DRAFT
NC TRACKS
PAPER REMITTANCE & STATUS REPORT PROPOSED LAYOUT

Provider Notification Page

The Provider Notification page displays information to all providers receiving paper remittances. The Notification page is generated after the payment (Check, Summout, or Payment Header) and before any remittance claim lines.

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XXXXXXXX                                                                                                XXXXXX

                                              DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                    NORTH CAROLINA NCTRACKS
                                                      REMITTANCE STATEMENT                  PAGE: ZZZZ9
                                                                                            DATE: 99/99/9999
                                                                                            CHECKWRITE DATE: 99/99/9999
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                           PROVIDER NOTIFICATION
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                           PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                           REMITTANCE NO: 99999999999
       XXXXXXXXXXXXXXXX, XX 99999-9999

                                                                                            PLEASE ADVISE THE FISCAL AGENT
                                                                                            IN WRITING IMMEDIATELY IF YOUR
                                                                                            ADDRESS CHANGES.
                                                                                            MEDICAID PROVIDER ENROLLMENT
                                                                                            PO BOX 9999
                                                                                            RALEIGH NC  99999-9999

            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
            XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX
```

Provider Notification Page Data Elements

Report Field	**Data Element Name**
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
PROVIDER NOTIFICATION	Constant Value
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
P O BOX	Constant Value
Unlabeled Remit Message Text	Remittance Advice (RA) Broadcast Message Line

Provider Summout Page

A Summout indicates that a provider had claim activity during the payment cycle but is receiving no payment. A Summout is not generated for providers receiving electronic remittances. Providers receiving paper remittances will always get a Summout, EFT header, or paper check along with their remittance.

```
XXXXXXXX                                                                                      XXXXXX

                                    DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                        NORTH CAROLINA NCTRACKS
                                        REMITTANCE STATEMENT                PAGE: ZZZZ9
                                                                            DATE: 99/99/9999
                                                                            CHECKWRITE DATE: 99/99/9999
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                            PROVIDER SUMMOUT
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                            PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                            REMITTANCE NO: 99999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999



             NO PAYMENT WILL BE RECEIVED THIS CYCLE.  SEE REMITTANCE FOR DETAILS.
```

Provider Summout Page Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PROVIDER SUMMOUT	Constant Value
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number

Payment Header

A Payment Header indicates that the total payment amount on a provider's remittance will be paid via an EFT (or a check, in cases of emergency). Providers receiving paper remittances with EFT or Check payment will receive a Payment Header. Providers receiving electronic remittances do not receive a Payment Header.

Payment Header Layout

```
XXXXXXXX                                                                                            XXXXXX

                                         DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                             NORTH CAROLINA NCTRACKS
                                             REMITTANCE STATEMENT                   PAGE: ZZZZ9
                                                                                    DATE: 99/99/9999
                                                                                    CHECKWRITE DATE: 99/99/9999
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                    PAYMENT HEADER
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                    PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                    REMITTANCE NO: 99999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999



                        PAYER : XXX     PAYMENT NUMBER : 999999999999999     PAYMENT AMOUNT : ZZZ,ZZZ,ZZZ.99

                        PAYER : XXX     PAYMENT NUMBER : 999999999999999     PAYMENT AMOUNT : ZZZ,ZZZ,ZZZ.99

                        PAYER : XXX     PAYMENT NUMBER : 999999999999999     PAYMENT AMOUNT : ZZZ,ZZZ,ZZZ.99

                        PAYER : XXX     PAYMENT NUMBER : 999999999999999     PAYMENT AMOUNT : ZZZ,ZZZ,ZZZ.99

                        TOTAL ASSOCIATED PAYMENT :  ZZZ,ZZZ,ZZZ.99
```

Payment Header Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PAYMENT HEADER	Constant Value
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
PAYER	Payer Short Name
PAYMENT NUMBER	Payment Number
PAYMENT AMOUNT	Payment Amount
TOTAL ASSOCIATED PAYMENT	Calculated value

Practitioner/Professional Remittance Report

This is the remittance layout for Practitioner, Medicare Part B Crossover, Clinic, Hearing Aid, Private Duty Nursing Personal Care Services, Independent Laboratory / X-Ray, Mental Health, DME / O&P, Ambulance, Home Infusion Therapy, Services, Professional Capitation, Optical Claims. Claims are grouped by paid original claims, paid adjustment claims, void claims, denied original claims, and denied adjustment claims, with a total amount shown for each claim grouping.

```
XXXXXXXX                                                                                                                XXXXXX
                                                   DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                           NORTH CAROLINA NCTRACKS
                                                            REMITTANCE STATEMENT
                                                                                                   PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999                                                              REMITTANCE NO: 99999999999


                                                      PRACTITIONER PAID ORIGINAL CLAIMS

RECIPIENT NAME               TCN               DATES OF     DAYS/UNITS     NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                 ORIGINAL TCN      SERVICE      TOTAL BILLED   TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X 999999999999999  99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        999999999999999  99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 999999999999999  99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        999999999999999  99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999     999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999   ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


           PRACTITIONER :  TOTAL AMOUNT OF PAID ORIGINAL CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                      XXXXXX

                                                                DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                        NORTH CAROLINA NCTRACKS
                                                                         REMITTANCE STATEMENT
                                                                                                              PAGE: ZZZZ9
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                             DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                             CHECKWRITE DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                             PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXXX, XX 99999-9999                                                                        REMITTANCE NO: 99999999999


                                                                PRACTITIONER PAID ADJUSTMENT CLAIMS

RECIPIENT NAME                TCN              DATES OF     DAYS/UNITS    NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                  ORIGINAL TCN     SERVICE      TOTAL BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999  99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999  99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999  99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999  99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999     999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                     99/99/9999   ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

           PRACTITIONER :  TOTAL AMOUNT OF PAID ADJUSTMENT CLAIMS       ZZZ,ZZZ,ZZZ.99       NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                                   XXXXXX

                                                                  DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                          NORTH CAROLINA NCTRACKS
                                                                           REMITTANCE STATEMENT
                                                                                                                     PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                     DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                     CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                     PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                                 REMITTANCE NO: 99999999999

                                                                  PRACTITIONER VOID CLAIMS

RECIPIENT NAME               TCN               DATES OF     DAYS/UNITS    NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                 ORIGINAL TCN      SERVICE      TOTAL BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999 99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999 99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999 99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999 99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99      ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99    ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

              PRACTITIONER :  TOTAL AMOUNT OF VOID CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                   XXXXXX

                                                     DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                            NORTH CAROLINA NCTRACKS
                                                             REMITTANCE STATEMENT
                                                                                                PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                            REMITTANCE NO: 99999999999


