FROM Linda Clark, Regulatory Appeals Analyst
5757 Plaza Drive MS CA 124-0157
Cypress. CA 90630
Toll -Free # 866-744-4543
Direct# (714) 226-6742

RECEIVED
DEPT. OF INSURANCE
LOS ANGELES

07 JAN 25 AM 12: 03

[redacted]

PacifiCare®

January 24, 2007

[redacted]

Insured:	[redacted]
Patient:	same
Patient ID:	074022400
Plan Type:	PPO

California DOI file: **CSB-6232755**

Dear Mr. [redacted]

This letter is written in reference to the letter of complaint that PacifiCare, a United Healthcare Company received from the California Department of Insurance on January 5, 2007. The information contained in our response pertains to your claims reimbursement for the services you obtained from the Turner Eye Institute and Horizon Vision for dates of service July 24, 2006 and August 7, 2006.

The Department of Insurance has asked that we evaluate the matter of your request for assistance regarding the reimbursement for the services that you obtained from the Turner Eye Institute and Horizon Vision for the eye surgeries that you obtained on July 24, 2006 and August 7, 2006. Your letter states that you have sent the claims to PacifiCare so that the reimbursement could be sent to you. However, to date, you have not received it.

Upon receipt of the California Department of Insurance, PacifiCare investigated this issue. Our records indicate that the claim from Horizon Vision was initially denied as not a covered benefit pending receipt of proof of payment. On December 27, 2006, the claim was re-processed for payment and a check in the amount of $772.60 was sent to you, which included interest in the amount of $22.60.

The related claim for Turner Eye Institute for date of service July 24, 2006, was received on August 1, 2006 and processed for payment on September 7, 2006. A check was sent to the provider on September 7, 2006, in the amount of $655.49, check number 006003998386.

P.O. Box 6006 • Cypress, California 90630-0006
www.pacificare.com

[redacted]

For date of service August 7, 2006, the claim for Horizon Medical was denied on January 13, 2007, due to examiner error. On January 13, 2007, the claim was re-processed for payment and a check in the amount of $697.50 was sent to you, check number 00600523338. No interest was paid as the claims department did not receive the claim until January 5, 2007.

The claim for Turner Eye Institute for date of service August 7, 2006, was received on August 22, 2006 and processed for payment on September 14, 2006, in the amount of $1038.34, check number 006004030069, sent to the provider.

We hope that this resolves the issues you have pre
and concerns please do not hesitate to call our cust
9776.

$697.50 =

Recovery

1/13/07 - denied claim in error.

Sincerely,

Linda Clark

Linda Clark, Analyst
Regulatory Appeals
PacifiCare Life and Health Insurance Company
5757 Plaza Drive MS CY 44-157
Cypress, CA 90630

cc: Steven Brunelle, Senior Insurance Compliance Officer

[redacted]

For date of service August 7, 2006, the claim for Horizon Medical was denied on January 13, 2007, due to examiner error. On January 13, 2007, the claim was re-processed for payment and a check in the amount of $697.50 was sent to you, check number 00600523338. No interest was paid as the claims department did not receive the claim until January 5, 2007.

The claim for Turner Eye Institute for date of service August 7, 2006, was received on August 22, 2006 and processed for payment on September 14, 2006, in the amount of $1038.34, check number 006004030069, sent to the provider.

We hope that this resolves the issues you have presented. If you have further questions and concerns please do not hesitate to call our customer services department at 866 316-9776.

Sincerely,

Linda Clark

Linda Clark, Analyst
Regulatory Appeals
PacifiCare Life and Health Insurance Company
5757 Plaza Drive MS CY 44-157
Cypress, CA 90630

cc: Steven Brunelle, Senior Insurance Compliance Officer

Enclosures: Claims Payment Screens
Copies of receipt from Mr. [redacted]
Complete Certificate
Schedule of Benefits
Member Service Call notes

[redacted]

Member service Call notes.

Family Phone Log Inquiry csi-2

Client 90219335 SPORTS LEADERSHIP GROUP Detail
Enrollee SSN [redacted] All
Member e [redacted]
From Date 01/01/2000 Calls 2 No. Scrolled 2

Call	Date	Description	Rep	Claim	Mem	Inq	Stat
3032841	05/31/2006		ABU		e	IBN	f

p: opthalmologist states mbr needs eye surgery

s: IF MEDICALLY NECESSARY IT WILL BE COVERED AND SUB
JECT TO DEDUCT AND COINS. REFERRAL IS NOT NEEDED

3068861	06/13/2006		OSJ		e	IBN f

p: OP SURG BENE COV AT 70%/ 30% AFTER DED 1000
NONE HAVE BEEN MET

Enter Call Number, Log, (D)ate, (R)estart,
(E)nd or Return to Continue

[redacted]

