020
Patient Account Number: C0A00NQ2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204148347600. These services were provided to [redacted] on 09/28/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723309B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014230

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271718533B
Amount Due: $411.14
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/13/2020
Patient Account Number: C0A00NPW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $411.14 has been made for a Medi-Cal Member on claim number 204144938100. These services were provided to [redacted] on 09/28/2020 in the billed amount of $1,012.77.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $411.14 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271718533B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000112

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719145B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/09/2020
Patient Account Number: C0A00NQ3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204148460500. These services were provided to [redacted] on 09/29/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719145B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000206

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721427B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/13/2020
Patient Account Number: C0A00NPZ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204148669900. These services were provided to [redacted] on 09/29/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721427B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021529

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720297B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/13/2020
Patient Account Number: C0A00VG1

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 204184078200. These services were provided to [redacted] on 10/01/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720297B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018230

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719380B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/13/2020
Patient Account Number: C0A00VG0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204182441900. These services were provided to [redacted] on 10/05/2020 in the billed amount of $223.37.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719380B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610023587

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Womens Health and Wellness Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719479B
Amount Due: $88.67
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/20/2020
Patient Account Number: C0A017R0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $88.67 has been made for a Medi-Cal Member on claim number 204261596600. These services were provided to [redacted] on 10/05/2020 in the billed amount of $274.89.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $88.67 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719479B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000563

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719475B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01T98

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 204359578100. These services were provided to [redacted] on 10/05/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719475B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000195

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723141B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/16/2020
Patient Account Number: C0A011TN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204226509600. These services were provided to [redacted] on 10/06/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723141B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022317

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723276B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/16/2020
Patient Account Number: C0A014QO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 204240257700. These services were provided to [redacted] on 10/07/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723276B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620012130

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723107B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/20/2020
Patient Account Number: C0A0174O

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204262735200. These services were provided to [redacted] on 10/08/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723107B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610023962

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Womens Health and Wellness Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723468B
Amount Due: $97.07
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01CA2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $97.07 has been made for a Medi-Cal Member on claim number 204278922600. These services were provided to [redacted] on 10/08/2020 in the billed amount of $191.05.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $97.07 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723468B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000058

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721229B
Amount Due: $22.08
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01HH2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $22.08 has been made for a Medi-Cal Member on claim number 204300866300. These services were provided to [redacted] on 10/08/2020 in the billed amount of $125.12.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $22.08 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721229B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650019742

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719470B
Amount Due: $65.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01QKX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $65.41 has been made for a Medi-Cal Member on claim number 204339810000. These services were provided to [redacted] on 10/12/2020 in the billed amount of $108.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $65.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719470B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004069

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720156B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01RJ4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 204359857300. These services were provided to [redacted] on 10/12/2020 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720156B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650002362

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721445B
Amount Due: $349.40
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/27/2020
Patient Account Number: C0A01V9G

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $349.40 has been made for a Medi-Cal Member on claim number 204376293000. These services were provided to [redacted] on 10/12/2020 in the billed amount of $776.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $349.40 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721445B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004154

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719456B
Amount Due: $79.89
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02K5Y

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $79.89 has been made for a Medi-Cal Member on claim number 204492904500. These services were provided to [redacted] on 10/12/2020 in the billed amount of $868.44.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $79.89 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719456B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000131

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719445B
Amount Due: $63.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01TFG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $63.47 has been made for a Medi-Cal Member on claim number 204358834200. These services were provided to [redacted] on 10/13/2020 in the billed amount of $82.48.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $63.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719445B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019918

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723140B
Amount Due: $71.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/27/2020
Patient Account Number: C0A01WGV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $71.47 has been made for a Medi-Cal Member on claim number 204376076400. These services were provided to [redacted] on 10/13/2020 in the billed amount of $482.60.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $71.47 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723140B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021748

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Los Angeles, CA 92004-2369

A/R Number: AR2107271723102B
Amount Due: $54.91
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/10/2020
Patient Account Number: C0B009AH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $54.91 has been made for a Medi-Cal Member on claim number 204585649100. These services were provided to [redacted] on 10/13/2020 in the billed amount of $254.12.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $54.91 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723102B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610021336

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721221B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/23/2020
Patient Account Number: C0A01YS3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 204377685800. These services were provided to [redacted] on 10/14/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721221B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610025723

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720130B
Amount Due: $40.50
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02TIP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $40.50 has been made for a Medi-Cal Member on claim number 204515025900. These services were provided to [redacted] on 10/15/2020 in the billed amount of $259.85.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $40.50 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720130B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620020297

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720097B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/06/2020
Patient Account Number: C0A02WRW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 204534424100. These services were provided to [redacted] on 10/19/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720097B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610020867

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720153B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/06/2020
Patient Account Number: C0A02XYR

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 204534856700. These services were provided to [redacted] on 10/19/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720153B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000030

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271722489B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12000L3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210512219500. These services were provided to [redacted] on 10/20/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722489B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000904

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723127B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/30/2020
Patient Account Number: C0A02CEE

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 204448816500. These services were provided to [redacted] on 10/20/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723127B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014497

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723139B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/12/2021
Patient Account Number: C0A02Y73

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210266347400. These services were provided to [redacted] on 10/21/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723139B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021703

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722312B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/30/2020
Patient Account Number: C0A02B7H

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 204449169900. These services were provided to [redacted] on 10/21/2020 in the billed amount of $328.85.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722312B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610011039

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720118B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02THV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204514637100. These services were provided to [redacted] on 10/22/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720118B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620012543

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271721452B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02WS0

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 204534999900. These services were provided to [redacted] on 10/23/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721452B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000348

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723108B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02XYU

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204534398000. These services were provided to [redacted] on 10/26/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723108B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610024416

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720269B
Amount Due: $59.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02XYW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $59.88 has been made for a Medi-Cal Member on claim number 204534502400. These services were provided to [redacted] on 10/26/2020 in the billed amount of $104.55.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $59.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720269B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610015906

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722458B
Amount Due: $207.06
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/06/2020
Patient Account Number: C0A02XYX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $207.06 has been made for a Medi-Cal Member on claim number 204533965100. These services were provided to [redacted] on 10/26/2020 in the billed amount of $858.31.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $207.06 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722458B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211670027420

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722014B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/10/2020
Patient Account Number: C0B00M50

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 204643519300. These services were provided to [redacted] on 10/27/2020 in the billed amount of $130.43.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722014B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620011983

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723305B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00NS4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 204680731000. These services were provided to [redacted] on 10/27/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723305B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610010930

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271719121B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/10/2020
Patient Account Number: C0B00LLN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 204644860200. These services were provided to [redacted] on 10/28/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719121B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000119

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720296B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00YIM

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 204718692700. These services were provided to [redacted] on 10/28/2020 in the billed amount of $326.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720296B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017983

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719375B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/20/2020
Patient Account Number: C0B01K6M

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 204844523700. These services were provided to [redacted] on 10/28/2020 in the billed amount of $515.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719375B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610021661

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719473B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/10/2020
Patient Account Number: C0B00FI6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204627067400. These services were provided to [redacted] on 10/29/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719473B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000036

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

August 3, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271723277B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/20/2020
Patient Account Number: C0B01K6N

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 204847114000. These services were provided to [redacted] on 10/30/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723277B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017715

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720125B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00NQK

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 204680787200. These services were provided to [redacted] on 11/02/2020 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720125B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017781

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271718540B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00NQL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 204681590500. These services were provided to [redacted] on 11/02/2020 in the billed amount of $140.32

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271718540B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650021691

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720119B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00NQO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204680774800. These services were provided to [redacted] on 11/03/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720119B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620013214

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720093B
Amount Due: $16.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00VHY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $16.55 has been made for a Medi-Cal Member on claim number 204699066600. These services were provided to [redacted] on 11/03/2020 in the billed amount of $75.00.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $16.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720093B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610016485

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719425B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/13/2020
Patient Account Number: C0B00XHB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 204718082600. These services were provided to [redacted] on 11/03/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719425B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610037703

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720105B
Amount Due: $77.69
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B01385

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $$77.69 has been made for a Medi-Cal Member on claim number 204760169600. These services were provided to [redacted] on 11/04/2020 in the billed amount of $379.75.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $77.69 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720105B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610027468

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723118B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12000L4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210513209300. These services were provided to [redacted] on 11/11/2020 in the billed amount of $579.50.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723118B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620003545

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720142B
Amount Due: $25.31
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/20/2020
Patient Account Number: C0B017ZB

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.31 has been made for a Medi-Cal Member on claim number 204821201700. These services were provided to [redacted] on 11/11/2020 in the billed amount of $364.62.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.31 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720142B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000148

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720101B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/20/2020
Patient Account Number: C0B017ZC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204825449100. These services were provided to [redacted] on 11/11/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720101B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610024224

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722496B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/20/2020
Patient Account Number: C0B01BBE

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204825860200. These services were provided to [redacted] on 11/11/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722496B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650022748

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271723157B
Amount Due: $50.68
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C000YV

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $50.68 has been made for a Medi-Cal Member on claim number 205036628000. These services were provided to [redacted] on 11/13/2020 in the billed amount of $484.38.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $50.68 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723157B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000239