                                                      PRACTITIONER DENIED ORIGINAL CLAIMS

RECIPIENT NAME               TCN                DATES OF     DAYS/UNITS    NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                 ORIGINAL TCN       SERVICE      TOTAL BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999  99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999  99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

           PRACTITIONER :  TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                                    XXXXXX

                                                                                  DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                                          NORTH CAROLINA NCTRACKS
                                                                                           REMITTANCE STATEMENT
                                                                                                                    PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                    PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                                REMITTANCE NO: 99999999999


                                                                PRACTITIONER DENIED ADJUSTMENT CLAIMS

RECIPIENT NAME                TCN                DATES OF    DAYS/UNITS    NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                  ORIGINAL TCN       SERVICE     TOTAL BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999  99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999  99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999    999.99       ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                      99/99/9999  ZZZ,ZZZ.99     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

           PRACTITIONER :  TOTAL AMOUNT OF DENIED ADJUSTMENT CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

Practitioner/Professional Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
PRACTITIONER(Claim Type)	Constant Value
PAID(Claim Status)	Constant Value
ORIGINAL (Claim Header Transaction Type)	Constant Value
RECIPIENT NAME	Client Last Name
TCN	Transaction Control Number
DATES OF SERVICE(Top)	Claim Service Begin Date
DAYS/UNITS	Claim Line Quantity or Units Submitted
NON ALLOWED	Calculated Value
PYBLE CUTBACK	Calculated Value
TPL AMT	Claim Third Party Liability (TPL) Amount
PAID AMOUNT	Claim Reimbursement Amount
RECIPIENT ID	Client Identification Number (CIN) (Current)
ORIGINAL TCN	Transaction Control Number
DATES OF SERVICE(Bottom)	Claim Service End Date
TOTAL BILLED	Claim Charge Amount
TOT ALLOWED	Claim Calculated Allowed Amount
PYBLE CHARGES	Calculated Value
OTHER CHARGES	Calculated Value
HIC	Medicare Health Insurance Claim (HIC) Number
PATIENT ACCOUNT NUMBER	Claim Patient Account Number
MEDICAL RECORD NUMBER	Medical Record Number
DED	Deductible
PAT LIAB	Patient Liability Amount
COPAY	Claim Co-payment Amount
EOB	Remittance Advice (RA) Explanation of Benefits (EOB) Code
ERRORS	Claim Edit Code
REMARK CODE	HIPAA Remittance Advice Remark Code
ADJUSTMENT REASON CODE	HIPAA Adjustment Reason Code
LI NO	Claim or Prior Authorization/Approval (PA) Line Number
BENEFIT PLAN	Benefit Plan Short Name
PROC CODE	Procedure Code
DESC	Procedure Code Short Description
M1	Claim Procedure Modifier Code
M2	Claim Procedure Modifier Code
M3	Claim Procedure Modifier Code
M4	Claim Procedure Modifier Code
DATES OF SERVICE(Top)	Claim Service Begin Date
DAYS/UNITS	Claim Line Quantity or Units Submitted
NON ALLOWED	Calculated Value
PYBLE CUTBACK	Calculated Value

TPL AMT	Claim Third Party Liability (TPL) Amount
PAID AMOUNT	Claim Reimbursement Amount
RECIPIENT ID	Client Identification Number (CIN) (Current)
ORIGINAL TCN	Transaction Control Number
DATES OF SERVICE(Bottom)	Claim Service End Date
TOTAL BILLED	Claim Charge Amount
TOT ALLOWED	Claim Calculated Allowed Amount
PYBLE CHARGES	Calculated Value
OTHER CHARGES	Calculated Value
ATTENDING PROV ID	Provider Identification Number or National Provider Identifier
EOB	Remittance Advice (RA) Explanation of Benefits (EOB) Code
ERRORS	Claim Edit Code
REMARK CODE	HIPAA Remittance Advice Remark Code
ADJUSTMENT REASON CODE	HIPAA Adjustment Reason Code
TPL CARR NAME	Carrier Name
CONTACT(Left)	Carrier Contact Last Name
CONTACT(Middle)	Carrier Contact First Name
CONTACT(Right)	Carrier Contact Phone Number
EXT	Carrier Contact Phone Number Extension
DATES OF SVC	Claim Service Begin Date
TOTAL AMOUNT OF PAID ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF PAID ADJUSTED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF VOIDED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ADJUSTED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value

Dental Remittance Report

This is the remittance layout for Dental claims. Claims are grouped by paid original claims, paid adjustment claims, void claims, denied original claims, and denied adjustment claims, with a total amount shown for each claim grouping.

```
XXXXXXXX                                                                                                                                        XXXXXX

                                                                DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                        NORTH CAROLINA NCTRACKS
                                                                         REMITTANCE STATEMENT
                                                                                                                            PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                            DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                            CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                            PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999                                                                                       REMITTANCE NO: 99999999999


                                                                      DENTAL PAID ORIGINAL CLAIMS

RECIPIENT NAME                  TCN                 DATES OF        DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                    ORIGINAL TCN        SERVICE         TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999    99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX           9999999999999999                   ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999    99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX           9999999999999999                   ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999         999.999   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

            DENTAL :  TOTAL AMOUNT OF PAID ORIGINAL CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
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XXXXXXXX                                                                                                                      XXXXXX

                                                  DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                         NORTH CAROLINA NCTRACKS
                                                          REMITTANCE STATEMENT
                                                                                                    PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                REMITTANCE NO: 99999999999


                                                  DENTAL PAID ADJUSTMENT CLAIMS

RECIPIENT NAME                 TCN                  DATES OF       DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT         PAID
RECIPIENT ID                   ORIGINAL TCN         SERVICE        TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES   AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999   99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999                  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999   99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999                  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

             DENTAL :  TOTAL AMOUNT OF PAID ADJUSTMENT CLAIMS       ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                                        XXXXXX

                                                                    DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                            NORTH CAROLINA NCTRACKS
                                                                            REMITTANCE STATEMENT
                                                                                                                   PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                   DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                   CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                   PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                               REMITTANCE NO: 99999999999


                                                                      DENTAL VOID CLAIMS

RECIPIENT NAME                 TCN                  DATES OF       DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                   ORIGINAL TCN         SERVICE        TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999     99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999                    ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999   99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999                  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX



            DENTAL :  TOTAL AMOUNT OF VOID CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                      XXXXXX

                                                        DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                               NORTH CAROLINA NCTRACKS
                                                                REMITTANCE STATEMENT
                                                                                                                 PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                 DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                 CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                 PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                             REMITTANCE NO: 99999999999


                                                          DENTAL DENIED ORIGINAL CLAIMS

RECIPIENT NAME               TCN                 DATES OF       DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                 ORIGINAL TCN        SERVICE        TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999    99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999                   ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                      ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                      ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                      ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999    99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999                   ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                      ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                      ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                      ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

             DENTAL :  TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                                     XXXXXX
                                                                         DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                                NORTH CAROLINA NCTRACKS
                                                                                 REMITTANCE STATEMENT
                                                                                                                      PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                      DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                      CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                      PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999                                                                                 REMITTANCE NO: 99999999999

                                                                         DENTAL DENIED ADJUSTMENT CLAIMS

RECIPIENT NAME                 TCN                DATES OF       DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                   ORIGINAL TCN       SERVICE        TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999   99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999                  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999   99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999                  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   PROC CODE - DESC
NO   PLAN      MI M2 M3 M4

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX         99/99/9999        999.999  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
               XX XX XX XX                                       ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999   TOOTH CODE: XX   SURF CODE: X X X X X
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

             DENTAL :  TOTAL AMOUNT OF DENIED ADJUSTMENT CLAIMS       ZZZ,ZZZ,ZZZ.99       NUMBER OF CLAIMS 999,999
```