Family Phone Log Inquiry csi-2

Client 90219335 SPORTS LEADERSHIP GROUP Detail
Enrollee SSN [redacted] All
Member e [redacted]
From Date 01/01/2000 Calls 5 No. Scrolled 5

Call	Date	Description	Rep	Claim	Mem	Inq	Stat
3176799	07/24/2006		SOR		e	IBN	f
p:	PAR PROVIDER CCKING IF OUTPAT SURGERY WLD BE COVERED-$1K DED ONLY $436.42,PRE CERT 866-863 9776 OPT 5/3-FOR CPT CODE 0099T,PAR OUPT SURGER BEN ARE 70% AFTER DED						
3176983	07/24/2006		IDJ		e	IBN	f
p:	par op surg 1000ded 70% 436.42 of ded met, code 0099T no auth req,						
3306499	09/01/2006		OHO		e	IBN	f

Enter Call Number, Log, (D)ate, (R)estart, (E)nd or Return to Continue

[redacted]

Family Phone Log Inquiry csi-2

Client 90219335 SPORTS LEADERSHIP GROUP Detail

Enrollee SSN [redacted] All

Member e [redacted]

From Date 01/01/2000 Calls 6 No. Scrolled 6

Call	Date	Description	Rep	Claim	Mem	Inq	Stat
p:		I:CLM #19296986-01 DOS 8.15.06 $150.00 CLM SENT TO MBR STATING THAT EYE EXAM IS NOT COV A:CLM NOT PAID BC THE EYE EXAMS AND LENS ADJUSTSS NOT COV					
3375714	09/26/2006		4TF		e	IPC	f
p:		VDOB/CLM DOS 8.15.06 $150.00 TURNEER EYE..PROV STATED THAT THIS IS A MEDICAL DX					
s:		REF #/REVA 1641759 ADV 15-30 DAYS TO PROCESS/CLM 19296986-01					

Enter Call Number, Log, (D)ate, (R)estart,
(E)nd or Return to Continue

[redacted]

Family Phone Log Inquiry csi-2

Client 90219335 SPORTS LEADERSHIP GROUP Detail
Enrollee SSN [redacted] All
Member e [redacted]
From Date 01/01/2000 Calls 8 No. Scrolled 8

Call	Date	Description	Rep	Claim	Mem	Inq	Stat
3477919	11/06/2006		KIW		e	IPC	f

p: I:DOS:08.15.06 TCH:$150.00
A:Eye exams glasses contact lenses and routine eye refractions are not covered

3478512	11/06/2006		SKW		e	ICS	f

p: CL#19661755 MBR SHOULD HAVE BEEN PD FOR THIS CLAIM IT WAS FOR SURGERY AND NOT FOR LENSES SENT TO REVA REWORKS/
OPS CLM#:19661755/074022400-E/1735033

s: FOR DOS 8.17.06 CLAIM IS NOT ON FILE
866.504.2284/

Enter Call Number, Log, (D)ate, (R)estart, (E)nd or Return to Continue

[redacted]

Scott, Carol L

From: Jacobson, Kari L
Sent: Friday, January 05, 2007 12:00 PM
To: PPO New Mail
Subject: URGENT - ISSUE FROM bROKER SERVICES
Attachments: M0240464070056127500.tif

I sent this over originally on 12/21/06. I need confirmation that this is logged (batched) in RIMS.

Thank you,

Kari Jacobson

Broker Services, Escalation Team
Direct (714) 226-7608
Fax (866) 392-7072
Customer Service (800) 947-1672

DATE RECEIVED

JAN 0 5 2007

PPO FRONT-END SUPPORT

[redacted]

Itemized Bill Attached

PacifiCare®

PPO/Indemnity Medical Claim Form

Instructions for Submitting Claims

1. Use a separate form for each family member, each different provider of service and each itemized bill.
2. Attach a fully itemized bill or ask the provider to complete the other side of this form.
   FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION: Date of service, diagnosis, type of service, procedure number, charge for each service, provider name, address, phone number, provider tax ID number.
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs PacifiCare to pay the provider. If you choose not to sign this authorization, benefits will be paid to you.
4. Please send claims to PacifiCare: P.O. Box 6099, Cypress, CA 90630
5. If you have questions regarding your claim or need additional claim forms or claim record envelopes, please call: 1-866-316-9776.
6. Reimbursement of pharmacy expense is outlined in your member materials. (Do not use this form for pharmacy claims.)