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720275B
Amount Due: $23.30
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C002L1

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.30 has been made for a Medi-Cal Member on claim number 205041919700. This overpaid amount includes interest of $0.04. These services were provided to [redacted] on 11/13/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.30 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107271720275B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610022028

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271721225B
Amount Due: $25.97
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C000YY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.97 has been made for a Medi-Cal Member on claim number 205042771000. This overpaid amount includes interest of $0.05. These services were provided to [redacted] on 11/13/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.97 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107271721225B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620022002

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O BOX 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720127B
Amount Due: $37.13
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C12000L5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $37.13 has been made for a Medi-Cal Member on claim number 210512560500. These services were provided to [redacted] on 11/13/2020 in the billed amount of $259.85.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $37.13 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720127B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620019547

Enclosure(s)
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722069B
Amount Due: $8.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B023Z2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $8.33 has been made for a Medi-Cal Member on claim number 204950015600. These services were provided to [redacted] on 11/13/2020 in the billed amount of $8.41.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $8.33 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722069B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610034940

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723464B
Amount Due: $16.74
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0B01ZDP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $16.74 has been made for a Medi-Cal Member on claim number 204932442700. This overpaid amount includes interest of $0.09. These services were provided to [redacted] on 11/16/2020 in the billed amount of $16.82.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $16.74 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107271723464B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610024411

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721360B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B027X5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204970054000. These services were provided to [redacted] on 11/16/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721360B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620008906

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720102B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B027X6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204970634600. These services were provided to [redacted] on 11/16/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720102B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610024452

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723121B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C0056T

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 205059213900. These services were provided to [redacted] on 11/17/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723121B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620009301

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721432B
Amount Due: $17.97
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0B02ACW

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.97 has been made for a Medi-Cal Member on claim number 204986273900. This overpaid amount includes interest of $0.05. These services were provided to [redacted] on 11/18/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.97 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107271721432B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000121

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719136B
Amount Due: $61.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/02/2021
Patient Account Number: C0B02D47

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.88 has been made for a Medi-Cal Member on claim number 205029171800. This overpaid amount includes interest of $0.06. These services were provided to [redacted] on 11/19/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107271719136B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004031

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719478B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C007O5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 205083544700. These services were provided to [redacted] on 11/19/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719478B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000432

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723120B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B027XC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204970533300. These services were provided to [redacted] on 11/19/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723120B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620008336

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721437B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B0292Q

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 204970317800. These services were provided to [redacted] on 11/20/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721437B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002941

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719477B
Amount Due: $17.93
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C001ES

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.93 has been made for a Medi-Cal Member on claim number 205039062700. This overpaid amount includes interest of $0.01. These services were provided to [redacted] on 11/23/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.93 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2107271719477B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000413

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720121B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C00578

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 205059277900. These services were provided to [redacted] on 11/24/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720121B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014182

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720258B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C00A6X

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 205082464100. These services were provided to [redacted] on 11/24/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720258B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610000741

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 2, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723125B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 01/15/2021
Patient Account Number: C0C00HLT

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205132141700. These services were provided to [redacted] on 11/25/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723125B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620012333

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720122B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C00455

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205059218500. These services were provided to [redacted] on 11/30/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720122B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620014859

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721423B
Amount Due: $61.78
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C00H2G

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.78 has been made for a Medi-Cal Member on claim number 205130561300. These services were provided to [redacted] on 11/30/2020 in the billed amount of $290.94.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.78 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721423B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620020267

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719376B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C00UC3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 205302192100. These services were provided to [redacted] on 11/30/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719376B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610021945

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719436B
Amount Due: $25.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100E4X

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.92 has been made for a Medi-Cal Member on claim number 210155996800. These services were provided to [redacted] on 12/01/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719436B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620015611

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719467B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100947

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210109649600. These services were provided to [redacted] on 12/01/2020 in the billed amount of $323.76.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719467B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003485

Enclosure(s)
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721419B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C00OI2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 205237324900. These services were provided to [redacted] on 12/03/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721419B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610017068

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723310B
Amount Due: $39.07
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100FEN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $39.07 has been made for a Medi-Cal Member on claim number 210156208200. These services were provided to [redacted] on 12/04/2020 in the billed amount of $198.16.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $39.07 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723310B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620020048

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720285B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 01/15/2021
Patient Account Number: C0C00QNH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205237820900. These services were provided to [redacted] on 12/07/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720285B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000879

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721358B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C00SB6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205273514000. These services were provided to [redacted] on 12/07/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721358B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610018646

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723112B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C00SB3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205273622400. These services were provided to [redacted] on 12/07/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723112B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610033199

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720140B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100949

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210110447800. These services were provided to [redacted] on 12/07/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720140B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000102

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721439B
Amount Due: $315.06
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C013I4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $315.06 has been made for a Medi-Cal Member on claim number 205362860700. These services were provided to [redacted] on 12/08/2020 in the billed amount of $776.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $315.06 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721439B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003053

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723151B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01N5G

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 205539344400. These services were provided to [redacted] on 12/11/2020 in the billed amount of $162.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723151B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000075

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721359B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01GK2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205502225300. These services were provided to [redacted] on 12/14/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721359B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610028517

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723132B
Amount Due: $65.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C019ZO

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $65.41 has been made for a Medi-Cal Member on claim number 205418636500. These services were provided to [redacted] on 12/15/2020 in the billed amount of $108.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $65.41 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723132B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620017773

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723134B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100HTY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210207703900. These services were provided to [redacted] on 12/15/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723134B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018769

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720132B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01HHN

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76has been made for a Medi-Cal Member on claim number 205502287500. These services were provided to [redacted] on 12/16/2020 in the billed amount of $201.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720132B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021728

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723133B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C11009Z4

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210110491900. These services were provided to [redacted] on 12/16/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723133B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018260

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721440B
Amount Due: $25.31
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C01IUY

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $25.31 has been made for a Medi-Cal Member on claim number 205519420600. These services were provided to [redacted] on 12/16/2020 in the billed amount of $332.17.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $25.31 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

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Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721440B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003089

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O BOX 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271719459B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100FH7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210156116500. These services were provided to [redacted] on 12/16/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719459B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002907

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Los angeles, CA 92004-2369

A/R Number: AR2107271723103B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100HTZ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210207656200. These services were provided to [redacted] on 12/17/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723103B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610021914

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720138B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100H1H

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210207680700. These services were provided to [redacted] on 12/17/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720138B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620027634

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

August 3, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271723275B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01DUJ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 205461884300. These services were provided to [redacted] on 12/18/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723275B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620000045

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720099B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01K22

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 205519532000. These services were provided to [redacted] on 12/18/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720099B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610021316

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271723113B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01GK7

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205502132900. These services were provided to [redacted] on 12/21/2020 in the billed amount of $23.76.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271723113B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610033496

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271718554B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01GK8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 205502162100. These services were provided to [redacted] on 12/21/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271718554B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018408

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721446B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01GK6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205502429400. These services were provided to [redacted] on 12/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721446B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000046

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720141B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01IV6

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205518693500. These services were provided to [redacted] on 12/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720141B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630000139

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721228B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01IV8

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205519018800. These services were provided to [redacted] on 12/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721228B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000218

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 2, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271722314B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01IV9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205519820200. These services were provided to [redacted] on 12/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722314B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610033736

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721447B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01IV2

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205520061000. These services were provided to [redacted] on 12/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721447B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000053

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719480B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C01IV3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205519641800. These services were provided to [redacted] on 12/21/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719480B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650008940

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271719440B
Amount Due: $19.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01K1Y

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $19.55 has been made for a Medi-Cal Member on claim number 205519532900. These services were provided to [redacted] on 12/23/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $19.55 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271719440B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620018344

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 31, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721438B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0C01N4P

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205539447400. These services were provided to [redacted] on 12/28/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721438B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630002949

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720131B
Amount Due: $56.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100Q9I

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $56.63 has been made for a Medi-Cal Member on claim number 210295191800. These services were provided to [redacted] on 12/28/2020 in the billed amount of $304.53.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $56.63 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720131B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211620021369

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271720271B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C11005VL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210076310100. These services were provided to [redacted] on 12/28/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720271B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610018996

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271720150B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C11004NQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 210075601500. These services were provided to [redacted] on 12/30/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271720150B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630004052

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2107271721420B
Amount Due: $61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100FEL

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 210156449900. These services were provided to [redacted] on 12/30/2020 in the billed amount of $86.36.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $61.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721420B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610027133

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

July 30, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2107271721451B
Amount Due: $23.26
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100UV1

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.26 has been made for a Medi-Cal Member on claim number 210334722400. These services were provided to [redacted] on 12/30/2020 in the billed amount of $144.46.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.26 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721451B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650000202

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271722011B
Amount Due: $23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C11004NS

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 210076011000. These services were provided to [redacted] on 12/31/2020 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271722011B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610011586

Enclosure(s):
Appeals-Provider/Hospitals

blue california
Promise Health Plan

July 30, 2021

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721453B
Amount Due: $17.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/02/2021
Patient Account Number: C110019S

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $17.92 has been made for a Medi-Cal Member on claim number 210088485600. These services were provided to [redacted] on 12/31/2020 in the billed amount of $140.32.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $17.92 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721453B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211650002341

Enclosure(s):
Appeal - Provider / Hospital

blue california
Promise Health Plan

July 31, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2107271721444B
Amount Due: $40.50
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C1100XRP

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $40.50 has been made for a Medi-Cal Member on claim number 210367533000. These services were provided to [redacted] on 12/31/2020 in the billed amount of $259.85.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We would appreciate your refund of $40.50 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2107271721444B.

