Currently, Kaiser Permanente in California provides several types of remittance advices. These will be consolidated into one EOP type, used statewide.

- The new EOP will contain a detailed explanation of payment, including:
  - Patient information – including benefit and member type information
  - Claim information – billed services
  - Basic payment information – pricing detail, member cost share, etc.
- When multiple claims are adjudicated for provider during a certain time frame, the EOP will consolidate all the claims payments onto one check.
- Based on the current process design, paper checks and EOPs will be included in the same mailing.

Please see the following pages which contain a sample EOP form based on a northern California claim.
MEMORIAL HOSPITAL
1234 MAIN ST
SAN FRANCISCO, CA 94199

**ACCOUNT SUMMARY**

<p>| | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td># of Claims</td>
<td>Billed Amount</td>
<td>Allowed Amount</td>
<td>Disallowed Amount/Discount</td>
<td>Not Cov’d Amount</td>
<td>Applied to Deductible</td>
<td>CoPay</td>
<td>Coins</td>
<td>Other Ins</td>
</tr>
<tr>
<td>Claims Payment Total</td>
<td>8</td>
<td>1</td>
<td>72.12</td>
<td>1.45</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>70.67</td>
</tr>
<tr>
<td>Interest Amount</td>
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<td>1</td>
<td>72.12</td>
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<td>1</td>
<td>72.12</td>
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<td>0.00</td>
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<tr>
<td>Method of Payment:</td>
<td>21</td>
<td>Check/EFT Amount</td>
<td>22</td>
<td>70.85</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total Payment Amount</td>
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<td>70.85</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other / Claims Related Transactions</td>
<td>24</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Account Summary shows the current Provider account status with the KP region shown above, in this case Northern California.

SECURITY NOTE: The face of this check is printed on a blue background. See reverse for additional security features.

Kaiser Permanente
California Claims Administration
Northern California
Kaiser Foundation HealthPlan, Inc.
P.O. Box 12923
Oakland, CA 94604-2923

Pay * Seventy and 85/100 Dollars *
To the order of MEMORIAL HOSPITAL
1234 MAIN ST
SAN FRANCISCO, CA 94199

Check No: 2000002368
Date: 04/01/2016

Non-Negotiable

$ ****70.85****

Void

Authorized Signature MP
The following security features (and others not listed) exceed industry standards:

<table>
<thead>
<tr>
<th>Security Features</th>
<th>Document appearance if altered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Screen</td>
<td>Absence or modification of &quot;Original Document&quot; screen on back of check</td>
</tr>
<tr>
<td>Microprint Signature Line</td>
<td>Absence of any words or dotted line appear in signature line</td>
</tr>
<tr>
<td>Padlock Icon</td>
<td>Absence of padlock icon</td>
</tr>
</tbody>
</table>

© Padlock design is a certification mark of Check Payment Systems Association
# Explanation of Payment

<table>
<thead>
<tr>
<th>#</th>
<th>Service Dates</th>
<th>Service Code</th>
<th>Service Mod</th>
<th>Billed Amount</th>
<th>Disallowed Amount/Discount</th>
<th>Not Cov'd Amount</th>
<th>Applied to Deductible</th>
<th>CoPay</th>
<th>Other Ins</th>
<th>Plan Pays</th>
<th>Remark Code(s)</th>
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<tbody>
<tr>
<td>1</td>
<td>01/25/2016</td>
<td>0250</td>
<td></td>
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<td>0.01</td>
<td>0.72</td>
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<td>0.00</td>
<td>0.71</td>
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<tr>
<td>2</td>
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<td>0250</td>
<td></td>
<td>1.63</td>
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<td>0270</td>
<td></td>
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<tr>
<td>11</td>
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<td></td>
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</table>