Dental Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
DENTAL(Claim Type)	Constant Value
PAID(Claim Status)	Constant Value
ORIGINAL (Claim Header Transaction Type)	Constant Value
RECIPIENT NAME	Client Last Name
TCN	Transaction Control Number
DATES OF SERVICE	Claim Service Begin Date
DAYS/UNITS	Claim Line Quantity or Units Submitted
NON ALLOWED	Calculated Value
PYBLE CUTBACK	Calculated Value
TPL AMT	Claim Third Party Liability (TPL) Amount
PAID AMOUNT	Claim Reimbursement Amount
RECIPIENT ID	Client Identification Number (CIN) (Current)
ORIGINAL TCN	Transaction Control Number
TOTAL BILLED	Claim Charge Amount
TOT ALLOWED	Claim Calculated Allowed Amount
PYBLE CHARGES	Calculated Value
OTHER CHARGES	Calculated Value
HIC	Health Insurance Claim (HIC) Number
PATIENT ACCOUNT NUMBER	Claim Patient Account Number
MEDICAL RECORD NUMBER	Medical Record Number
DED	Deductible
PAT LIAB	Patient Liability Amount
COPAY	Claim Co-payment Amount
EOB	Remittance Advice (RA) Explanation of Benefits (EOB) Code
ERRORS	Claim Edit Code
REMARK CODE	HIPAA Remittance Advice Remark Code
ADJUSTMENT REASON CODE	HIPAA Adjustment Reason Code
LI NO	Claim or Prior Authorization/Approval (PA) Line Number
BENEFIT PLAN	Benefit Plan Short Name
PROC CODE	Procedure Code
DESC	Procedure Code Short Description
M1	Claim Procedure Modifier Code
M2	Claim Procedure Modifier Code
M3	Claim Procedure Modifier Code
M4	Claim Procedure Modifier Code
DATES OF SERVICE	Claim Service Begin Date
DAYS/UNITS	Claim Line Quantity or Units Submitted
NON ALLOWED	Calculated Value

PYBLE CUTBACK	Calculated Value
TPL AMT	Claim Third Party Liability (TPL) Amount
PAID AMOUNT	Claim Reimbursement Amount
RECIPIENT ID	Client Identification Number (CIN) (Current)
ORIGINAL TCN	Transaction Control Number
TOTAL BILLED	Claim Charge Amount
TOT ALLOWED	Claim Calculated Allowed Amount
PYBLE CHARGES	Calculated Value
OTHER CHARGES	Calculated Value
ATTENDING PROV ID	Provider Identification Number or National Provider Identifier
TOOTH CODE	Tooth Code
SURF CODE	Dental Tooth Surface Code
EOB	Remittance Advice (RA) Explanation of Benefits (EOB) Code
ERRORS	Claim Edit Code
REMARK CODE	HIPAA Remittance Advice Remark Code
ADJUSTMENT REASON CODE	HIPAA Adjustment Reason Code
TPL CARR NAME	Carrier Name
CONTACT(Left)	Carrier Contact Last Name
CONTACT(Middle)	Carrier Contact First Name
CONTACT(Right)	Carrier Contact Phone Number
EXT	Carrier Contact Phone Number Extension
DENTAL(Claim Type)	Constant Value
TOTAL AMOUNT OF PAID ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF PAID ADJUSTED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF VOIDED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ADJUSTED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value