Prov_19_071_CR

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211630003882

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

August 3, 2021

Borrego Medical Clinic
Po Box 2369
Borrego Springs, CA 92004-2369
Attn: Patient Accounts

A/R Number:AR21080311451507
Amount Due:$61.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 01/22/2021
Patient Account Number:10084000025YX

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $61.82 has been made for a Medi-Cal Member on claim number 210244079400. These services were provided to [redacted] on 01/01/2021 in the billed amount of $2,893.95.

This payment has been identified as an incorrect payment due to the following reason(s):

This claim was reimbursed at an incorrect negotiated contract rate.

We would appreciate your refund of $61.82 Due within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR#AR21080311451507.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211610037217

Enclosure:
Appeals Provider /Hospital

blue california
Promise Health Plan

August 17, 2021

Centro Medico Escondido
Po Box 2369
Borrego Springs, CA 92004
Attn: Patient Accounts

A/R Number:AR21081710453253
Amount Due:$54.19
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 09/22/2020
Patient Account Number:C0901HM7

Dear Patient Accounts,

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medicare Member in error, which has resulted in an overpayment to you in the amount of $54.19 Due for services dated from 09/02/2020 to 09/02/2020 for claim number: 203832186500. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Retro contract change created overpayment.

Check number 2020092211000046 dated on 09/22/2020 for the amount of $54.19 was sent to you.

Under existing regulations 42 CFR 405.374, you have 15 calendar days from the date of this demand letter to submit a statement and/or evidence stating why this recoupment should not take place. If we do not hear from you within 15 calendar days and have not received a refund from you in 30 calendar days, we will start recouping payments starting 09/19/2021.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR#AR21081710453253.

Prov_19_068_CR

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 09/19/2021 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 211530021975

Enclosure:
Appeals Provider /Hospital

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number:AR21081710453253
Claim Number: 203832186500

Amount Due:$54.19
Patient Name: [redacted]
Amount Paid: $
Date of Service: 09/02/2020 to 09/02/2020

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____
Date of Expiration: _____
Credit Card Number: _____
Phone Number: Day: _____
Evening: _____
Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

blue california
Promise Health Plan

October 28, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2110251608060B
Amount Due: $289.78
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/06/2020
Patient Account Number: C0A02VIH

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $289.78 for services dated on October 14, 2020 for claim number: 204533424500. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s): Services not paid according to Medi-cal allowable.

Check number 163248 dated on 11/06/2020 for the amount of $315.70 was sent to you.

Under existing regulations 42 CFR 405.374, you have 15 calendar days from the date of this demand letter to submit a statement and/or evidence stating why this recoupment should not take place. If we do not hear from you within 15 calendar days and have not received a refund from you in 30 calendar days, we will start recouping payments starting 11/30/2021.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_20_069

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 11/30/2021 you must notify our office before 11/30/2021. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 11/30/2021 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212990010478

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

October 28, 2021

Julian Medical Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2110251608063B
Amount Due: $252.59
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 12/24/2020
Patient Account Number: C0B01MNQ

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $252.59 has been made for a Medi-Cal Member on claim number 204842895900. These services were provided to [redacted] on 11/11/2020 in the billed amount of $754.05.

This payment has been identified as an incorrect payment due to the following reason(s): Services not paid according to Medi-cal allowable.

Check number 2020122414800366 dated on 12/24/2020 for the amount of $278.51 was sent to you.

We would appreciate your refund of $252.59 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2110251608063B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212990006009

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

October 28, 2021

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2110261628295B
Amount Due: 97.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/03/2020
Patient Account Number: C0A02EG9

Dear Patient Accounts,

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medicare Member in error, which has resulted in an overpayment to you in the amount of $97.41 for services dated from 10/20/2020 to 10/20/2020 for claim number: 204472223300. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 99214 and 90471 are not separately reportable when performed on the same date without bypass modifiers

Check number 163071 dated on 11/03/2020 for the amount of 112.93 was sent to you.

Under existing regulations 42 CFR 405.374, you have 15 calendar days from the date of this demand letter to submit a statement and/or evidence stating why this recoupment should not take place. If we do not hear from you within 15 calendar days and have not received a refund from you in 30 calendar days, we will start recouping payments starting 12/12/2021.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2110261628295B.

Prov_19_068_CR

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 12/12/2021 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212870000684

Enclosure(s):
Appeals-Provider/Hospital

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number: AR2110261628295B
Claim Number: 204472223300

Amount Due: 97.41
Patient Name: [redacted]
Amount Paid: $97.41
Date of Service: 10/20/2020 to 10/20/2020

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____
Date of Expiration: _____
Credit Card Number: _____
Phone Number: Day: _____
Evening: _____
Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

PROVIDER DISPUTES OR APPEALS

MEDICARE NON-CONTRACTED PROVIDER DISPUTES:

Provider Disputes must be submitted to Blue Shield of California Promise Health Plan, at the address listed below, within 120 calendar days after receipt of the notice of the initial payment determination.

Items that may be filed as Provider Disputes include:

- Underpayment (the amount paid by Blue Shield of California Promise Health Plan for covered services is less than the amount that would have been paid under original Medicare); or
- Disagreement about Blue Shield of California Promise Health Plan's decision to make payment on a more appropriate code.

Denials of payments due to coverage and medical necessity determinations are not subject to the Provider Dispute Process. These items must be submitted as a Provider Appeal.

MEDICARE NON-CONTRACTED PROVIDER APPEALS:

Provider Appeals must be submitted to Blue Shield of California Promise Health Plan within 60 calendar days after receipt of the notice of the initial determination/decision.

Non-contracted providers must also submit a signed Waiver of Liability statement holding the member harmless regardless of the outcome of the appeal.

Copy of Waiver of Liability form can be found at: www.blueshieldca.com/promise/provider

Blue Shield of California Promise Health Plan
ATTN: Provider Dispute Dept.
P.O. Box 3829
Montebello, CA 90640

blue california
Promise Health Plan

October 28, 2021

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2110261628184B
Amount Due: 46.61
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/20/2021
Patient Account Number: C1400KIH

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $46.61 has been made for a Medi-Cal Member on claim number 211793665800. These services were provided to [redacted] on 01/21/2021 in the billed amount of $379.29.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 99202 and 90460 are not separately reportable when performed on the same date without bypass modifiers

Check number 194426 dated on 04/20/2021 for the amount of 90.89 was sent to you.

We would appreciate your refund of $46.61 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2110261628184B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212880033930

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

November 3, 2021

Centro Medico Cathedral City
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2110281139048B
Amount Due: 23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 11/20/2020
Patient Account Number: C0B010O9

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 204740914900. These services were provided to [redacted] on 11/05/2020 in the billed amount of $616.51.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 99213 and 58100 are not separately reportable when performed on the same date without bypass modifiers

Check number 166223 dated on 11/20/2020 for the amount of 70.75 was sent to you.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2110281139048B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212880034882

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

November 4, 2021

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2111020837176B
Amount Due: 15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/07/2021
Patient Account Number: C15000J5

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 212112113900. These services were provided to [redacted] on 02/02/2021 in the billed amount of $820.47.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 96160 and 90460 are not separately reportable when performed on the same date without bypass modifiers

Check number 196978 dated on 05/07/2021 for the amount of 394.10 was sent to you.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2111020837176B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212880033314

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

November 4, 2021

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2111020837205B
Amount Due: 15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/20/2021
Patient Account Number: C1400ECR

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 211727333700. These services were provided to [redacted] on 03/04/2021 in the billed amount of $855.23.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 96160 and 90460 are not separately reportable when performed on the same date without bypass modifiers

Check number 194426 dated on 04/20/2021 for the amount of 379.86 was sent to you.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2111020837205B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212910001152

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

November 5, 2021

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2111041038268B
Amount Due: 15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/29/2021
Patient Account Number: C1601BPG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 213068709300. These services were provided to [redacted] on 05/20/2021 in the billed amount of $819.47.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 96160 and 90460 are not separately reportable when performed on the same date without bypass modifiers

Check number 206191 dated on 06/29/2021 for the amount of 393.80 was sent to you.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2111041038268B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212910002001

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

November 5, 2021

Julian Medical Center
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2111041038198B
Amount Due: 23.76
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 01/15/2021
Patient Account Number: C0C00HLU

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $23.76 has been made for a Medi-Cal Member on claim number 205131324400. These services were provided to [redacted] on 11/30/2020 in the billed amount of $224.19.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 99213 and 69209 are not separately reportable when performed on the same date without bypass modifiers

Check number 177665 dated on 01/15/2021 for the amount of 35.18 was sent to you.