**Payment Date:** 04/01/2016
**Explanation of Payment**

<table>
<thead>
<tr>
<th>Date</th>
<th>Billed Amount</th>
<th>Disallowed Amount</th>
<th>Not Cov’ed Amount</th>
<th>Applied to Deductible</th>
<th>CoPay</th>
<th>Other Ins</th>
<th>Plan Pays</th>
<th>Remark Code(s)</th>
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<tbody>
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<td>15.86</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>45</td>
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<tr>
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<td>0.00</td>
<td>0.00</td>
<td>15.54</td>
<td>45</td>
</tr>
</tbody>
</table>

**Total** 72.12 1.45 0.00 0.00 70.67

**Method of Payment:** Check / EFT Amount 70.65

**Provider:** MEMORIAL HOSPITAL

**Provider NPI:** 1XXXXXXXX

**POS:** TOB: 131

**LOB:** SRA - SENIOR ADVANTAGE

**Patient Acct No (Provider):** 4001437040001B

**Vendor TIN:** 9XXXXXXXX

**Claim #:** 54699

**Auth #:** 50

**Remark Code(s):** 45

Chg exceeds fee sched/max allowable or contract/ltd fee, use only with Group Codes PR/CO

**Claim Remark Codes and Descriptions**

- **45:** Chg exceeds fee sched/max allowable or contract/ltd fee, use only with Group Codes PR/CO
<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
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<tr>
<td>9</td>
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<td>11</td>
<td>Allowed Amount</td>
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<tr>
<td>14</td>
<td>Applied to Deductible</td>
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<tr>
<td>50</td>
<td>Authorization Number</td>
</tr>
<tr>
<td>51</td>
<td>Claim Payment Amount</td>
</tr>
<tr>
<td>8</td>
<td>Claim Payment Total</td>
</tr>
<tr>
<td>16</td>
<td>Coins</td>
</tr>
<tr>
<td>15</td>
<td>CoPay</td>
</tr>
<tr>
<td>12</td>
<td>Disallowed Amount/Discount</td>
</tr>
<tr>
<td>19</td>
<td>Interest Amount</td>
</tr>
<tr>
<td>44</td>
<td>Line of Business</td>
</tr>
<tr>
<td>21</td>
<td>Method of Payment</td>
</tr>
<tr>
<td>13</td>
<td>Not Covered Amount</td>
</tr>
<tr>
<td>24</td>
<td>Other Claim Related Transactions</td>
</tr>
<tr>
<td>17</td>
<td>Other Ins</td>
</tr>
<tr>
<td>46</td>
<td>Patient Account Number (Provider)</td>
</tr>
<tr>
<td>40</td>
<td>Patient ID/MRN</td>
</tr>
<tr>
<td>39</td>
<td>Patient Name</td>
</tr>
<tr>
<td>3</td>
<td>Payment Date</td>
</tr>
<tr>
<td>37</td>
<td>Plan Pays</td>
</tr>
<tr>
<td>43</td>
<td>Place of Service</td>
</tr>
<tr>
<td>41</td>
<td>Provider</td>
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<td>42</td>
<td>Provider NPI</td>
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</tr>
<tr>
<td>26</td>
<td>Check/EFT Number</td>
</tr>
<tr>
<td>35</td>
<td>Check/EFT Amount</td>
</tr>
<tr>
<td>48</td>
<td>Claim Number</td>
</tr>
<tr>
<td>55</td>
<td>Claim Payment Amount</td>
</tr>
<tr>
<td>4</td>
<td>Total Payment Amount</td>
</tr>
<tr>
<td>5</td>
<td>Vendor ID No</td>
</tr>
<tr>
<td>47</td>
<td>Vendor Tax ID No</td>
</tr>
<tr>
<td>10</td>
<td>Billed Amount</td>
</tr>
<tr>
<td>22</td>
<td>Check/EFT Number</td>
</tr>
<tr>
<td>34</td>
<td>CoPay</td>
</tr>
<tr>
<td>30</td>
<td>Disallowed Amount/Discount</td>
</tr>
<tr>
<td>31</td>
<td>Interest Amount</td>
</tr>
<tr>
<td>52</td>
<td>Line of Business</td>
</tr>
<tr>
<td>53</td>
<td>Claim Payment Total</td>
</tr>
<tr>
<td>52</td>
<td>Method of Payment</td>
</tr>
</tbody>
</table>

**UNDERSTANDING YOUR EXPLANATION OF PAYMENT (EOP) STATEMENT**

Please retain for your records.