Employee Information (Complete for All Claims)

Employer Name: Sports Leadership Group	Group Number: 90219335
Employee's Name (Last, First, M.I.): [redacted]	Employee's Street Address: [redacted]
Employee's Date of Birth: 11-16-56 / Employee's SSN: [redacted]	City: [redacted] / State: [redacted] / Zip Code: [redacted]

This claim is for: ☒ Self ☐ Spouse ☐ Child ☐ Other - Please specify

Patient Information

Patient's Name (Last, First, M.I.): [redacted]	Patient's Date of Birth: 11-16-56 / PacifiCare ID#: 074022400 - 01

Patient is (Check if applicable): ☐ Female ☐ Married ☐ Disabled ☐ Retired ☒ Male ☐ Single ☐ On Medicare ☐ Student

If patient is disabled, give date of disability

Patient was treated for: ☒ Illness ☐ Pregnancy ☐ Injury at Work ☐ Accidental Injury ☐ Other - Please specify

If accident involved, give date, how and where accident occurred

Does patient have other health coverage? ☐ Yes ☒ No	If Yes, Name of Insurance Company: n/a	Group Number	Policy Number
Address of Insurance Company: n/a			
Name of Policy Holder	Sex of Policy Holder: ☐ Male ☐ Female	Policy Holder's Date of Birth	
Name of Policy Holder's Employer	Policy Holder's Employer's Address		

DATE RECEIVED
JAN 0 5 2007
PPO FRONT-END SUPPORT

Authorizations

RELEASE OF INFORMATION
I hereby authorize the release of any medical information [redacted] to process this claim.

[redacted] 8-7-06
Patient's or Authorized Person's Signature Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER
I hereby authorize benefits to be paid directly to the provider of service for this claim.

Patient's or Authorized Person's Signature Date

PLEASE ATTACH AN ITEMIZED BILL OR ASK THE PROVIDER OF SERVICE TO FILL OUT THE OTHER SIDE OF THIS CLAIM FORM

[redacted]

HORIZON VISION CENTERS

14895 East 14th Street, Suite 360
San Leandro, CA 94578

PATIENT RECEIPT

Patient: [redacted]

Address: _____

Home # _____ Surgery Date: 8/7/06

Work # _____ Surgeon: Turner

Type of Surgery:

Procedure	Eyes
• PRK/LASEK	Right Eye
• EPI-LASEK	Left Eye
• LASIK	Both Eyes
• WAVEFRONT	
• INTRALASE	
• INTACS	
• AK	
• RETREAT	Original Surgery Date: _____

Place of Surgery: Horizon Vision Centers

- ✓ San Leandro
- San Jose
- Concord
- Petaluma
- San Francisco
- Sacramento
- Roseville

Diagnosis Code: Myopia (367.1) Hyperopia (367.0) Keratoconus (371.61) (circle one)

Procedure Code: Corneal Refractive Surgery – Conventional (65760) Custom (66999) INTACS (00997) (circle one)

Total Amount Received: $1395.00

Check # Discover American Express Visa MasterCard

Corporate Office: (510) 297-5050 Fax: 297-5057
TAX ID # 30-0097822

[redacted]

PacifiCare®

PPO/Indemnity Medical Claim Form

Instructions for Submitting Claims

1. Use a separate form for each family member, each different provider of service and each itemized bill.
2. Attach a fully itemized bill or ask the provider to complete the other side of this form.
   FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION: Date of service, diagnosis, type of service, procedure number, charge for each service, provider name, address, phone number, provider tax ID number.
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs PacifiCare to pay the provider. If you choose not to sign this authorization, benefits will be paid to you.
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5. If you have questions regarding your claim or need additional claim forms or claim record envelopes, please call: 1-866-316-9776.
6. Reimbursement of pharmacy expense is outlined in your member materials. (Do not use this form for pharmacy claims.)

Employee Information (Complete for All Claims)

Employer Name: SPORTS LEADERSHIP GROUP	Group Number: 90219335
Employee's Name (Last, First M.I.): [redacted]	Employee's Street Address: [redacted]
Employee's Date of Birth: 11-16-1956 / Employee's SSN: [redacted]	City: [redacted] / State: [redacted] / Zip Code: [redacted]

This claim is for: ☒ Self ☐ Spouse ☐ Child ☐ Other - Please specify

Patient Information

Patient's Name (Last, First M.I.): [redacted]	Patient's Date of Birth: 11-16-1956 / PacifiCare ID#: 074022400-01

Patient is (Check if applicable): ☐ Female ☒ Married ☐ Disabled ☐ Retired ☒ Male ☐ Single ☐ On Medicare ☐ Student

If patient is disabled, give date of disability

Patient was treated for: ☒ Illness ☐ Pregnancy ☐ Injury at Work ☐ Accidental Injury ☐ Other - Please specify

If accident involved, give date, how and where accident occurred

Does patient have other health coverage? ☐ Yes ☒ No	If Yes, Name of Insurance Company	Group Number	Policy Number

Address of Insurance Company

Name of Policy Holder	Sex of Policy Holder ☐ Male ☐ Female	Policy Holder's Date of Birth
Name of Policy Holder's Employer	Policy Holder's Employer's Address	

Authorizations

RELEASE OF INFORMATION
I hereby authorize the release of any medical information necessary to process this claim.