We would appreciate your refund of $23.76 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2111041038198B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212880034207

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

November 8, 2021

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2111080948334B
Amount Due: 50.96
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/27/2021
Patient Account Number: C1400RYA

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $50.96 has been made for a Medi-Cal Member on claim number 211898118400. These services were provided to [redacted] on 03/10/2021 in the billed amount of $887.46.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 99214 and 90460 are not separately reportable when performed on the same date without bypass modifiers

Check number 195536 dated on 04/27/2021 for the amount of 367.58 was sent to you.

We would appreciate your refund of $50.96 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2111080948334B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212880028976

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

November 8, 2021

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2111080948130B
Amount Due: 15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/20/2021
Patient Account Number: C1400KIG

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $15.00 has been made for a Medi-Cal Member on claim number 211794667700. These services were provided to [redacted] on 03/18/2021 in the billed amount of $467.69.

This payment has been identified as an incorrect payment due to the following reason(s): procedures 96160 and 96110 are not separately reportable when performed on the same date without bypass modifiers

Check number 194426 dated on 04/20/2021 for the amount of 194.02 was sent to you.

We would appreciate your refund of $15.00 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2111080948130B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 212880034455

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

December 16, 2021

Borrego Medical Clinic
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112151139088B
Amount Due: 29.71
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 06/25/2021
Patient Account Number: C16012U3

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $29.71 has been made for a Medi-Cal Member on claim number 212984735800. These services were provided to [redacted] on 06/15/2021 in the billed amount of $179.30.

This payment has been identified as an incorrect payment due to the following reason(s): services were rendered on or after the cancellation date of 2021-05-31. Please verify with the member if they have other coverage and bill other insurance for payment.

Check number 205928 dated on 06/25/2021 for the amount of 29.71 was sent to you.

We would appreciate your refund of $29.71 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2112151139088B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480042252

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

December 29, 2021

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112171101241B
Amount Due: $81.11
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 10/27/2020
Patient Account Number: C0A01Y6G

Dear Patient Accounts,

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medicare Member in error, which has resulted in an overpayment to you in the amount of $81.11 for services dated on 10/14/2020 for claim number: 204376259200. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s): After additional review, we identified an overpayment on claim 204376259200 due to a National Correct Coding Initiative (NCCI) Procedure-To-Procedure Edit. There is an overpayment for services rendered to the same member on the same date of service by the same rendering provider. Please see the enclosed corrected Explanation of Benefits (EOB) for the accurate processing of this claim line.

Check number 2020102712300486 dated on 10/27/2020 for the amount of $160.69 was sent to you.

We would appreciate your refund of $81.11 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_19_068_CR

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR# AR2112171101241B.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 01/28/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213370032026

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number: AR2112171101241B
Claim Number: 204376259200

Amount Due: $81.11
Patient Name: [redacted]
Amount Paid:
Date of Service: 10/14/2020

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____
Date of Expiration: _____
Credit Card Number: _____
Phone Number: Day: _____
Evening: _____
Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

PROVIDER DISPUTES OR APPEALS

MEDICARE NON-CONTRACTED PROVIDER DISPUTES:

Provider Disputes must be submitted to Blue Shield of California Promise Health Plan, at the address listed below, within 120 calendar days after receipt of the notice of the initial payment determination.

Items that may be filed as Provider Disputes include:

- Underpayment (the amount paid by Blue Shield of California Promise Health Plan for covered services is less than the amount that would have been paid under original Medicare); or
- Disagreement about Blue Shield of California Promise Health Plan's decision to make payment on a more appropriate code.

Denials of payments due to coverage and medical necessity determinations are not subject to the Provider Dispute Process. These items must be submitted as a Provider Appeal.

MEDICARE NON-CONTRACTED PROVIDER APPEALS:

Provider Appeals must be submitted to Blue Shield of California Promise Health Plan within 60 calendar days after receipt of the notice of the initial determination/decision.

Non-contracted providers must also submit a signed Waiver of Liability statement holding the member harmless regardless of the outcome of the appeal.

Copy of Waiver of Liability form can be found at: www.blueshieldca.com/promise/provider

Blue Shield of California Promise Health Plan
ATTN: Provider Dispute Dept.
P.O. Box 3829
Montebello, CA 90640

blue california
Promise Health Plan

December 23, 2021

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112171100534B
Amount Due: $19.17
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0B01TJO

Dear Patient Accounts,

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medicare Member in error, which has resulted in an overpayment to you in the amount of $19.17 for services dated on 11/17/2020 for claim number: 204886068800. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

Check number 2021020511801434 dated on 02/05/2021 for the amount of $19.17 was sent to you.

We would appreciate your refund of $19.17 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_068_CR

To avoid delay in processing, please submit your payment referencing AR# AR2112171100534B.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after January 22, 2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213400000724

Enclosure(s):
Appeals-Provider/Hospital

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number: AR2112171100534B
Claim Number: 204886068800

Amount Due: $19.17
Patient Name: [redacted]
Amount Paid:
Date of Service: 11/17/2020

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____
Date of Expiration: _____
Credit Card Number: _____
Phone Number: Day: _____
Evening: _____
Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

PROVIDER DISPUTES OR APPEALS

MEDICARE NON-CONTRACTED PROVIDER DISPUTES:

Provider Disputes must be submitted to Blue Shield of California Promise Health Plan, at the address listed below, within 120 calendar days after receipt of the notice of the initial payment determination.

Items that may be filed as Provider Disputes include:

- Underpayment (the amount paid by Blue Shield of California Promise Health Plan for covered services is less than the amount that would have been paid under original Medicare); or
- Disagreement about Blue Shield of California Promise Health Plan's decision to make payment on a more appropriate code.

Denials of payments due to coverage and medical necessity determinations are not subject to the Provider Dispute Process. These items must be submitted as a Provider Appeal.

MEDICARE NON-CONTRACTED PROVIDER APPEALS:

Provider Appeals must be submitted to Blue Shield of California Promise Health Plan within 60 calendar days after receipt of the notice of the initial determination/decision.

Non-contracted providers must also submit a signed Waiver of Liability statement holding the member harmless regardless of the outcome of the appeal.

Copy of Waiver of Liability form can be found at: www.blueshieldca.com/promise/provider

Blue Shield of California Promise Health Plan
ATTN: Provider Dispute Dept.
P.O. Box 3829
Montebello, CA 90640

blue california
Promise Health Plan

January 6, 2022

Eastside Health Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291247066B
Amount Due: $34.82
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/05/2021
Patient Account Number: C13004RC

Dear Patient Accounts

We have determined that an incorrect payment in the amount of $34.82 has been made for a Medi-Cal Member on claim number 211016508100. These services were provided to [redacted] on 02/23/2021 in the billed amount of $34.82.

This payment has been identified as an incorrect payment due to the following reason(s): Services paid above contracted percentage without NTE cap.

Check number 2021030511601326 dated on 03/05/2021 for the amount of $34.82 was sent to you.

We would appreciate your refund of $34.82 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

Prov_19_071_CR

To avoid delay in processing, please submit your payment referencing AR# AR2112291247066B.

If you have further questions, please contact us by calling toll free at (800) 468-9935, Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430001844

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291246229B
Amount Due: $23.49
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/05/2021
Patient Account Number: C1100QWG

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $23.49 for services dated on January 6, 2021 for claim number: 210292548700. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 181142 dated on 02/05/2021 for the amount of $23.49 was sent to you.

We would appreciate your refund of $23.49 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430024826

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 8, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291249233B
Amount Due: $62.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/16/2021
Patient Account Number: C1200A3X

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $62.04 for services dated on January 14, 2021 for claim number: 210644268800. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021021612601504 dated on 02/16/2021 for the amount of $83.33 was sent to you.

We would appreciate your refund of $62.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/10/2022 you must notify our office before 2/10/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/10/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430031514

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 7, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291247348B
Amount Due: $377.61
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/16/2021
Patient Account Number: C1200BED

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $377.61 for services dated on January 14, 2021 for claim number: 210665378700. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021021612601504 dated on 02/16/2021 for the amount of $392.61 was sent to you.

We would appreciate your refund of $377.61 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/9/2022 you must notify our office before 2/9/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/9/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480000209

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 7, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291249263B
Amount Due: $481.34
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/16/2021
Patient Account Number: C1200FYX

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $481.34 for services dated on January 18, 2021 for claim number: 210709872400. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021021612601504 dated on 02/16/2021 for the amount of $496.34 was sent to you.

We would appreciate your refund of $481.34 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/9/2022 you must notify our office before 2/9/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/9/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440000182

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291246246B
Amount Due: $377.61
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/16/2021
Patient Account Number: C1200FYW

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $377.61 for services dated on January 18, 2021 for claim number: 210709933700. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 183090 dated on 02/16/2021 for the amount of $392.61 was sent to you.

We would appreciate your refund of $377.61 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430040787

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 5, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291246526B
Amount Due: $305.89
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 03/16/2021
Patient Account Number: C1300CLK

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $305.89 for services dated on February 2, 2021 for claim number: 211080904100. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021031614901023 dated on 03/16/2021 for the amount of $320.89 was sent to you.