- Refunds Received - Funds received from the vendor for identified overpaid claims.
- Remark Code - Codes describing how the claim was processed.
- Remittance Number - A unique number identifying this Explanation of Payment (EOP).
- Reversal Claims - Used to account for adjusted claims.
- Service Code - A code used to describe the medical services and procedures provided.
- Service Dates - The dates on which the services were provided.
- Service Mod (Service Modifier) - An alpha and/or numeric code appended to a CPT/HCPCS procedure code to clarify the services or procedures being billed.
- Total Payment Amount - The sum of the individual claims.
- Total Payment Amount = Claims Payment Amount + Interest Amount + Penalty Amount.
- TOB (Type of Bill) - A three digit code located on a claim form that describes the type of bill a provider is submitting.
- Vendor ID No - The internal account number that Kaiser Permanente assigns each vendor.
- Vendor NPI - A CMS number assigned to the vendor for billing and identification purposes.
- Vendor Tax ID No - Federally issued tax identification number.
- Write-Offs - Vendor balance forgiven by Kaiser Permanente.
- Write-Ons - Used to account for existing overpayment balances.
This page is intentionally left blank.

This page of an actual EOP contains information related to provider dispute rights and mailing addresses for the Kaiser Permanente region issuing the EOP.
Currently, Kaiser Permanente in California provides several types of remittance advices. These will be consolidated into one EOP type, used statewide.

- The new EOP will contain a detailed explanation of payment, including:
  - Patient information – including benefit and member type information
  - Claim information – billed services
  - Basic payment information – pricing detail, member cost share, etc.
- When multiple claims are adjudicated for provider during a certain time frame, the EOP will consolidate all the claims payments onto one check.
- Based on the current process design, paper checks and EOPs will be included in the same mailing.

Please see the following pages which contain a sample EOP form based on a Southern California claim.
Questions? Call Customer Service at (800) 390-3510
Weekdays Mon - Fri 8:00AM - 5:00PM PST
Weekends Sat - Sun 8:00AM - 6:00PM PST

Check / EFT #: 800000XXXX
Remittance Number: EOPVEnXXX
Payment Date: 06/23/2016
Total Payment Amt: 110.00
Vendor Tax ID No: 13XXXXXXX
Vendor ID No: 1XXXXXXXXX
Vendor NPI No: 1XXXXXXXXX

***ACCOUNT SUMMARY***

<table>
<thead>
<tr>
<th># of Claims</th>
<th>Billed Amount</th>
<th>Disallowed Amount/Discount</th>
<th>Not Cov'd Amount</th>
<th>Applied to Deductible</th>
<th>CoPay</th>
<th>Other Ins</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Payment Total</td>
<td>2</td>
<td>180.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>70.00</td>
<td>110.00</td>
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<tr>
<td>Total Payment Amount</td>
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<td>180.00</td>
<td>0.00</td>
<td>0.00</td>
<td>70.00</td>
<td>110.00</td>
<td></td>
</tr>
</tbody>
</table>

Method of Payment:
Check/EFT Amount: 110.00
Total Payment Amount: 110.00

Other / Claims Related Transactions: 0.00

SECURITY NOTE: The face of this check is printed on a blue background. See reverse for additional security features.