Pharmacy Remittance Report

This is the remittance layout for Pharmacy Claims. Claims are grouped by paid original claims, paid adjustment claims, void claims, denied original claims, and denied adjustment claims, with a total amount shown for each claim grouping.

```
XXXXXXXX                                                                                                                       XXXXXX

                                                          DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                  NORTH CAROLINA NCTRACKS
                                                                   REMITTANCE STATEMENT
                                                                                                         PAGE: ZZZZ9
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        CHECKWRITE DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXXX, XX 99999-9999                                                                   REMITTANCE NO: 99999999999


                                                        PHARMACY PAID ORIGINAL CLAIMS

RECIPIENT NAME                TCN                RX       DATES OF SVC  TOTAL        TOTAL
RECIPIENT ID                  ORIGINAL TCN       NUMBER   QUANTITY      BILLED       ALLOWED      COPAY         TPL AMT        PAID AMT

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999

DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

            PHARMACY :  TOTAL AMOUNT OF PAID ORIGINAL CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                              XXXXXX

                                                  DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                          NORTH CAROLINA NCTRACKS
                                                           REMITTANCE STATEMENT
                                                                                                              PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                          REMITTANCE NO: 99999999999


                                                        PHARMACY PAID ADJUSTMENT CLAIMS

RECIPIENT NAME               TCN              RX       DATES OF SVC  TOTAL        TOTAL
RECIPIENT ID                 ORIGINAL TCN     NUMBER   QUANTITY      BILLED       ALLOWED     COPAY         TPL AMT        PAID AMT
XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999   ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999   ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999   ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999   ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999

DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999   ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

            PHARMACY :  TOTAL AMOUNT OF PAID ADJUSTMENT CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
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XXXXXXXX                                                                                                                          XXXXXX

                                                    DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                            NORTH CAROLINA NCTRACKS
                                                             REMITTANCE STATEMENT
                                                                                                          PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                      REMITTANCE NO: 99999999999


                                                        PHARMACY VOID CLAIMS
RECIPIENT NAME               TCN                RX       DATES OF SVC  TOTAL        TOTAL
RECIPIENT ID                 ORIGINAL TCN       NUMBER   QUANTITY      BILLED       ALLOWED      COPAY         TPL AMT        PAID AMT
XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999            999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999            999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999            999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999            999.999

DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99   ZZZ,ZZZ.99   ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999            999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

             PHARMACY :  TOTAL AMOUNT OF VOID CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
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XXXXXXXX                                                                                                                    XXXXXX

                                                  DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                          NORTH CAROLINA NCTRACKS
                                                           REMITTANCE STATEMENT
                                                                                                  PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                  DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                  CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                  PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                              REMITTANCE NO: 99999999999


                                                        PHARMACY DENIED ORIGINAL CLAIMS
RECIPIENT NAME               TCN                RX      DATES OF SVC  TOTAL        TOTAL
RECIPIENT ID                 ORIGINAL TCN       NUMBER  QUANTITY      BILLED       ALLOWED      COPAY         TPL AMT        PAID AMT
XXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999

DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999

DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXX XXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

            PHARMACY :  TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS       ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                     XXXXXX

                                                      DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                              NORTH CAROLINA NCTRACKS
                                                               REMITTANCE STATEMENT
                                                                                                         PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999                                                                    REMITTANCE NO: 99999999999

                                                        PHARMACY DENIED ADJUSTMENT CLAIMS

RECIPIENT NAME                TCN                RX       DATES OF SVC  TOTAL        TOTAL
RECIPIENT ID                  ORIGINAL TCN       NUMBER   QUANTITY      BILLED       ALLOWED      COPAY         TPL AMT        PAID AMT
XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999

DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999

DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


XXXXXXXXXXXXXX XXXXXXXXXXXX X 9999999999999999  9999999  99/99/9999    ZZZ,ZZZ.99  ZZZ,ZZZ.99  ZZZ,ZZZ.99    ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX         9999999999999999           999.999
DRUG CODE: 99999999999  DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXX
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

             PHARMACY :  TOTAL AMOUNT OF DENIED ADJUSTMENT CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

Pharmacy Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
PHARMACY(Claim Type)	Constant Value
PAID(Claim Status)	Constant Value
ORIGINAL (Claim Header Transaction Type)	Constant Value
RECIPIENT NAME	Client Last Name
TCN	Transaction Control Number
RX NUMBER	Claim Prescription Number
DATES OF SERVICE	Claim Service Begin Date
TOTAL BILLED	Claim Charge Amount
TOTAL ALLOWED	Claim Calculated Allowed Amount
COPAY	Claim Co-payment Amount
TPL AMT	Claim Third Party Liability (TPL) Amount
PAID AMOUNT	Claim Reimbursement Amount
RECIPIENT ID	Client Identification Number (CIN) (Current)
ORIGINAL TCN	Transaction Control Number
QUANTITY	Drug Quantity (Submitted)
DRUG CODE	National Drug Code (NDC)
DESCRIPTION	Drug Label Name
EOB	Remittance Advice (RA) Explanation of Benefits (EOB) Code
ERRORS	Claim Edit Code
REMARK CODE	HIPAA Remittance Advice Remark Code
ADJUSTMENT REASON CODE	HIPAA Adjustment Reason Code
TPL CARR NAME	Carrier Name
CONTACT(Left)	Carrier Contact Last Name
CONTACT(Middle)	Carrier Contact First Name
CONTACT(Right)	Carrier Contact Phone Number
EXT	Carrier Contact Phone Number Extension
PHARMACY	Constant Value
TOTAL AMOUNT OF PAID ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF PAID ADJUSTED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF VOIDED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ADJUSTED CLAIMS	Calculated Value

Inpatient/Institutional Remittance Report

This is the remittance layout for Inpatient, Medicare Part A Crossover (inpatient crossover), Long Term Care, Hospice, Home Health, Institutional Capitation, Residential Health Care, Outpatient, Medicare Part B Crossover UB (outpatient crossover), Institutional Ambulance Claims. Claims are grouped by paid original claims, paid adjustment claims, void claims, denied original claims, and denied adjustment claims, with a total amount shown for each claim grouping.

```
XXXXXXXX                                                                                                                                XXXXXX

                                                           DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                   NORTH CAROLINA NCTRACKS
                                                                    REMITTANCE STATEMENT
                                                                                                                   PAGE: ZZZZ9
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                  DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                  CHECKWRITE DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                  PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXX, XX 99999-9999                                                                              REMITTANCE NO: 99999999999


                                                            INPATIENT PAID ORIGINAL CLAIMS

RECIPIENT NAME                 TCN              DATES OF    DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                   ORIGINAL TCN     SERVICE     TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999 99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999 99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX


            INPATIENT :  TOTAL AMOUNT OF PAID ORIGINAL CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                        XXXXXX

                                                         DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                NORTH CAROLINA NCTRACKS
                                                                 REMITTANCE STATEMENT
                                                                                                              PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                              PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                          REMITTANCE NO: 99999999999


                                                        INPATIENT PAID ADJUSTMENT CLAIMS

RECIPIENT NAME                 TCN               DATES OF    DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                   ORIGINAL TCN      SERVICE     TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999  99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999  99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99

HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999  99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999  99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99

HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

            INPATIENT :  TOTAL AMOUNT OF PAID ADJUSTMENT CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                          XXXXXX

                                                    DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                          NORTH CAROLINA NCTRACKS
                                                          REMITTANCE STATEMENT
                                                                                                          PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                      REMITTANCE NO: 99999999999


                                                   INPATIENT VOID CLAIMS

RECIPIENT NAME                 TCN               DATES OF    DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT         PAID
RECIPIENT ID                   ORIGINAL TCN      SERVICE     TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES   AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXX X  9999999999999999  99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999  99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99

HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

RECIPIENT NAME                 TCN               DATES OF    DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT         PAID
RECIPIENT ID                   ORIGINAL TCN      SERVICE     TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES   AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXX X  9999999999999999  99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999  99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99

HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX        99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99      ZZZ,ZZZ.99
                                                 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX
            INPATIENT :  TOTAL AMOUNT OF VOID CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                     XXXXXX

                                                 DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                        NORTH CAROLINA NCTRACKS
                                                         REMITTANCE STATEMENT
                                                                                         PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                         DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                         CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                         PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                     REMITTANCE NO: 99999999999