We would appreciate your refund of $305.89 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/7/2022 you must notify our office before 2/7/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/7/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480042107

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 12, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291249070B
Amount Due: $58.92
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1300DV9
Date of Service: February 4, 2021
Overpayment Issue Date: March 12, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $58.92 has been made on claim number 211115703200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $58.92 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing AR2112291249070B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480042351

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 13, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291250053B
Amount Due: $21.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1400KII
Date of Service: February 15, 2021
Overpayment Issue Date: April 23, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $21.00 has been made on claim number 211792861600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

After additional review, we identified an overpayment on claim 211792861600 due to a National Correct Coding Initiative (NCCI) Procedure-To-Procedure Edit. There is an overpayment for services rendered to the same member on the same date of service by the same rendering provider. Please see the enclosed corrected Explanation of Benefits (EOB) for the accurate processing of this claim line.

We request reimbursement for this overpayment in the amount of $21.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291250053B.

Prov_21_205

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213400028240

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico Escondido
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291247076B
Amount Due: $57.80
Member Number: [redacted]
Member Name:
Patient Name:
Issue Date: 03/02/2021
Patient Account Number: C1201V44

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $57.80 for services dated on February 16, 2021 for claim number: 210959784200. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021030216100441 dated on 03/02/2021 for the amount of $94.60 was sent to you.

We would appreciate your refund of $57.80 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430020899

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 7, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291248013B
Amount Due: $334.68
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/06/2021
Patient Account Number: C14001JY

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $334.68 for services dated on February 18, 2021 for claim number: 211547960900. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021040613500166 dated on 04/06/2021 for the amount of $362.97 was sent to you.

We would appreciate your refund of $334.68 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/9/2022 you must notify our office before 2/9/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/9/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440024502

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291247205B
Amount Due: $112.34
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/09/2021
Patient Account Number: C14003VO

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $112.34 for services dated on February 19, 2021 for claim number: 211608670800. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021040917100396 dated on 04/09/2021 for the amount of $127.34 was sent to you.

We would appreciate your refund of $112.34 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213450000112

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291246375B
Amount Due: $65.57
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/13/2021
Patient Account Number: C1400342

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $65.57 for services dated on February 19, 2021 for claim number: 211580742800. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021041311201259 dated on 04/13/2021 for the amount of $106.36 was sent to you.

We would appreciate your refund of $65.57 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213450000089

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 7, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291248401B
Amount Due: $36.54
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/12/2021
Patient Account Number: C13006OA

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $36.54 for services dated from February 26, 2021 to February 26, 2021 for claim number: 211039595900. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021031211701351 dated on 03/12/2021 for the amount of $79.43 was sent to you.

We would appreciate your refund of $36.54 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/9/2022 you must notify our office before 2/9/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/9/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440001038

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291247206B
Amount Due: $502.84
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/16/2021
Patient Account Number: C1400ECS

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $502.84 for services dated on March 2, 2021 for claim number: 211727539200. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services not paid according to Medi-cal allowable.

Check number 2021041614700015 dated on 04/16/2021 for the amount of $517.84 was sent to you.

We would appreciate your refund of $502.84 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213450000141

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 5, 2022

Borrego Community Health Foundation
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291246310B
Amount Due: $381.14
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 03/26/2021
Patient Account Number: C1300NI7

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount $381.14 for services dated on March 4, 2021 for claim number: 211239432200. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021032611000513 dated on 03/26/2021 for the amount of $414.48 was sent to you.

We would appreciate your refund of $381.14 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/7/2022 you must notify our office before 2/7/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/7/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440014293

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291247179B
Amount Due: $111.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 04/06/2021
Patient Account Number: C14000LJ

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $111.88 for services dated on March 23, 2021 for claim number: 211548422400. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021040613500166 dated on 04/06/2021 for the amount of $111.88 was sent to you.

We would appreciate your refund of $111.88 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440030459

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 6, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291247242B
Amount Due: $282.05
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 05/28/2021
Patient Account Number: C1500STX

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $282.05 for services dated on April 20, 2021 for claim number: 212501853500. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021052811400136 dated on 05/28/2021 for the amount of $405.38 was sent to you.

We would appreciate your refund of $282.05 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 02/08/2022 you must notify our office before 02/08/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 02/08/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213450001476

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 3, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291246091B
Amount Due: $282.05
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 05/28/2021
Patient Account Number: C1500STZ

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $282.05 for services dated on April 20, 2021 for claim number: 212501855700. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021052811400136 dated on 05/28/2021 for the amount of $413.39 was sent to you.

We would appreciate your refund of $282.05 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/5/2022 you must notify our office before 2/5/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/5/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213450005442

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 12, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291249546B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C15003V2
Date of Service: April 26, 2021
Overpayment Issue Date: May 11, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 212158817900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

There was an overpayment on claim 212158817900 due to an NCCI Procedure-To-Procedure edit. This claim is an overpayment for services rendered to the same member on the same date of service by the same rendering provider. Please see the enclosed corrected Explanation of Benefits (EOB) for the accurate processing of this claim line.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291249546B.

Prov_21_205

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213400020878

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 12, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291250223B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A001O5
Date of Service: September 27, 2021
Overpayment Issue Date: October 8, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214781725600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291250223B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500006367

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 6, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291247021B
Amount Due: $253.84
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0B01YRR

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $253.84 for services dated on October 27, 2020 for claim number: 204928628600. This overpaid amount includes interest of $1.25. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $252.59 was sent to you.

We would appreciate your refund of $253.84 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213420023474

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 6, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291247082B
Amount Due: $364.62
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0B01YRO

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $364.62 for services dated on October 28, 2020 for claim number: 204926025200. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $379.62 was sent to you.

We would appreciate your refund of $364.62 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430025698

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 13, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291249515B
Amount Due: $165.63
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1100OID
Date of Service: October 28, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $165.63 has been made on claim number 210266260300 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $165.63 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291249515B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001429

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 8, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291249223B
Amount Due: $296.15
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C016H4

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $296.15 for services dated on November 2, 2020 for claim number: 205393184100. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $324.74 was sent to you.

We would appreciate your refund of $296.15 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/10/2022 you must notify our office before 2/10/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/10/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430017262

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 12, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291249091B
Amount Due: $32.67
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0B01YRQ
Date of Service: November 2, 2020
Overpayment Issue Date: June 15, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $32.67 has been made on claim number 204926002801 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $32.67 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291249091B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001324

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291247515B
Amount Due: $490.14
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0B01YRS

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $490.14 for services dated on November 4, 2020 for claim number: 204922475000. This overpaid amount includes interest of $2.43. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $490.14 was sent to you.

We would appreciate your refund of $490.14 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430010273

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 6, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291247364B
Amount Due: $56.30
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/02/2021
Patient Account Number: C0B017LI

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $56.30 for services dated on November 6, 2020 for claim number: 204820481100. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020213600120 dated on 02/02/2021 for the amount of $71.30 was sent to you.

We would appreciate your refund of $56.30 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480001195

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291246513B
Amount Due: $44.37
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C010JZ

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $44.37 for services dated on November 6, 2020 for claim number: 205336855400. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 181140 dated on 02/05/2021 for the amount of $72.66 was sent to you.

We would appreciate your refund of $44.37 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480000184

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291246231B
Amount Due: $73.56
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C010K0

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $73.56 for services dated on November 10, 2020 for claim number: 205336174800. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 181140 dated on 02/05/2021 for the amount of $88.86 was sent to you.

We would appreciate your refund of $73.56 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430027008

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291247526B
Amount Due: $62.69
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C00UC0

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $62.69 for services dated on November 11, 2020 for claim number: 205296107500. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $77.69 was sent to you.

We would appreciate your refund of $62.69 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430027124

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291246280B
Amount Due: $441.44
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C010JY

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $441.44 for services dated on November 11, 2020 for claim number: 205336290600. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services not paid according to Medi-cal allowable.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $456.44 was sent to you.

We would appreciate your refund of $441.44 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440001277

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 12, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291249474B
Amount Due: $69.32
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0C000YU
Date of Service: November 13, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $69.32 has been made on claim number 205036687400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $69.32 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291249474B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480000217

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291246249B
Amount Due: $441.44
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C016H2

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $441.44 for services dated on November 16, 2020 for claim number: 205393121600. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 181140 dated on 02/05/2021 for the amount of $456.74 was sent to you.

We would appreciate your refund of $441.44 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430040810

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 7, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291248378B
Amount Due: $41.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C00462

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $41.04 for services dated on November 18, 2020 for claim number: 205060964600. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $62.33 was sent to you.

We would appreciate your refund of $41.04 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/9/2022 you must notify our office before 2/9/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/9/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430040747

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 8, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291249229B
Amount Due: $23.28
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/05/2021
Patient Account Number: C0C009L7

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $23.28 for services dated on November 23, 2020 for claim number: 205083794900. This overpaid amount includes interest of $0.02. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $23.26 was sent to you.

We would appreciate your refund of $23.28 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/10/2022 you must notify our office before 2/10/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/10/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430024917

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 7, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291248456B
Amount Due: $179.02
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/05/2021
Patient Account Number: C1100NGT

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $179.02 for services dated on November 24, 2020 for claim number: 210244549800. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020519500162 dated on 02/05/2021 for the amount of $215.82 was sent to you.