[redacted] 7-26-06
Patient's or Authorized Person's Signature Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER
I hereby authorize benefits to be paid directly to the provider of service for this claim.

Patient's or Authorized Person's Signature Date

PLEASE ATTACH AN ITEMIZED BILL OR ASK THE PROVIDER OF SERVICE TO FILL OUT THE OTHER SIDE OF THIS CLAIM FORM

NN000
NN000

[redacted]

Medical Claim Form (Continued)

Physician or Supplier Information

Date of illness (first symptom) OR injury (accident) OR pregnancy (LMP)	Date you were first consulted for this condition	If patient has had same or similar injury, give dates	If emergency, check here ☐

Date patient able to return to work	Dates of total disability: From	Through	Dates of partial disability: From	Through

Name of referring physician or other source (e.g. Public Health Agency)	For services related to hospitalization, give dates: Admitted	Discharged
Name and address of facility where services were rendered (if other than home or office)	Was laboratory work performed outside your office? ☐ Yes ☐ No	

Diagnosis or nature of illness or injury
1
2
3
4
Please relate diagnosis to procedures using reference numbers (1,2,3, etc.)

FAMILY PLANNING ☐ Yes ☐ No

Prior Authorization # (if applicable)

Date of Service	Place of Service	Procedure Code	Fully describe procedures, medical services or supplies for each date (explain unusual services or circumstances)	Diagnosis Code	Charges	Days or units	TOS	For PacifiCare use only
			See receipt attached					

Patient's Account #	Total Charge	Amt Paid	Balance Due.

Provider's Name	Provider's Address
Provider's Phone #	Provider's Tax ID #

21	(IH)	Inpatient Hospital	12	(H)	Patient's Home	32	(NH)	Nursing Home	99	(OL)	Other Locations
22	(OH)	Outpatient Hospital	52	(PSY)	Day Care Facility	31	(SNF)	Skilled Nursing Facility	81	(IL)	Independent Laboratory
11	(O)	Doctor's Office	52	(PSY)	Night Care Facility	41	(AMB)	Ambulance	99	(OMF)	Other Medical Facility

I hereby certify that the services listed above have been performed and payment is therefore due.

Signature of Provider (including degree or credentials) Date

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM FORM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE FOUND GUILTY OF INSURANCE FRAUD.

P.O. Box 6098
Cypress, CA 90630

Customer Service:
866-316-9776
866-816-2018 (TDHI)
www.pacificare.com

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CM-303-42762.10
PC3012-003 Rev. 3/03

Underwritten by PacifiCare Life and Health Insurance Company

HORIZON VISION CENTERS

14895 East 14th Street, Suite 360
San Leandro, CA 94578

PATIENT RECEIPT

Patient: [redacted]

Address: _____

_____

Home # _____ Surgery Date: 7/24/06

Work # _____ Surgeon: Turner

Type of Surgery:

Procedure	Eyes
• PRK/LASEK	(Right Eye)
• EPI-LASEK	Left Eye
• LASIK	Both Eyes
• WAVEFRONT	
• INTRALASE	
• (INTACS)	
• AK	
• RETREAT	Original Surgery Date: _____

Place of Surgery: Horizon Vision Centers

- ✓ San Leandro
- o San Jose
- o Concord
- o Petaluma
- o San Francisco
- o Sacramento
- o Roseville

Diagnosis Code: Myopia (367.1) Hyperopia (367.0) [Keratoconus (371.61)] (circle one)

Procedure Code: Corneal Refractive Surgery – Conventional (65760) Custom (66999) [INTACS (00997)] (circle one)

Total Amount Received: $2245.00

Check # Discover American Express [Visa] MasterCard

Corporate Office: (510) 297-5050 Fax: 297-5057
TAX ID # 30-0007822

[redacted]