Pay * One Hundred Ten Dollars *
To the order of SAMPLE PROVIDER
1234 MAIN STREET
LOS ANGELES, CA 99999-9999

62-XX / XXX
Citibank, N.A.
One Penn's Way
New Castle, DE 19720
Check No: 800000XXXX
Date: 06/23/2016

Non-Negotiable

$ ****110.00****

VOID

Authorized Signature
# Explanation of Payment

## Patient Name: TEST PATIENT 1

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>06/13/2016 90837 90.00 90.00</td>
<td>06/13/2016 90.00</td>
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<td>70.00</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total 90.00 0.00 0.00 0.00 20.00</td>
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<td>70.00</td>
<td>0.00</td>
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<tr>
<td>Claim Payment Total</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Method of Payment:</td>
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<td>Check / EFT Amount</td>
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## Patient Name: TEST PATIENT 2

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<th></th>
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<td>0.00</td>
<td>50.00</td>
<td>40.00</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 90.00 0.00 0.00 0.00 50.00</td>
<td>0.00</td>
<td>40.00</td>
<td>0.00</td>
<td></td>
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<td></td>
<td></td>
</tr>
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<td>Claim Payment Total</td>
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<td></td>
<td></td>
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<tr>
<td>Method of Payment:</td>
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<td>Check / EFT Amount</td>
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</tr>
<tr>
<td>Total Payment Amount</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Remark Codes

3 Co-payment Amount
# Line Number - The line number that coincides with the
# line number on the submitted claim.

**Number of Claims** - The total number of
claims covered by this Explanation of Payment (EOP).

Allowed Amount - The total allowable amount as
determined by contract, other provider agreement, or
reasonable and customary payment guidelines.

Applied to Deductible - The amount of member's
deductible applied to the claim.

# Authorization Number - An assigned number that
identifies the authorization for approved services identified
on the claim.

Billed Amount - The amount billed by the provider
for a specific service or set of services.

Check/EFT Amount - The net amount of the check/EFT payment.

Check/EFT No - The payment instrument number issued on a check/EFT
paid to the vendor or member/subscriber.

Claim # - A number assigned by Kaiser Permanente to an individual claim.

Claim Payment Amount - The sum of the individual claims
Total amounts covered by this Explanation of Payment
(EOP).

Claim Payment Total - The total amount of the claim,
interest, and penalty paid by the Plan.

Coinsurance - A percentage of the payment amount
of the insured pays against a claim.

CoPay - A fixed amount the insured pays against a claim.

Disallowed Amount/Discount - Reflects contractual
allowances, usual and customary (U&C) charges, provider
responsibility/not covered, and discounts.

Interest Amount - The interest penalty amount required
under governing rules for the specific Line of Business.

LOB - The relevant rules under which
the patient is enrolled as Kaiser Foundation Health Plan
member.

Method of Payment - Describes the method of payment
for the Claim Payment Total or Total Payment Amount (e.g.
check/EFT, recoupment, prepayment, etc., as applicable).

Not Covered Amount - Services not included under the terms of the insurer's health care
coverage.

Other Claim Related Transactions - Includes reversal
claims, refunds received, recoupments applied, prepayments,
write-ons and write-offs.

Other Ins - The amount paid by another
financially responsible insurance carrier as primary on the
claim, under Coordination of Benefits, Third Party Liability or
Workers' Compensation.

Patient Acct No/Provider ID/MRN - The patient account number for the patient.

Patient ID/MRN - The Kaiser Permanente identification
number or medical record number for the patient.

Patient Name - The name of the patient to whom the
services were provided on this claim.

Patient Out of Pocket - Remaining cost share from the
amount determined by primary coverage that the patient
owes after additional payment by Kaiser Permanente on
non-primary claims.

Payment Date - The date the claims represented on
this Explanation of Payment (EOP) were paid.

Penalty Amount - A payment amount other than interest
that may be required to pay the provider under governing
rules for the specific Line of Business.

Plan Pays - The total amount paid by Kaiser Permanente
for all payable services on the individual claim or total of all
claims.

POS - The location where the service was
provided.

Prepayments - Funds paid to provider in advance of
services used to satisfy liability of submitted claims
consistent with the terms of the provider's contractual
agreement.

Provider - The provider of services associated
with the claim.

Provider ID - A CMS number assigned to the vendor for billing
and identification purposes.

Recoupments - Funds resulting from overpayments used to
offset payment of claims.

Refunds Received - Funds received from the vendor for
identified overpaid claims.