                                                     INPATIENT DENIED ORIGINAL CLAIMS

RECIPIENT NAME               TCN               DATES OF    DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                 ORIGINAL TCN      SERVICE     TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999  99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999  99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99

HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXXX XXXXXXXXXXXX X  9999999999999999  99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX          9999999999999999  99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99

HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                                99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

            INPATIENT :  TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

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XXXXXXXX                                                                                                                                XXXXXX

                                                                DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                        NORTH CAROLINA NCTRACKS
                                                                         REMITTANCE STATEMENT
                                                                                                                          PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                          DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                          CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                          PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                                      REMITTANCE NO: 99999999999

                                                        INPATIENT DENIED ADJUSTMENT CLAIMS

RECIPIENT NAME               TCN              DATES OF    DAYS/UNITS  NON ALLOWED  PYBLE CUTBACK  TPL AMT        PAID
RECIPIENT ID                 ORIGINAL TCN     SERVICE     TOT BILLED  TOT ALLOWED  PYBLE CHARGES  OTHER CHARGES  AMOUNT
XXXXXXXXXXXXX XXXXXXXXXXX X  9999999999999999 99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99

HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXXXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX

XXXXXXXXXXXXX XXXXXXXXXXX X  9999999999999999 99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
          XXXXXXXXXXX        9999999999999999 99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
HIC : XXXXXXXXXXXX PATIENT ACCOUNT NUMBER: XXXXXXXXXXXXXXXXXXXX MEDICAL RECORD NUMBER: XXXXXXXXXXXXXXXXXXXX
DED : ZZZ,ZZZ.99  PAT LIAB: ZZZ,ZZZ.99 COPAY : ZZZ,ZZZ.99
ADMIT DATE : 99/99/9999 RCC : .99  COST STLMT % : 9.9999 DRG CODE : 999 ALOS : 9.9 WEIGHT : .9999 DRG AMT : 999.99
DIAG : XXXXX  PROC : XXXX  OUTLIER :    OUTLIER AMT : 999.99
EOB: XXXXX XXXXX
ERRORS: XXXXX  XXXXX
REMARK CODE: XXX XXX
ADJUSTMENT REASON CODE: XXXXX XXXXX

LI   BENEFIT   REV/HCPCS CODE - DESC
NO   PLAN
99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX

99   XXXXXX    XXXXX-XXXXXXXXXXXXXXXXXXX       99/99/9999  999.999     ZZZ,ZZZ.99   ZZZ,ZZZ.99     ZZZ,ZZZ.99     ZZZ,ZZZ.99
                                               99/99/9999  ZZZ,ZZZ.99  ZZZ,ZZZ.99   ZZZ,ZZZ.99
ATTENDING PROV ID: 99999999/9999999999
EOB:  XXX
ERRORS: XXXXX
REMARK CODE: XXX
ADJUSTMENT REASON CODE: XXXXX
TPL CARR NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CONTACT:XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX XXX-XXX-XXXX EXT XXXX
             INPATIENT :  TOTAL AMOUNT OF DENIED ADJUSTMENT CLAIMS       ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999
```

Inpatient/Institutional Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
INPATIENT(Claim Type)	Constant Value
PAID(Claim Status)	Constant Value
ORIGINAL (Claim Header Transaction Type)	Constant Value
RECIPIENT NAME	Client Last Name
TCN	Transaction Control Number
DATES OF SERVICE(Top)	Claim Service Begin Date
DAYS/UNITS	Claim Line Quantity or Units Submitted
NON ALLOWED	Calculated Value
PYBLE CUTBACK	Calculated Value
TPL AMT	Claim Third Party Liability (TPL) Amount
PAID AMOUNT	Claim Reimbursement Amount
RECIPIENT ID	Client Identification Number (CIN) (Current)
ORIGINAL TCN	Transaction Control Number
DATES OF SERVICE(Bottom)	Claim Service End Date
TOT BILLED	Claim Charge Amount
TOT ALLOWED	Claim Calculated Allowed Amount
PYBLE CHARGES	Calculated Value
OTHER CHARGES	Calculated Value
HIC	Medicare Health Insurance Claim (HIC) Number
PATIENT ACCOUNT NUMBER	Claim Patient Account Number
MEDICAL RECORD NUMBER	Medical Record Number
DED	Deductible
PAT LIAB	Patient Liability Amount
COPAY	Claim Co-payment Amount
ADMIT DATE	Claim Admission Date
RCC	Rate Code
COST STLMT %	Cost Settlement Percentage
DRG CODE	Diagnosis Related Group (DRG) Code
ALOS	Diagnosis Related Group (DRG) Length of Stay Average
WEIGHT	Diagnosis Related Group (DRG) Weight
DRG AMT	Diagnosis Related Group (DRG) Amount
DIAG	Diagnosis Code
PROC	Procedure Code
OUTLIER	Outlier Days Number
OUTLIER AMT	Outlier Amount
EOB	Remittance Advice (RA) Explanation of Benefits (EOB) Code
ERRORS	Claim Edit Code
REMARK CODE	HIPAA Remittance Advice Remark Code
ADJUSTMENT REASON CODE	HIPAA Adjustment Reason Code
LI NO	Claim or Prior Authorization/Approval (PA) Line Number

BENEFIT PLAN	Benefit Plan Short Name
REV/HCPCS CODE	Revenue Code
DESC	Revenue Code Short Description
DATES OF SERVICE(Top)	Claim Service Begin Date
DAYS/UNITS	Claim Line Quantity or Units Submitted
NON ALLOWED	Calculated Value
PYBLE CUTBACK	Calculated Value
TPL AMT	Claim Third Party Liability (TPL) Amount
PAID AMOUNT	Claim Reimbursement Amount
DATES OF SERVICE(Bottom)	Claim Service End Date
TOT BILLED	Claim Charge Amount
TOT ALLOWED	Claim Calculated Allowed Amount
PYBLE CHARGES	Calculated Value
OTHER CHARGES	Calculated Value
ATTENDING PROV ID	Provider Identification Number or National Provider Identifier
TPL CARR NAME	Carrier Name
CONTACT(Left)	Carrier Contact Last Name
CONTACT(Middle)	Carrier Contact First Name
CONTACT(Right)	Carrier Contact Phone Number
EXT	Carrier Contact Phone Number Extension
INPATIENT(Claim Type)	Constant Value
TOTAL AMOUNT OF PAID ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF PAID ADJUSTED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF VOIDED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ORIGINAL CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL AMOUNT OF DENIED ADJUSTED CLAIMS	Calculated Value
NUMBER OF CLAIMS	Calculated Value

Pended Claims Remittance Report

This is the remittance layout for all pended claim types, although the graphic displays the inpatient pended claims only.