We would appreciate your refund of $179.02 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 02/09/2022 you must notify our office before 02/09/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 02/09/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440030488

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291247089B
Amount Due: $42.05
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C1100NGS

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $42.05 for services dated on November 24, 2020 for claim number: 210244612600. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020519500162 dated on 02/05/2021 for the amount of $78.85 was sent to you.

We would appreciate your refund of $42.05 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430029448

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 6, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291247519B
Amount Due: $93.71
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Issue Date: 02/05/2021
Patient Account Number: C0C013I9

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $93.71 for services dated on December 8, 2020 for claim number: 205362465000. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020519500162 dated on 02/05/2021 for the amount of $93.71 was sent to you.

We would appreciate your refund of $93.71 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/8/2022 you must notify our office before 2/8/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/8/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430022662

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 8, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2112291249224B
Amount Due: $45.28
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/05/2021
Patient Account Number: C0C01K4M

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $45.28 for services dated on December 11, 2020 for claim number: 205518137300. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $60.28 was sent to you.

We would appreciate your refund of $45.28 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/10/2022 you must notify our office before 2/10/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/10/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430018674

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 12, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291249093B
Amount Due: $42.60
Member Number: [redacted]
Member Name [redacted]
Patient Name: [redacted]
Patient Account Number: C1100H1I
Date of Service: December 18, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $42.60 has been made on claim number 210206469300 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $42.60 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291249093B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001379

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 12, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291247135B
Amount Due: $39.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0C01IV4
Date of Service: December 23, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $39.00 has been made on claim number 205518882800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $39.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291247135B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440001446

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 12, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2112291247122B
Amount Due: $250.67
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C11005VI
Date of Service: December 28, 2020
Overpayment Issue Date: June 11, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $250.67 has been made on claim number 210075697201 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $250.67 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291247122B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440000988

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 13, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291249512B
Amount Due: $354.35
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1100XRL
Date of Service: December 29, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $354.35 has been made on claim number 210366292500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $354.35 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2112291249512B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001314

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 7, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2112291248194B
Amount Due: $62.69
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Issue Date: 02/05/2021
Patient Account Number: C1100W3A

Dear Patient Accounts

This is to inform you that you have received a Blue Shield of California Promise Health Plan payment for a Medi-Cal Member in error, which has resulted in an overpayment to you in the amount of $62.69 for services dated on December 30, 2020 for claim number: 210365947100. The following explains how this happened.

This payment has been identified as an incorrect payment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

Check number 2021020514000183 dated on 02/05/2021 for the amount of $77.69 was sent to you.

We would appreciate your refund of $62.69 within 30 working days of your receipt of this letter. If you disagree with this request for a refund of an overpayment, you must file appeal/ grievance within 30 working days of your receipt of this letter. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you agree with this demand, please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Prov_20_069

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To ensure appropriate recording of reimbursement, please include a copy of this letter or a list of claim numbers with the refund check.

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan would start from the date of this letter. If you decide to have us withhold and offset the payments from your future payments, please notify us by telephone or in writing. This request must be received within 30 days from the date of this letter.

If you have reason to believe that the withhold should not occur on 2/9/2022 you must notify our office before 2/9/2022. Blue Shield of California Promise Health Plan will review your documentation. Our office will advise you of our decision in 15 calendar days from your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

Interest Assessment:

If you do not refund in 30 days: in accordance with 42 CFR 405.378 simple interest at the rate of 1.375% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then, after each payment, interest will continue to accrue on the remaining principal balance, at the rate of 1.375%. In addition, please note that Medicare rules require that payment be either received in our office by the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 2/9/2022 will cause an additional month's interest to be assessed on the overpayment amount.

If you have further questions, please contact us by calling toll free at (800) 468-9935. Monday through Friday between 8:00 a.m. to 4:00 p.m.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213480000245

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 17, 2022

Eastside Health Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111148101B
Amount Due: $293.59
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C13004QZ
Date of Service: February 23, 2021
Overpayment Issue Date: March 26, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $293.59 has been made on claim number 211016147900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $293.59 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148101B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If you agree with this overpayment but prefer to have us withhold and offset the amount of this overpayment from your future claims payments instead of repaying the overpayment in a single payment, please notify us in writing within thirty (30) working days from the date of this letter. We will work with you to accommodate your request.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213420041775

Enclosure(s):
Appeals-Provider/Hospital

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]

A/R Number: AR2201111148101B
Claim Number: 211016147900

Amount Due: $293.59
Patient Name: [redacted]

Amount Paid:
Date of Service: 02/23/2021

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____

Date of Expiration: _____

Credit Card Number: _____

Phone Number: Day: _____

Evening: _____

Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

blue california
Promise Health Plan

January 18, 2022

Arlanza Family Health Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111148307B
Amount Due: $491.61
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0C00CLS
Date of Service: November 18, 2020
Overpayment Issue Date: January 15, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $491.61 has been made on claim number 205097046500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $491.61 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201111148307B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If you agree with this overpayment but prefer to have us withhold and offset the amount of this overpayment from your future claims payments instead of repaying the overpayment in a single payment, please notify us in writing within thirty (30) working days from the date of this letter. We will work with you to accommodate your request.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430014597

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number: AR2201111148307B
Claim Number: 205097046500

Amount Due: $491.61
Patient Name: [redacted]
Amount Paid:
Date of Service: 11/18/2020

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____

Date of Expiration: _____

Credit Card Number: _____

Phone Number: Day: _____

Evening: _____

Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

blue california
Promise Health Plan

January 18, 2022

Arlanza Family Health Center
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111148090B
Amount Due: $62.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0C00LXW
Date of Service: December 2, 2020
Overpayment Issue Date: January 15, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $62.33 has been made on claim number 205192255500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $62.33 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148090B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_204

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If you agree with this overpayment but prefer to have us withhold and offset the amount of this overpayment from your future claims payments instead of repaying the overpayment in a single payment, please notify us in writing within thirty (30) working days from the date of this letter. We will work with you to accommodate your request.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213420032119

Enclosure(s):
Appeals-Provider/Hospital

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]

A/R Number: AR2201111148090B
Claim Number: 205192255500

Amount Due: $62.33
Patient Name: [redacted]

Amount Paid:
Date of Service: 12/02/2020

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____

Date of Expiration: _____

Credit Card Number: _____

Phone Number: Day: _____

Evening: _____

Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

blue california
Promise Health Plan

January 17, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2201111148359B
Amount Due: $481.34
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C12007AC
Date of Service: January 11, 2021
Overpayment Issue Date: February 9, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $481.34 has been made on claim number 210578954800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $481.34 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148359B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440001325

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 18, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111150371B
Amount Due: $46.98
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C14000HX
Date of Service: February 16, 2021
Overpayment Issue Date: April 6, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $46.98 has been made on claim number 211547958100 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $46.98 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150371B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213590000680

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 19, 2022

Borrego Community Health Foundation
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201111150061B
Amount Due: $340.29
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C13005JY
Date of Service: February 25, 2021
Overpayment Issue Date: March 9, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $340.29 has been made on claim number 211016562100 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $340.29 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150061B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001366

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 18, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201111148405B
Amount Due: $491.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C14000GW
Date of Service: March 25, 2021
Overpayment Issue Date: April 6, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $491.04 has been made on claim number 211547980300 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $491.04 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148405B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440025988

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 18, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111148393B
Amount Due: $24.04
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1400D33
Date of Service: April 6, 2021
Overpayment Issue Date: April 13, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $24.04 has been made on claim number 211694231600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $24.04 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148393B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440019126

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 14, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111147280B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C1500AJ7
Date of Service: April 8, 2021
Overpayment Issue Date: May 11, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 212204435600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

An overpayment on claim 212204435600 due to a National Correct Coding Initiative (NCCI) Procedure-To-Procedure Edit. There is an overpayment for services rendered to the same member on the same date of service by the same rendering provider. Please see the enclosed corrected Explanation of Benefits (EOB) for the accurate processing of this claim line.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111147280B.

Prov_21_205

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213400030932

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 14, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111147402B
Amount Due: $21.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C15000OQ
Date of Service: April 26, 2021
Overpayment Issue Date: May 7, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $21.00has been made on claim number 212112248000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

There was an overpayment on claim 212112248000 due to an NCCI Procedure-To-Procedure edit. This claim is an overpayment for services rendered to the same member on the same date of service by the same rendering provider. Please see the enclosed corrected Explanation of Benefits (EOB) for the accurate processing of this claim line.

We request reimbursement for this overpayment in the amount of $21.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111147402B.