Horizon

```
                          Claim Header Inquiry                          hi
Claim/worksht .. 19661755-01  Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ....... [redacted]
Member ......... e[redacted]                          Rec'd ... 07/31/2006
Adjuster ....... BGQ      Inc .. 07/24/2006-07/24/2006   Proc'd .. 09/13/2006
Diagnosis ...... KERATOCONUS, STABLE                     Paid .... 09/14/2006
Benefit Type.... M                                       Statuses.f f Cln y
Referring Phys .                                         Batch ... CH625425
Provider ID .... -                                       Reference 002373
OC Claim Control                                               HCFA Electronic
 *Group Notes on File* *Family Notes on File*

   in(q)uiry, (s)croll, notes(f), le(t)ter, line(a), (d)iag codes, a(u)dit,
     835(w), 835 ad(j), (v)iew creditable cov, view pre-e(x) details : a
```

[redacted]

CDI00229764

19661755-01 Worksheet Inquiry hi

Line	01-0	
Incurred	07/24-07/24	
Diagnosis code	KERATOCONUS,	
Benefit Code/% Paid.	z1C / 0/ 0	
Proc cd/Mod/Plan ex.	0099T//C	
DVTs/POS/TOS/Ben Sfx	1.00/11//M	Totals
Charge amount.....	2245.00	2245.00
Copay amount.....	.00	.00
Benefit amount	.00	.00
Benefit deductible .	.00	.00
Co-ins deductible .	.00	.00
1st co-insurance ...	.00	.00
2nd co-insurance ...	.00	.00
Ineligible amount ..	2245.00 vb	2245.00
Other carrier pmt ..	.00	.00
PPO back-end disc ..	.00	.00
C.O.B. savings	.00	.00
Payment reduction ..	.00	.00
Paid to claimant ...	.00	.00
Paid to provider ...	.00	.00
Provider	HORIZON VISIO	

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]

DATE: 09/14/2006

CLAIMANT:
[redacted]

ENROLLEE: [redacted]
PATIENT: [redacted]
GROUP: SPORTS LEADERSHIP GROUP
GROUP ID: 90219335
PAT ID: [redacted]
CLM NO: 19661755-01
PROCESSOR: GOTSCHALL, BROOKE L
BATCH NBR: CH525425
REFER NBR: 2373

NATURE OF SERVICE/PROVIDER	DATE OF SERVICE FROM	TO	TOTAL CHARGE	INELIGIBLE AMOUNT	CD	AMOUNT %	AMOUNT %	AMOUNT %	AMOUNT %
*INV PL EX CD		*							
HORIZON VISION	07/24/06	07/24/06	2245.00	2245.00	vb				

TOTALS 2245.00 2245.00
LESS DEDUCTIBLE
BALANCE
CO-PAYMENT %
BENEFIT

TOTAL BENEFIT
NET PAYMENT
TOTAL NET BENEFIT 0.00

=R E M A R K S=

vb Eye exams, glasses, contact lenses and routine eye refractions are not covered. Please refer to your Certificate, Section 8, "Exclusions and Limitations," Part I, "Exclusions," #14.

=PAYABLE TO=CHECK #=AMOUNT=DATE=
NO CHECK PRODUCED FOR THIS CLAIM.

[redacted]

Horizon

Claim Header Inquiry hi

Claim/worksht .. 19661755-02 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e [redacted]
Adjuster ..... SSD Inc .. 07/24/2006-07/24/2006
Diagnosis ..... KERATOCONUS, STABLE
Benefit Type.... M
Referring Phys .
Provider ID .... -
OC Claim Control

Rec'd ... 07/31/2006
Proc'd .. 12/27/2006
Paid 12/27/2006
Statuses.f f Cln

Group Notes on File *Family Notes on File*

in(q)uiry, (s)croll, notes(f), le(t)ter, line(a), (d)iag codes, a(u)dit,
835(w), 835 ad(j), (v)iew creditable cov, view pre-e(x) details : a

[redacted]

19661755-02 Worksheet Inquiry hi

Line	01-0	02-0	
Incurred	07/24-07/24	07/24-07/24	
Diagnosis code	KERATOCONUS,	KERATOCONUS,	
Benefit Code/% Paid.	jHCD/ 50/ 50	INTR/ 0/ 0	
Proc cd/Mod/Plan ex.	U360//	INTR//	
DVTs/POS/TOS/Ben Sfx	1.00/22//M	.00/22//I	Totals
Charge amount.....	2245.00	22.60	2267.60
Copay amount.....	.00	.00	.00
Benefit amount	.00	22.60	22.60
Benefit deductible .	.00	.00	.00
Co-ins deductible .	.00	.00	.00
1st co-insurance ...	750.00	.00	750.00
2nd co-insurance ...	.00	.00	.00
Ineligible amount ..	745.00 1A	.00 IN	745.00
Other carrier pmt ..	.00	.00	.00
PPO back-end disc ..	.00	.00	.00
C.O.B. savings	.00	.00	.00
Payment reduction ..	.00	.00	.00
Paid to claimant ...	750.00	22.60	772.60
Paid to provider ...	.00	.00	.00
Provider	HORIZON VISIO no provider		