```
XXXXXXXX                                                                                                                      XXXXXX

                                                          DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                  NORTH CAROLINA NCTRACKS
                                                                   REMITTANCE STATEMENT
                                                                                                        PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999                                                                   REMITTANCE NO: 99999999999


                                                        INPATIENT PEND CLAIMS


RECIPIENT NAME                  RECIPIENT ID   TCN               MEDICAL RECORD NUMBER  DATES OF SVC  TOT BILLED

XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX
XXXXXXXXXXXXXX  XXXXXXXXXX   X  XXXXXXXXXXX    9999999999999999  XXXXXXXXXXXXXXXXXXXX   99/99/9999    ZZZ,ZZZ.99
EOB : XXXXX XXXXX XXXXX XXXXX

            INPATIENT :  TOTAL AMOUNT CLAIMS PEND        ZZZ,ZZZ,ZZZ.99        NUMBER OF CLAIMS 999,999


PROVIDER XXXXXXXXXX/XXXXXXXXXX TOTALS - INPATIENT

                               TOTAL PAID ORIGINAL                             ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               TOTAL PAID ADJUSTMENTS                          ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               TOTAL PAID VOIDS                                ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               NET TOTAL PAID                                  ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999

                               TOTAL DENIED ORIGINAL                           ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               TOTAL DENIED ADJUSTMENTS                        ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               NET TOTAL DENIED                                ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999

                               NET TOTAL PENDED                                ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
```

Pend Claims Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO (Line 4,left)	Provider Address City
TO (Line 4,middle)	Provider Address State/Province Code
TO (Line 4,right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
INPATIENT(Claim Type)	Constant Value
PEND(Claim Status)	Constant Value
RECIPIENT NAME	Client Last Name
RECIPIENT ID	Client Identification Number (CIN) (Current)
TCN	Transaction Control Number
MEDICAL RECORD NUMBER	Medical Record Number
DATES OF SERVICE	Claim Service Begin Date
TOTAL BILLED	Claim Charge Amount
PROVIDER	Provider Identification Number or National Provider Identifier
TOTAL PAID ORIGINAL	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL PAID ADJUSTMENTS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL PAID VOIDS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
NET TOTAL PAID	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL DENIED ORIGINAL	Calculated Value
NUMBER OF CLAIMS	Calculated Value
TOTAL DENIED ADJUSTMENTS	Calculated Value
NUMBER OF CLAIMS	Calculated Value
NET TOTAL DENIED	Calculated Value
NUMBER OF CLAIMS	Calculated Value
NET TOTAL PENDED	Calculated Value

Financial Transactions Remittance Report

This is the remittance layout for all Financial Transactions processed during the checkwrite cycle.

```
XXXXXXXX                                                                                                              XXXXXX

                                                        DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                              NORTH CAROLINA NCTRACKS
                                                               REMITTANCE STATEMENT
                                                                                                      PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXXX, XX 99999-9999                                                                 REMITTANCE NO: 99999999999

                                                              FINANCIAL TRANSACTIONS


                   FINANCIAL      FINANCIAL                   FINANCIAL
FCN                REASON CODE    REASON CODE DESCRIPTION     TRANS TYPE          DATE         AMOUNT          PAYER
999999999999999    XXX            XXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX  99/99/9999   -ZZZ,ZZZ.99       XXXXX
999999999999999    XXX            XXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX  99/99/9999   -ZZZ,ZZZ.99       XXXXX
999999999999999    XXX            XXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX  99/99/9999   -ZZZ,ZZZ.99       XXXXX
999999999999999    XXX            XXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX  99/99/9999   -ZZZ,ZZZ.99       XXXXX

 NET FINANCIAL TRANSACTION AMOUNT -ZZZ,ZZZ,ZZZ.99   NUMBER OF FINANCIAL TRANSACTIONS  999,999
```

Financial Transactions Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO(Line4, left)	Provider Address City
TO(Line4, middle)	Provider Address State/Province Code
TO(Line4, right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
FCN	Financial Control Number
FINANCIAL REASON CODE	Financial Reason Code
FINANCIAL REASON CODE DESCRIPTION	Financial Reason Code Short Description
FINANCIAL TRANS TYPE	Financial Reason Type Code
DATE	Financial Applied Date
AMOUNT	Financial Applied Amount
PAYER	Payer Short Name
NET FINANCIAL TRANSACTION AMOUNT	Calculated Value
NUMBER OF FINANCIAL TRANSACTIONS	Calculated Value

Accounts Receivable Remittance Report

This is the remittance layout for all Accounts Receivables with outstanding balances at the end of the checkwrite cycle.

```
XXXXXXXX                                                                                                                            XXXXXX

                                                            DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                    NORTH CAROLINA NCTRACKS
                                                                     REMITTANCE STATEMENT
                                                                                                          PAGE: ZZZZ9
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         CHECKWRITE DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXXX, XX 99999-9999                                                                    REMITTANCE NO: 99999999999


                                                              ACCOUNT RECEIVABLES


   FCN            RSN        REASON CODE              ORIG BAL         AMT APLD        CURR BAL    RECOUP ESTABLISHED  PAYER
                  CODE       DESCRIPTION                                                           %/AMT      DATE
999999999999999 XXX   XXXXXXXXXXXXXXXXXXXXXXXX ZZZ,ZZZ,ZZZ.99 ZZZ,ZZZ,ZZZ.99 ZZZ,ZZZ,ZZZ.99 999    99/99/9999    XXX
999999999999999 XXX   XXXXXXXXXXXXXXXXXXXXXXXX ZZZ,ZZZ,ZZZ.99 ZZZ,ZZZ,ZZZ.99 ZZZ,ZZZ,ZZZ.99 999    99/99/9999    XXX
999999999999999 XXX   XXXXXXXXXXXXXXXXXXXXXXXX ZZZ,ZZZ,ZZZ.99 ZZZ,ZZZ,ZZZ.99 ZZZ,ZZZ,ZZZ.99 999    99/99/9999    XXX