Remark Code - Codes describing how the claim was
processed.

Remittance Number - A unique number identifying this
Explanation of Payment (EOP).

Reversal Claims - Used to account for adjusted claims.

Service Code - A code used to describe the medical
services and procedures provided.

Service Dates - The dates on which the services were
provided.

Service Mod - An alpha and/or numeric
code appended to a CPT/HCPCS procedure code to clarify
the services or procedures being billed.

Total Payment Amount - The sum of the individual claims
Total amounts covered by this Explanation of Payment
(EOP). Total Payment Amount = Claims Payment Amount +
Interest Amount + Penalty Amount.

TOB - A three digit code located on a claim form that describes the type of bill a provider is submitting.

Vendor ID No - The internal account number that Kaiser Permanente assigns
each vendor.

Vendor NPI No - A CMS number assigned to the vendor for billing
and identification purposes.

Vendor Tax ID No - Federally issued tax identification number.

Withheld Amount - Payments made to 3rd parties/ lien
holders on behalf of the vendor.

Write Offs - Vendor balance forgiven by Kaiser Permanente

Write Ons - Used to account for existing overpayment
balances.
IMPORTANT INFORMATION ABOUT YOUR RIGHTS TO DISPUTE OUR DETERMINATION ON THIS CLAIM

For information generally about a paid claim, please call: (800) 390-3910. If you wish to dispute our action or decision, you must submit your dispute in writing to one of the following addresses:

Please make a note of this address to use for all future correspondence with us regarding our provider dispute resolution process.

Kaiser Foundation Health Plan, Inc.
California Claims Administration
Post Office Box 7006
Downey, CA 90242-7006

You must include the following minimum information with your written dispute or it will be returned to you:
- Provider tax identification number (TIN)
- Kaiser Permanente initial claim number
- Patient's Kaiser Permanente medical record number
- Date(s) of service
- A clear explanation of the basis for your belief that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action on the claim is incorrect.

Time Period for Submission of Provider Payment Disputes

Subject to any other period specifically permitted under your agreement or required under applicable law, provider payment disputes must be received by KP within 365 days from our most recent action or inaction that led to the dispute.

If you would like to receive a Kaiser Permanente Provider Payment Dispute Resolution Form, please contact our Call Center at 1-800-390-3510.

If all necessary information has been included in your written dispute, your dispute will be acknowledged within 15 working days of our receiving it. We will promptly consider your issue(s) and inform you of our decision within 45 working days of the date we received your dispute. If we require more information which you have not previously provided, or which we have previously returned to you, we will notify you shortly after receiving your dispute of the specific information that we need. We must receive this information within 30 working days of our request, or our initial determination will be automatically upheld. Your dispute will be promptly considered once we receive the requested information. We will communicate our final decision, including the specific reason for any denial of your request, to you in writing. If you choose to take advantage of our provider dispute resolution process, we strongly urge you not to bill the patient during the dispute resolution period.

Regarding the Practice of Balance Billing

Kaiser Permanente enrollees are financially responsible for their contractual cost share amounts, e.g., copayments, coinsurance, deductibles, etc. California regulations prohibit balance billing of HMO members by contracted providers and providers of emergency services.
(professional and institutional) for amounts in excess of these cost shares. Please refer to the applicable state rules prior to billing Kaiser Permanente enrollees. Follow the included provider payment dispute guidelines to resolve non-cost share related payment issues.

Please remember, if you are a provider of services to a Medi-Cal No-Share-of-Cost patient, you are precluded by regulation from seeking reimbursement from our member for any item(s) or service(s) that have been denied unless he/she was previously informed that he/she may be financially responsible. **If that notification was not given, the member is not responsible for payment of this claim and you may not balance bill this member.**

Please also note, if you are a Medicare participating provider, you are precluded from balance billing beneficiaries enrolled in Medicare because you have agreed to accept the Medicare allowed amount as payment in full.

Sincerely,

Kaiser Foundation Health Plan, Inc.