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]

DATE: 12/27/2006

CLAIMANT:
[redacted]

ENROLLEE: [redacted]
PATIENT: [redacted]
GROUP: SPORTS LEADERSHIP GROUP
GROUP ID: 90219135
PAT ID: [redacted]
CLM NO: 19661755-02
PROCESSOR: DELOSSANTOS, SANDRA

NATURE OF SERVICE/PROVIDER	DATE OF SERVICE FROM	TO	TOTAL CHARGE	INELIGIBLE AMOUNT	CD	AMOUNT %	AMOUNT %	AMOUNT 100 %	AMOUNT 50 %
*Hsp Svcs		*							
HORIZON VISION	07/24/06	07/24/06	2245.00	745.00	1A				1500.00
*not on file		*							
	07/24/06	07/24/06	22.60		IN			22.60	
		TOTALS	2267.60	745.00				22.60	1500.00

LESS DEDUCTIBLE		
BALANCE	22.60	1500.00
CO-PAYMENT %	100	50
BENEFIT	22.60	750.00
TOTAL BENEFIT		772.60
NET PAYMENT		
TOTAL NET BENEFIT		772.60

R E M A R K S

1A This charge exceeds the maximum benefit provision of your plan. Please refer to your Schedule of Benefits.

IN INTEREST PAYMENT
This is an adjustment to a previously considered claim 19661755-01.

PAYABLE TO	CHECK #	AMOUNT	DATE
[redacted]	005004449776	772.60	12/27/06

[redacted]

Claim Header Inquiry hi

Claim/worksht .. 19661755-02 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e[redacted] Rec'd ... 07/31/2006
Adjuster ..... SSD Inc .. 07/24/2006-07/24/2006 Proc'd .. 12/27/2006
Diagnosis ..... KERATOCONUS, STABLE Paid 12/27/2006
Benefit Type.... M Statuses.f f Cln
Referring Phys .
Provider ID .... -

TBL	Check number	ST	CT	835	Check date	Payee	Amount
[1]	006004449776	a	n		12/27/2006	[redacted]	772.60

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]

Inner Eye

Claim Header Inquiry hi

Claim/worksht .. 19260082-01 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e [redacted] Rec'd ... 08/01/2006
Adjuster ..... 9TS Inc .. 07/24/2006-07/24/2006 Proc'd .. 08/15/2006
Diagnosis ..... KERATOCONUS, STABLE Paid 09/07/2006
Benefit Type.... M PPO .. CAN Statuses.f f Cln y
Referring Phys . Batch ... CH621615
Provider ID .... - Reference 007587
OC Claim Control HCFA Electronic
Group Notes on File *Family Notes on File*

in(q)uiry, (s)croll, notes(f), le(t)ter, line(a), (d)iag codes, a(u)dit,
835(w), 835 ad(j), (v)iew creditable cov, view pre-e(x) details : a

[redacted]

19260082-01 Worksheet Inquiry hi

Line	01-0		
Incurred	07/24-07/24		
Diagnosis code	KERATOCONUS,		
Benefit Code/% Paid.	51CF/ 70/ 0		
Proc cd/Mod/Plan ex.	0099T/RT/		
DVTs/POS/TOS/Ben Sfx	1.00/24/2/P		Totals
Charge amount.....	3000.00		3000.00
Copay amount.....	.00		.00
Benefit amount	.00		.00
Benefit deductible .	.00		.00
Co-ins deductible .	563.58		563.58
1st co-insurance ...	655.49		655.49
2nd co-insurance ...	.00		.00
Ineligible amount ..	1500.00	Ab	1500.00
Other carrier pmt ..	.00		.00
PPO back-end disc ..	.00		.00
C.O.B. savings	.00		.00
Payment reduction ..	.00		.00
Paid to claimant ...	.00		.00
Paid to provider ...	655.49		655.49
Provider	TURNER EYE IN		

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]

Horizon

Claim Header Inquiry hi

Claim/worksht .. 33155154-01 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e [redacted] Rec'd ... 08/07/2006
Adjuster ..... NVT Inc .. 08/07/2006-08/07/2006 Proc'd .. 01/12/2007
Diagnosis ..... GENERAL SYMPTOMS Paid 01/13/2007
Benefit Type.... M Statuses.f f Cln n
Referring Phys . Batch ... CH701123
Provider ID .... - Reference 005430
OC Claim Control HCFA Electronic
Group Notes on File *Family Notes on File*

in(q)uiry, (s)croll, notes(f), le(t)ter, line(a), (d)iag codes, a(u)dit,
835(w), 835 ad(j), (v)iew creditable cov, view pre-e(x) details : a