   TOTAL AMOUNT DUE THE STATE  ZZZ,ZZZ,ZZZ.99
```

- ALERT! MAY BE SUBJECTED TO PENALTY AND INTEREST ON ADJUSTMENTS PROCESSED. MONIES ARE DUE BACK TO DHHS – DEPARTMENT OF HEALTH AND HUMAN SERVICES.
- PER NC STATUE 147 THIS RA SERVES AS YOUR REQUIRED DUNNING NOTIFICATION. ALL OUTSTANDING ADJUSTMENT BALANCES MUST BE PAID WITHIN 10 DAYS OR A 10% ONE-TIME PENALTY WILL BE ASSESSED AND INTEREST WILL BE CHARGED.
- IF YOU ALREADY ISSUED A REFUND RELATED TO YOUR DHHS ADJUSTMENT BALANCE DUE, PLEASE DISREGARD THIS NOTICE.
- IF YOU CANNOT PAY THIS BALANCE WITHIN 30 DAYS, PLEASE CONTACT THE APPROPRIATE PAYER TO MAKE PAYMENT ARRANGEMENTS.
- DISPUTES RELATED TO PENALTY AND INTEREST ASSESSMENTS MUST BE PROVIDED THROUGH WRITTEN NOTIFICATION TO CSC.

Accounts Receivable Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO(Line4, left)	Provider Address City
TO(Line4, middle)	Provider Address State/Province Code
TO(Line4, right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
FCN	Financial Control Number
RSN CODE	Financial Reason Code
REASON CODE DESCRIPTION	Financial Reason Code Short Description
ORIG BAL	Fiscal Transaction Total Amount
AMT APLD	Financial Applied Amount
CURR BAL	Financial Accounts Receivable Balance Amount (Current)
RECOUP % AMT	Financial Recoupment Percentage
ESTABLISHED DATE	Calculated Value
PAYER	Payer Short Name
TOTAL AMOUNT DUE THE STATE	Calculated Value

Management Fees Remittance Report

This is the remittance layout for Management Fees.

```
XXXXXXXX                                                                                                    XXXXXX
                                                      DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                              NORTH CAROLINA NCTRACKS
                                                               REMITTANCE STATEMENT
                                                                                               PAGE: ZZZZ9
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                              DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                              CHECKWRITE DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                              PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXXX, XX 99999-9999                                                         REMITTANCE NO: 99999999999

                                                              MANAGEMENT FEES
```

Management Fees Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO(Line4, left)	Provider Address City
TO(Line4, middle)	Provider Address State/Province Code
TO(Line4, right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number

Health Check Fees Remittance Report

This is the remittance layout for Health Check Fees.

```
XXXXXXXX                                                                                                              XXXXXX

                                                DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                        NORTH CAROLINA NCTRACKS
                                                         REMITTANCE STATEMENT
                                                                                                 PAGE: ZZZZ9
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                CHECKWRITE DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXXX, XX 99999-9999                                                           REMITTANCE NO: 99999999999


                                                        HEALTH CHECK FEES
```

Health Check Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO(Line4, left)	Provider Address City
TO(Line4, middle)	Provider Address State/Province Code
TO(Line4, right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number

EOB Page

This is the remittance layout which lists EOB Descriptions for all edits failed on the claims displayed on the remittance.

```
XXXXXXXX                                                                                                                   XXXXXX

                                                      DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                              NORTH CAROLINA NCTRACKS
                                                               REMITTANCE STATEMENT
                                                                                                       PAGE: ZZZZ9
TO:    XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECKWRITE DATE: 99/99/9999
       XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      PROV ID: 99999999/9999999999
       XXXXXXXXXXXXXXXX, XX 99999-9999                                                                 REMITTANCE NO: 99999999999

                                                        EOB DESCRIPTIONS


THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:
XXXX   XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX8XXXXXXXXX9XXXXXXXXX0XXXX
XXXX   XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX8XXXXXXXXX9XXXXXXXXX0XXXX
XXXX   XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX8XXXXXXXXX9XXXXXXXXX0XXXX
XXXX   XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX8XXXXXXXXX9XXXXXXXXX0XXXX
XXXX   XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX8XXXXXXXXX9XXXXXXXXX0XXXX
XXXX   XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3XXXXXXXXX4XXXXXXXXX5XXXXXXXXX6XXXXXXXXX7XXXXXXXXX8XXXXXXXXX9XXXXXXXXX0XXXX
```

EOB Page Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO(Line4, left)	Provider Address City
TO(Line4, middle)	Provider Address State/Province Code
TO(Line4, right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
UNLABELLED TEXT (Left)	Remittance Advice (RA) Explanation of Benefits (EOB) Code
UNLABELLED TEXT (Right)	Remittance Advice (RA) Explanation of Benefits (EOB) Text

Summary Page

This is the remittance layout which lists the Summary.

```
XXXXXXXX                                                                                                                             XXXXXX

                                                                 DEPARTMENT OF HEALTH AND HUMAN SERVICES
                                                                         NORTH CAROLINA NCTRACKS
                                                                          REMITTANCE STATEMENT
                                                                                                        PAGE: ZZZZ9
TO:   XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        CHECKWRITE DATE: 99/99/9999
      XXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        PROV ID: 99999999/9999999999
      XXXXXXXXXXXXXXX, XX 99999-9999                                                                    REMITTANCE NO: 99999999999


                                                                   SUMMARY PAGE



PROVIDER XXXXXXXXXX/XXXXXXXXXX TOTALS

                               TOTAL PAID ORIGINAL                                ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               TOTAL PAID ADJUSTMENTS                             ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               TOTAL PAID VOIDS                                   ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               NET TOTAL PAID                                     ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999

                               TOTAL DENIED ORIGINAL                              ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               TOTAL DENIED ADJUSTMENTS                           ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999
                               NET TOTAL DENIED                                   ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999

                               NET TOTAL PENDED                                   ZZZ,ZZZ,ZZZ.99-       NUMBER OF CLAIMS 999,999

TOTALS BY BENEFIT PLAN
                                    BENEFIT              BENEFIT                        CURRENT                YTD
                                    PLAN                 GROUPING                        PAID                  PAID
                                    NUMBER              DESCRIPTION                     AMOUNT                AMOUNT

                                    XXXXX          XXXXXXXXXXXXXXXXXXXXXXX            ZZZ,ZZZ.99-           ZZ,ZZZ,ZZZ.99-
                                    XXXXX          XXXXXXXXXXXXXXXXXXXXXXX            ZZZ,ZZZ.99-           ZZ,ZZZ,ZZZ.99-
                                    XXXXX          XXXXXXXXXXXXXXXXXXXXXXX            ZZZ,ZZZ.99-           ZZ,ZZZ,ZZZ.99-
                                    XXXXX          XXXXXXXXXXXXXXXXXXXXXXX            ZZZ,ZZZ.99-           ZZ,ZZZ,ZZZ.99-
                                    XXXXX          XXXXXXXXXXXXXXXXXXXXXXX            ZZZ,ZZZ.99-           ZZ,ZZZ,ZZZ.99-
                                    XXXXX          XXXXXXXXXXXXXXXXXXXXXXX            ZZZ,ZZZ.99-           ZZ,ZZZ,ZZZ.99-