Prov_21_205

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213400023679

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 18, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201111149444B
Amount Due: $328.24
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C15002YM
Date of Service: April 27, 2021
Overpayment Issue Date: May 11, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $328.24 has been made on claim number 212134337400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $328.24 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111149444B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213470009009

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 19, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111150074B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B006BL
Date of Service: September 28, 2021
Overpayment Issue Date: November 9, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215423489800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150074B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500006679

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 19, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111150073B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B006BK
Date of Service: September 28, 2021
Overpayment Issue Date: November 9, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215423561500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150073B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500006577

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 19, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201111150071B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A0186B
Date of Service: October 25, 2021
Overpayment Issue Date: November 2, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215268137300 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150071B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500006053

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 19, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111150052B
Amount Due: $68.85
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1100NL8
Date of Service: November 5, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $68.85 has been made on claim number 210244670500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $68.85 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150052B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001343

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 18, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111148243B
Amount Due: $62.69
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0B01YRM
Date of Service: November 6, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $62.69 has been made on claim number 204926520400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $62.69 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148243B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430013634

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 18, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201111148533B
Amount Due: $48.61
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1100NGN
Date of Service: November 10, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $48.61 has been made on claim number 210244754700 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $48.61 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148533B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440000005

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 18, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111148308B
Amount Due: $141.55
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C0B02A7A
Date of Service: November 12, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $141.55 has been made on claim number 204985783600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $141.55 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201111148308B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213430015854

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 19, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111150053B
Amount Due: $42.70
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0B02F7D
Date of Service: November 12, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $42.70 has been made on claim number 205037473600 for the member and dates of service identified above. The total amount of this overpayment includes an improper interest overpayment in the amount of $0.10. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $42.70 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150053B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001344

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 18, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2201111148086B
Amount Due: $23.27
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0C00E2B
Date of Service: November 25, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $23.27 has been made on claim number 205097427900 for the member and dates of service identified above. The total amount of this overpayment includes an improper interest overpayment in the amount of $0.01. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $23.27 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111148086B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213420029730

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 18, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201111150358B
Amount Due: $62.33
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0C01IXB
Date of Service: December 9, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $62.33 has been made on claim number 205518701000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $62.33 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150358B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213580004858

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 19, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 920042369

A/R Number: AR2201111150051B
Amount Due: $328.94
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1100G40
Date of Service: December 18, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $328.94 has been made on claim number 210207275500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $328.94 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201111150051B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Prov_21_205

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213500001282

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 25, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210940597B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900EG3
Date of Service: August 3, 2021
Overpayment Issue Date: September 24, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214497858700 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201210940597B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If you agree with this overpayment but prefer to have us withhold and offset the amount of this overpayment from your future claims payments instead of repaying the overpayment in a single payment, please notify us in writing within thirty (30) working days from the date of this letter. We will work with you to accommodate your request.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640029891

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]

A/R Number: AR2201210940597B
Claim Number: 214497858700

Amount Due: $15.00
Patient Name: [redacted]

Amount Paid:
Date of Service: 08/03/2021

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____

Date of Expiration: _____

Credit Card Number: _____

Phone Number: Day: _____

Evening: _____

Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

blue california
Promise Health Plan

January 25, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941047B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1800VTM
Date of Service: August 2, 2021
Overpayment Issue Date: August 27, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214057874100 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941047B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640033887

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941067B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1800UEI
Date of Service: August 9, 2021
Overpayment Issue Date: August 27, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214026869500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services not paid according to Medi-cal allowable.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941067B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640029945

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941059B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900BOL
Date of Service: August 10, 2021
Overpayment Issue Date: September 14, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214347424000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941059B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031658

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941054B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900BOJ
Date of Service: August 10, 2021
Overpayment Issue Date: September 14, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214347448200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941054B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640032869

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941049B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900BR8
Date of Service: August 10, 2021
Overpayment Issue Date: September 14, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $12.47 has been made on claim number 214347945200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services not paid according to Medi-cal allowable.

We request reimbursement for this overpayment in the amount of $12.47 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941049B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640030639

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 24, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941067B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1800UH9
Date of Service: August 12, 2021
Overpayment Issue Date: August 27, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214026478200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services not paid according to Medi-cal allowable.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941067B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031563

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941052B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900K5L
Date of Service: August 12, 2021
Overpayment Issue Date: September 17, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214434080600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941052B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640029273

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941069B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1800ZX5
Date of Service: August 16, 2021
Overpayment Issue Date: August 27, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214104837600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201210941069B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031916

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941060B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C18015R4
Date of Service: August 18, 2021
Overpayment Issue Date: September 3, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214188623100 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201210941060B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640029224

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 25, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941057B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C18015R3
Date of Service: August 18, 2021
Overpayment Issue Date: September 3, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214188966300 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201210941057B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031204

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 25, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941065B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C18015PW
Date of Service: August 18, 2021
Overpayment Issue Date: September 3, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214189203100 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941065B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640029387

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941063B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C18015R1
Date of Service: August 18, 2021
Overpayment Issue Date: September 3, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214189249600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941063B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031160

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941050B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C18019JT
Date of Service: August 19, 2021
Overpayment Issue Date: September 7, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214242902500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941050B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031110

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941062B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900O6X
Date of Service: August 19, 2021
Overpayment Issue Date: September 21, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214504469700 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941062B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640033709

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210940596B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C18019O5
Date of Service: August 24, 2021
Overpayment Issue Date: September 7, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214242304800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210940596B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640033107

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941071B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900EVH
Date of Service: August 30, 2021
Overpayment Issue Date: September 14, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214375660800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of _InsertAmt_ within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941071B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640032119

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941048B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900N4E
Date of Service: September 1, 2021
Overpayment Issue Date: September 21, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214483018900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201210941048B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640027978

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941064B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00RB7
Date of Service: September 8, 2021
Overpayment Issue Date: November 24, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215693438100 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941064B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640034081

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941053B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C1901211
Date of Service: September 13, 2021
Overpayment Issue Date: September 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214647543300 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941053B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640032228

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941045B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1901212
Date of Service: September 13, 2021
Overpayment Issue Date: September 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214647962400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941045B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640032171

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 24, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941040B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A0027L
Date of Service: September 27, 2021
Overpayment Issue Date: October 8, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214824326800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services not paid according to Medi-cal allowable.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941040B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640029170

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941066B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A00FCC
Date of Service: October 5, 2021
Overpayment Issue Date: October 15, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214952649000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201210941066B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640034184

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941070B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A00FCA
Date of Service: October 5, 2021
Overpayment Issue Date: October 15, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214953926000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941070B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640030055

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941041B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A00WLK
Date of Service: October 15, 2021
Overpayment Issue Date: October 29, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215138564800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941041B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031303

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 25, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941055B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00WFP
Date of Service: October 20, 2021
Overpayment Issue Date: November 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215781400400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941055B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640034292

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210940599B
Amount Due: $36.80
Member Number: [redacted]
Member Name [redacted]
Patient Name [redacted]
Patient Account Number: C1A016VL
Date of Service: October 21, 2021
Overpayment Issue Date: October 29, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $36.80 has been made on claim number 215241061400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $36.80 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210940599B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640032764

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210940598B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A016I5
Date of Service: October 21, 2021
Overpayment Issue Date: October 29, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215241314000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210940598B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640032428

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941044B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00WQ8
Date of Service: October 21, 2021
Overpayment Issue Date: November 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $12.47 has been made on claim number 215794663600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $12.47 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941044B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640033362

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 25, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941056B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00VRF
Date of Service: October 26, 2021
Overpayment Issue Date: November 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215781325300 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941056B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640034344

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941043B
Amount Due: $49.88
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00WVU
Date of Service: October 26, 2021
Overpayment Issue Date: November 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $49.88 has been made on claim number 215794235200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $49.88 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941043B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640032379

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

January 25, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941042B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00V2X
Date of Service: October 27, 2021
Overpayment Issue Date: November 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215781386000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201210941042B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031804

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941061B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00V2W
Date of Service: October 27, 2021
Overpayment Issue Date: November 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215781507200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941061B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031760

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210941046B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00V2Y
Date of Service: November 1, 2021
Overpayment Issue Date: November 30, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215781330600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941046B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640033266

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 25, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941068B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00PK4
Date of Service: November 11, 2021
Overpayment Issue Date: November 23, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215673980200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941068B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031453

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201210940595B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00POL
Date of Service: November 15, 2021
Overpayment Issue Date: November 23, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215674532600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services not paid according to Medi-cal allowable.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210940595B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640034231

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

January 24, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2201210941072B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B00RLA
Date of Service: November 15, 2021
Overpayment Issue Date: November 24, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 215693633200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201210941072B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640031962

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 3, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311436497B
Amount Due: $362.97
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1301FZQ
Date of Service: February 16, 2021
Overpayment Issue Date: April 6, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $362.97 has been made on claim number 211530420500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $362.97 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201311436497B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213440005197

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 3, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311436507B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1900BOI
Date of Service: August 9, 2021
Overpayment Issue Date: September 14, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 214347470900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201311436507B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213640033767

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 3, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311436595B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00BQ5
Date of Service: November 10, 2021
Overpayment Issue Date: December 21, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216057283000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201311436595B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220210017634

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 4, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311437141B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C1C00C2F
Date of Service: November 11, 2021
Overpayment Issue Date: December 14, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $12.47 has been made on claim number 216056314900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $12.47 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201311437141B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220200023245

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

February 3, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311437025B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00D27
Date of Service: November 11, 2021
Overpayment Issue Date: December 17, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216075709900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201311437025B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220200025198

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 3, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311437103B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00D26
Date of Service: November 11, 2021
Overpayment Issue Date: December 17, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216077214600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201311437103B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220200022844

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

February 4, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311437138B
Amount Due: $15.00
Member Number: [redacted]
Member Name:
Patient Name:
Patient Account Number: C1C00D28
Date of Service: November 12, 2021
Overpayment Issue Date: December 17, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216077587600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2201311437138B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220200020810