[redacted]

DATE: 01/13/2007

CLAIMANT:
[redacted]

ENROLLEE: [redacted]
PATIENT: [redacted]
GROUP: SPORTS LEADERSHIP GROUP
GROUP ID: 90219335
PAT ID: [redacted]
CLM NO: 33155154-01
PROCESSOR: TORRES, NANCY V
BATCH NBR: CH701123
REFER NBR: 5430

NATURE OF SERVICE/PROVIDER	DATE OF SERVICE FROM	TO	TOTAL CHARGE	INELIGIBLE AMOUNT	CD	AMOUNT %	AMOUNT %	AMOUNT %	AMOUNT %
*Ineligible									
HORIZON VISION	08/07/06	08/07/06	1395.00	1395.00	SC				

TOTALS 1395.00 1395.00
LESS DEDUCTIBLE
BALANCE
CO-PAYMENT %
BENEFIT
TOTAL BENEFIT
NET PAYMENT
TOTAL NET BENEFIT 0.00

R E M A R K S

SC SEE COMMENTS BELOW
Please refer to the Exclusions and Limitations section in your Benefits Information Materials.

PAYABLE TO CHECK # AMOUNT DATE
NO CHECK PRODUCED FOR THIS CLAIM.

[redacted]

Claim Header Inquiry hi

Claim/worksht .. 33155154-02 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e[redacted] Rec'd ... 01/05/2007
Adjuster ..... SSD Inc .. 08/07/2006-08/07/2006 Proc'd .. 01/15/2007
Diagnosis ..... KERATOCONUS, STABLE Paid 01/15/2007
Benefit Type.... M Statuses.f f Cln
Referring Phys .
Provider ID .... -
OC Claim Control
Group Notes on File *Family Notes on File*

in(q)uiry, (s)croll, notes(f), le(t)ter, line(a), (d)iag codes, a(u)dit,
835(w), 835 ad(j), (v)iew creditable cov, view pre-e(x) details : a

[redacted]

33155154-02 Worksheet Inquiry hi

Line	01-0	
Incurred	08/07-08/07	
Diagnosis code	KERATOCONUS,	
Benefit Code/% Paid.	jHCD/ 50/ 50	
Proc cd/Mod/Plan ex.	U360//	
DVTs/POS/TOS/Ben Sfx	1.00/22//M	Totals
Charge amount.....	1395.00	1395.00
Copay amount.....	.00	.00
Benefit amount	.00	.00
Benefit deductible .	.00	.00
Co-ins deductible .	.00	.00
1st co-insurance ...	697.50	697.50
2nd co-insurance ...	.00	.00
Ineligible amount ..	.00	.00
Other carrier pmt ..	.00	.00
PPO back-end disc ..	.00	.00
C.O.B. savings	.00	.00
Payment reduction ..	.00	.00
Paid to claimant ...	697.50	697.50
Paid to provider ...	.00	.00
Provider	HORIZON VISIO	

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]

DATE: 01/15/2007

CLAIMANT:
[redacted]

ENROLLEE: [redacted]
PATIENT: [redacted]
GROUP: SPORTS LEADERSHIP GROUP
GROUP ID: 90219335
PAT ID: [redacted]
CLM NO: 33155154-02
PROCESSOR: DELOSSANTOS, SANDRA

NATURE OF SERVICE/PROVIDER	DATE OF SERVICE FROM	TO	TOTAL CHARGE	INELIGIBLE AMOUNT	CD	AMOUNT %	AMOUNT %	AMOUNT %	AMOUNT 50 %
*Hsp Svcs		*							
HORIZON VISION	08/07/06	08/07/06	1395.00						1395.00

TOTALS	1395.00	1395.00
	LESS DEDUCTIBLE	
	BALANCE	1395.00
	CO-PAYMENT %	50
	BENEFIT	697.50
	TOTAL BENEFIT	697.50
	NET PAYMENT	
	TOTAL NET BENEFIT	697.50

R E M A R K S

This is an adjustment to a previously considered claim 33155154-01.