                                                                  TOTAL PAID     ZZ,ZZZ,ZZZ.99        Z,ZZZ,ZZZ,ZZZ.99

*** TOTAL AMOUNTS SHOULD EQUAL COLUMN A OF CLAIMS PAYMENT SUMMARY OF THE RA.

                         A                 B          C                  D            E              F            G           H

           CLAIMS        PAID CLAIMS       WITHHELD    NET PAY           CREDIT       NET 1099       IRS WITHHELD  OTHER       ADJUSTED
           PAID          AMOUNT            AMOUNT(*)   AMOUNT            AMOUNT       AMOUNT          AMOUNT        W/H        NET PAY
                                                        (A-B)                          (C-D)                                   (C-F-G)
CURRENT    999999        ZZZZZZZZZ.99      ZZZ.99      ZZZZZZZZZ.99      ZZZZZ.99     ZZZZZZZZZ.99    ZZZZ.9       ZZZ.99      ZZZZZZZZZ.99
MTD TOTAL  9999999       ZZZZZZZZZZ.99     ZZZZ.99     ZZZZZZZZZZ.99     ZZZZZZZ.99   ZZZZZZZZZZ.99   ZZZZZ.99     ZZZZZ.99    ZZZZZZZZZZ.99
YTD TOTAL  999999999     ZZZZZZZZZZZ.99    ZZZZZ.99    ZZZZZZZZZZZ.99    ZZZZZZZZZ.99 ZZZZZZZZZZZ.99  ZZZZZZ.99    ZZZZZZZ.99  ZZZZZZZZZZZ.99

1099 INFORMATION 9999 - THIS INFORMATION IS BEING FURNISHED TO THE INTERNAL REVENUE SERVICE
PROVIDER TAX ID: 99- 9999999 PROVIDER TAX NAME: XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X
PAYER ID: CSC, PO BOX 99999, RALEIGH, NC 99999 # 99-9999999

PLEASE VERIFY THE FOLLOWING IDENTIFICATION NUMBERS THAT HAVE BEEN ASSIGNED TO YOU. IF ANY OF THE NUMBERS ARE INCORRECT,
PLEASE SEND CORRECTIONS TO:
CSC
PO BOX 999999
RALEIGH, NORTH CAROLINA 99999
ATTENTION: PROVIDER ENROLLMENT
CLIA - XXXXXXXXXXX
DEA - XXXXXXXXXXXX

FOR BILLING QUESTIONS/INQUIRIES PLEASE

LOGON TO NCTRACKS PROVIDER PORTAL OR
CALL AUTOMATED VOICE RESPONSE (AVR)SYSTEM 1-999-999-9999 OR
CALL CSC PROVIDER SERVICES 1-999-999-9999
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Summary Page Remittance Report Data Elements

Report Field	Data Element Name
XXXXXXX (Northwest corner of report)	Financial Remittance Page Number
XXXXXXX (Northeast corner of report)	Financial Remittance Page Number
PAGE	Calculated Value
DATE	System Generated Element
CHECKWRITE DATE	Claim Payment Date
TO (Line 1)	Provider Last Name + Provider First Name + Provider Middle Name
TO (Line 2)	Provider Address Line
TO (Line 3)	Provider Address Line
TO(Line4, left)	Provider Address City
TO(Line4, middle)	Provider Address State/Province Code
TO(Line4, right)	Postal Code
PROV ID	Provider Identification Number or National Provider Identifier
REMITTANCE NO	Remittance Advice (RA) Number
TOTAL PAID ORIGINAL	Calculated Value
TOTAL PAID ADJUSTMENTS	Calculated Value
TOTAL PAID VOIDS	Calculated Value
NET TOTAL PAID	Calculated Value
TOTAL DENIED ORIGINAL	Calculated Value
TOTAL DENIED ADJUSTMENTS	Calculated Value
NET TOTAL DENIED	Calculated Value
NET TOTAL PENDED	Calculated Value
BENEFIT PLAN NUMBER	Benefit Plan Identifier
BENEFIT GROUPING DESCRIPTION	Benefit Service Group Short Name
CURRENT PAID AMOUNT	Calculated Value
YTD PAID AMOUNT	Calculated Value
CLAIMS PAID(CURRENT)	Calculated Value
PAID CLAIMS AMOUNT(CURRENT)	Calculated Value
WITHHELD AMOUNT(CURRENT)	Calculated Value
NET PAY AMOUNT(CURRENT)	Calculated Value
CREDIT AMOUNT(CURRENT)	Calculated Value
NET 1099 AMOUNT(CURRENT)	Calculated Value
IRS WITHHELD AMOUNT(CURRENT)	Calculated Value
OTHER W/H(CURRENT)	Calculated Value
ADJUSTED NET PAY(CURRENT)	Calculated Value
CLAIMS PAID(MTD TOTAL)	Calculated Value
PAID CLAIMS AMOUNT(MTD TOTAL)	Calculated Value
WITHHELD AMOUNT(MTD TOTAL)	Calculated Value
NET PAY AMOUNT(MTD TOTAL)	Calculated Value
CREDIT AMOUNT(MTD TOTAL)	Calculated Value
NET 1099 AMOUNT(MTD TOTAL)	Calculated Value
IRS WITHHELD AMOUNT(MTD TOTAL)	Calculated Value
OTHER W/H(MTD TOTAL)	Calculated Value
ADJUSTED NET PAY(MTD TOTAL)	Calculated Value
CLAIMS PAID(YTD TOTAL)	Calculated Value
PAID CLAIMS AMOUNT(YTD TOTAL)	Calculated Value
WITHHELD AMOUNT(YTD TOTAL)	Calculated Value
NET PAY AMOUNT(YTD TOTAL)	Calculated Value
CREDIT AMOUNT(YTD TOTAL)	Calculated Value
NET 1099 AMOUNT(YTD TOTAL)	Calculated Value
IRS WITHHELD AMOUNT(YTD TOTAL)	Calculated Value
OTHER W/H(YTD TOTAL)	Calculated Value
ADJUSTED NET PAY(YTD TOTAL)	Calculated Value
PROVIDER TAX ID	Provider Employer Identification Number (EIN)
PROVIDER TAX NAME	Provider Last Name + Provider First Name + Provider Middle Name

PAYER ID	Constant Value
CLIA	Provider License Number
DEA	Provider Drug Enforcement Agency (DEA) Number