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 3, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2201311437112B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00MJM
Date of Service: November 17, 2021
Overpayment Issue Date: December 21, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216185959000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2201311437112B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220200026842

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 23, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202170900481B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C210059W
Date of Service: December 3, 2021
Overpayment Issue Date: January 14, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 220109361900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2202170900481B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220410037082

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 23, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202170900480B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C21007ZD
Date of Service: December 16, 2021
Overpayment Issue Date: January 14, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 220141638000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of _InsertAmt_ within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2202170900480B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220410036834

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

February 24, 2022

Centro Medico El Cajon
Attn: Patient Accounts
Po Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202220942150B
Amount Due: 32.62
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1B010GU
Date of Service: October 27, 2021 to October 27, 2021
Overpayment Issue Date: December 7, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of 32.62 has been made on claim number 215892092800 for the member and dates of service identified above. The total amount of this overpayment includes an improper interest overpayment in the amount of 32.62. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

procedures 99213 and 90460 are not separately reportable when performed on the same date without bypass modifiers

We request reimbursement for this overpayment in the amount of 32.62 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2202220942150B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If you agree with this overpayment but prefer to have us withhold and offset the amount of this overpayment from your future claims payments instead of repaying the overpayment in a single payment, please notify us in writing within thirty (30) working days from the date of this letter. We will work with you to accommodate your request.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220470037590

Enclosure(s):
Appeals-Provider/Hospital

Please return this portion with remittance to the address listed below.

Subscriber Name: [redacted]
Subscriber Number: [redacted]
A/R Number: _InsertAR_
Claim Number: 215892092800

Amount Due: 32.62
Patient Name: [redacted]
Amount Paid: $
Date of Service: 10/27/2021 to 10/27/2021

To make the payment using your Visa or MasterCard, please complete the following information:

Name as stated on credit card: _____

Date of Expiration: _____

Credit Card Number: _____

Phone Number: Day: _____

Evening: _____

Signature of Card Holder: _____

Send payment to:

Blue Shield of California
Corporate Recovery Dept
P.O. Box 241012
Lodi, CA 95241

blue california
Promise Health Plan

March 2, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202251013164B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C2100307
Date of Service: November 30, 2021
Overpayment Issue Date: January 11, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 220070781500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2202251013164B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220270022035

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

March 2, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2202251013141B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00SEL
Date of Service: December 13, 2021
Overpayment Issue Date: December 24, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216275769200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2202251013141B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220270021051

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

March 1, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202251013136B
Amount Due: $12.47
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00TNU
Date of Service: December 14, 2021
Overpayment Issue Date: December 28, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $12.47 has been made on claim number 216314118600 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $12.47 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2202251013136B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220270022326

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

March 1, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202251013188B
Amount Due: $37.41
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00XOF
Date of Service: December 14, 2021
Overpayment Issue Date: December 31, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $37.41 has been made on claim number 216362658400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $37.41 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2202251013188B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220270020926

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

March 2, 2022

Centro Medico El Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202251013159B
Amount Due: $37.41
Member Number: [redacted]
Member Name [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00UUB
Date of Service: December 17, 2021
Overpayment Issue Date: December 28, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $37.41 has been made on claim number 216313798900 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $37.41 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2202251013159B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220270021125

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

March 1, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2202251013143B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1C00Z92
Date of Service: December 17, 2021
Overpayment Issue Date: December 31, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216421141100 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s): The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2202251013143B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220270021633

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

March 14, 2022

Borrego Medical Clinic
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2203111005265B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C1C014RR
Date of Service: December 23, 2021
Overpayment Issue Date: January 7, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 216475263800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

The submitted procedure is disallowed because an add on code was billed without the presence of a related and paid primary service/procedure. The denied service should not be billed to the beneficiary.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2203111005265B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working

days of your receipt of this overpayment notice. If you provide us with a timely written notice that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 220270021394

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

April 27, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2204181434229B
Amount Due: $66.02
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C0C01GGS
Date of Service: December 21, 2020
Overpayment Issue Date: February 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $66.02 has been made on claim number 205500494200 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $66.02 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2204181434229B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 213400006916

Enclosure(s):
Appeals-Provider/Hospital

PROVIDER DISPUTES OR APPEALS

MEDICARE NON-CONTRACTED PROVIDER DISPUTES:

Provider Disputes must be submitted to Blue Shield of California Promise Health Plan, at the address listed below, within 120 calendar days after receipt of the notice of the initial payment determination.

Items that may be filed as Provider Disputes include:

- Underpayment (the amount paid by Blue Shield of California Promise Health Plan for covered services is less than the amount that would have been paid under original Medicare); or
- Disagreement about Blue Shield of California Promise Health Plan's decision to make payment on a more appropriate code.

Denials of payments due to coverage and medical necessity determinations are not subject to the Provider Dispute Process. These items must be submitted as a Provider Appeal.

MEDICARE NON-CONTRACTED PROVIDER APPEALS:

Provider Appeals must be submitted to Blue Shield of California Promise Health Plan within 60 calendar days after receipt of the notice of the initial determination/decision.

Non-contracted providers must also submit a signed Waiver of Liability statement holding the member harmless regardless of the outcome of the appeal.

Copy of Waiver of Liability form can be found at: www.blueshieldca.com/promise/provider

Blue Shield of California Promise Health Plan
ATTN: Provider Dispute Dept.
P.O. Box 3829
Montebello, CA 90640

blue california
Promise Health Plan

May 9, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2205041127515B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C2200C0N
Date of Service: February 1, 2022
Overpayment Issue Date: February 18, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 220833165800 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2205041127515B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 221170000263

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 27, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2206141036108B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C220063Y
Date of Service: January 19, 2022
Overpayment Issue Date: February 11, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 220705662400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2206141036108B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 221170000156

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 27, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2206141036116B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C2200AY4
Date of Service: January 27, 2022
Overpayment Issue Date: February 18, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 220800100400 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2206141036116B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 221170000227

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

June 27, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2206141036119B
Amount Due: $15.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C2200C0D
Date of Service: February 1, 2022
Overpayment Issue Date: February 8, 2022

Dear Patient Accounts,

We have determined that an overpayment in the amount of $15.00 has been made on claim number 220832656500 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid above contracted percentage without NTE cap.

We request reimbursement for this overpayment in the amount of $15.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2206141036119B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 221170000244

Enclosure(s):
Appeals-Provider/Hospital

blue california
Promise Health Plan

September 8, 2022

Centro Medico EL Cajon
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004-2369

A/R Number: AR2209011720008B
Amount Due: $168.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name:
Patient Account Number: C19017WN
Date of Service: September 22, 2021
Overpayment Issue Date: October 5, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $168.00 has been made on claim number 214743015700 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid in error without authorization.

We request reimbursement for this overpayment in the amount of $168.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R#AR2209011720008B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 222500012974

Enclosure(s):
Appeals-Provider/Hospital
Explanation of Benefits

blue california
Promise Health Plan

September 8, 2022

Centro Medico Escondido
Attn: Patient Accounts
P O Box 2369
Borrego Springs, CA 92004

A/R Number: AR2209011720041B
Amount Due: $18.00
Member Number: [redacted]
Member Name: [redacted]
Patient Name: [redacted]
Patient Account Number: C1A00ZDI
Date of Service: October 19, 2021
Overpayment Issue Date: October 26, 2021

Dear Patient Accounts,

We have determined that an overpayment in the amount of $18.00 has been made on claim number 215153758000 for the member and dates of service identified above. 42 U.S.C. Section 1320a-7k(d)(2)(A); 42 U.S.C. Section 1320a-7k(d)(3)

This payment has been identified as an overpayment due to the following reason(s):

Services paid in error without authorization.

We request reimbursement for this overpayment in the amount of $18.00 within thirty (30) working days of your receipt of this letter. Please make the check payable to Blue Shield of California Promise Health Plan and send payment with a copy of this letter to:

Blue Shield of California Promise Health Plan
Attn: Cash Receiving
P.O. Box 241012
Lodi, CA 95241

To avoid delay in processing, please submit your payment referencing A/R# AR2209011720041B.

If you wish to contest this overpayment notice, you must provide us with a written notice stating the basis upon which you believe that the claim was not overpaid within thirty (30) working days of your receipt of this overpayment notice. If you provide us with a timely written notice

that you are contesting the overpayment, we will receive and treat your notice as a provider dispute and timely respond to your dispute.

Please be advised that, pursuant to Health & Safety Code Section 1371.1(b)(2), if reimbursement of an uncontested overpayment is not received within thirty (30) working days after your receipt of this notice, interest shall accrue at a rate of 10 percent per annum beginning with the first calendar day after the expiration of the thirty (30) working day period.

If we do not receive reimbursement of the amount of the overpayment or written notice that you are contesting this overpayment request within the thirty (30) working day period, we will commence offsetting the amount of the overpayment from your future claims payments as permitted by your provider participation agreement.

If you have further questions, please call us toll free at (800) 468-9935, 8:00 a.m. to 4:00 p.m., Monday through Friday.

Sincerely,

Corporate Recovery
Blue Shield of California Promise Health Plan
Inquiry Number: 222490020926

Enclosure(s):
Appeals-Provider/Hospital