PAYABLE TO	CHECK #	AMOUNT	DATE
[redacted]	006004523338	697.50	01/15/07

[redacted]

Claim Header Inquiry hi

Claim/worksht .. 33155154-02 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e[redacted] Rec'd ... 01/05/2007
Adjuster ..... SSD Inc .. 08/07/2006-08/07/2006 Proc'd .. 01/15/2007
Diagnosis ..... KERATOCONUS, STABLE Paid 01/15/2007
Benefit Type.... M Statuses.f f Cln
Referring Phys .
Provider ID .... -

TBL	Check number	ST	CT	835	Check date	Payee	Amount
[1]	006004523338	a	n		01/15/2007	[redacted]	697.50

*

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]

Jurner

Claim Header Inquiry hi

Claim/worksht .. 19454499-01 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e [redacted] Rec'd ... 08/22/2006
Adjuster ..... 9TS Inc .. 08/07/2006-08/07/2006 Proc'd .. 08/29/2006
Diagnosis ..... KERATOCONUS NOS Paid 09/14/2006
Benefit Type.... M PPO .. CAN Statuses.f f Cln y
Referring Phys . Batch ... CH624018
Provider ID .... - Reference 000444
OC Claim Control HCFA Electronic
Group Notes on File *Family Notes on File*

in(q)uiry, (s)croll, notes(f), le(t)ter, line(a), (d)iag codes, a(u)dit,
835(w), 835 ad(j), (v)iew creditable cov, view pre-e(x) details : a

[redacted]

19454499-01 Worksheet Inquiry hi

Line	01-0		
Incurred	08/07-08/07		
Diagnosis code	KERATOCONUS N		
Benefit Code/% Paid.	51CF/ 70/ 0		
Proc cd/Mod/Plan ex.	0099T/LT/		
DVTs/POS/TOS/Ben Sfx	1.00/24/2/P		Totals
Charge amount.....	3000.00		3000.00
Copay amount.....	.00		.00
Benefit amount	.00		.00
Benefit deductible .	.00		.00
Co-ins deductible .	16.66		16.66
1st co-insurance ...	1038.34		1038.34
2nd co-insurance ...	.00		.00
Ineligible amount ..	1500.00	Ab	1500.00
Other carrier pmt ..	.00		.00
PPO back-end disc ..	.00		.00
C.O.B. savings	.00		.00
Payment reduction ..	.00		.00
Paid to claimant ...	.00		.00
Paid to provider ...	1038.34		1038.34
Provider	TURNER EYE IN		

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]

DATE: 09/14/2006

CLAIMANT:
[redacted]

ENROLLEE: [redacted]
PATIENT: [redacted]
GROUP: SPORTS LEADERSHIP GROUP
GROUP ID: 90219335
PAT ID: [redacted]
CLM NO: 19454499-01
PROCESSOR: SMITH, TENA M
BATCH NBR: CH624018
REFER NBR: 444

NATURE OF SERVICE/PROVIDER	DATE OF SERVICE FROM	TO	TOTAL CHARGE	INELIGIBLE AMOUNT	CD	AMOUNT %	AMOUNT %	AMOUNT %	AMOUNT 70 %
*Transplant		*	Pat Nbr: 059685						
TURNER EYE INST	08/07/06	08/07/06	3000.00	1500.00	Ab				1500.00

TOTALS	3000.00	1500.00	1500.00
	LESS DEDUCTIBLE		16.66
	BALANCE		1483.34
	CO-PAYMENT %		70
	BENEFIT		1038.34
		TOTAL BENEFIT	1038.34
		NET PAYMENT	
		TOTAL NET BENEFIT	1038.34

R E M A R K S

Ab This amount represents the PacifiCare Network discount.

PAYABLE TO	CHECK #	AMOUNT	DATE
TURNER EYE INSTITUTE MEDI 420 ESTUDILLO AVE SAN LEANDRO CA 94577	006004030069	1038.34	09/14/06

[redacted]

Claim Header Inquiry hi

Claim/worksht .. 19454499-01 Group .. 90219335 SPORTS LEADERSHIP GROUP
Enrollee ..... [redacted]
Member ..... e [redacted] [redacted]
Adjuster ..... 9TS Inc .. 08/07/2006-08/07/2006 Rec'd ... 08/22/2006
Diagnosis ..... KERATOCONUS NOS Proc'd .. 08/29/2006
Benefit Type.... M PPO .. CAN Paid 09/14/2006
Referring Phys . Statuses.f f Cln y
Provider ID .... - Batch ... CH624018
Reference 000444

TBL Check number ST CT 835	Check date	Payee	Amount
[1] 006004030069 a	09/14/2006	TURNER EYE INSTITUTE MEDICAL G	1038.34
Provider: 942531569-08	420 ESTUDILLO AVE		
	SAN LEANDRO CA 94577-4908		*

(n, q, s, h, t, f, m, r, d, i, a, c, o, l, g, e, u, u#, p, v, x, y, w, j, ?)

[redacted]