6/26/24

Devoted Health
Member Reimbursements
Box 211037
Eagan, MN 55121

re: Doctor

I visited my Reflect doctor on 02/06/24 and paid $112.50 with my credit card. On 02/08/24, I submitted the invoice/receipt for reimbursement. The doctors office thought it over and decided to bill me an additional $52.50. I wrote them a check and paid that bill by mail.

I called Devoted on 03/04/24 to check on my reimbursement. I was told that Devoted could find no record of ever receiving my request for reimbursement.

On 3/4/24, I re-submitted the $112.50. I included a request for reimbursement of the $52.50 in the same envelope.

On 6/24/24, I received your check number 26920, in the amount of $87.50. See attached remittance advice (EOP).

I am re-submitting my request for reimbursement of the $52.50. "Proof of payment" is attached. Please mail me a check in the amount of $52.50 at your earliest convenience.

Philip Rice
11268 E Linvale Dr
Aurora, CO 80014

Member Number = D5SYZR
dob = 04/25/1953

List of exhibits:
#1) Reimbursement Form
#2) Remittance Advice (EOP)
#3) Proof of Payment

C:\Temp\reflect
reflect_02.txt

Reimbursement form
Get paid back for covered care

PROVIDE YOUR PERSONAL INFORMATION

First and last name:
Philip Rice

Birth date (mm/dd/yyyy):
04/25/1953

Member ID number:
D 55YZR

TELL US ABOUT WHAT YOU PAID FOR

Service or item:
Doctor

Date when you paid:
3/2/24 (check Date)

How much you paid:
52.50

Type of purchase: ☒ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks
☐ Other_____

Service or item:

Date when you paid:

How much you paid:

Type of purchase: ☐ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks
☐ Other_____

Service or item:

Date when you paid:

How much you paid:

Type of purchase: ☐ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks
☐ Other_____

SIGN THE FORM

Your signature:
Philip Rice

Today's date (mm/dd/yyyy):
6/26/24

Don't forget to attach your supporting documents! See next page for details.

Devoted
HEALTH PLANS

EXPLANATION OF PAYMENT (EOP)

Devoted Health Insurance Company of Colorado
PO BOX 211524
EAGAN, MN 55121

PHILIP RICE
11268 E LINVALE DR
AURORA, CO 80014

For questions concerning your EOP's contact 1-877-762-3515 for assistance.

BENEFIT REIMBURSEMENT

ID # D5SYZR

Claim #: AJXHCYEGAR **Check Date:** 06/18/2024

Provider: REFLECT HEALTH **Provider Acct #:**

Service Facility:

Line	Date of Service	Service Description	Code	Amount Requested	Copay/Coins	Adjustments	Paid Amount
1	02/06/2024			($112.50)	$0.00 $0.00	($112.50)	$0.00
2	03/02/2024			($52.50)	$0.00 $0.00	($52.50)	$0.00
		Claim Totals:		($165.00)	$0.00 $0.00	($165.00)	$0.00

Claim #: AJXHCYEGAR-1 **Check Date:** 06/18/2024

Provider: REFLECT HEALTH **Provider Acct #:**

Service Facility:

Line	Date of Service	Service Description	Code	Amount Requested	Copay/Coins	Adjustments	Paid Amount
1	02/06/2024			$112.50	$0.00 $0.00	$25.00	$87.50

REFLECT HEALTH, LLC

REFLECT HEALTH, LLC
PO BOX 32313
BELFAST, ME 04915-0210
billing phone: (303) 357-2559

printed 04/30/2024
02:13 PM

GUARANTOR NAME AND ADDRESS	PATIENT #	PATIENT NAME	DOCTOR	DATE	DEPARTMENT
PHILIP G RICE 11268 E LINVALE DR AURORA, CO 80014-3071	1066478	PHILIP G RICE			

DOB	TELEPHONE	INSURANCE NAME	CERTIFICATE#	AUTH#
04/25/1953	(214) 666-4321			

PATIENT PAYMENT SUMMARY

	Originally Collected For						
Post Date	**Date of Service**	**Procedure Code**	**Original Plan**	**Supervising Provider**	**Reason For Payment**	**Method of Payment**	**Amount**
02/06/2024	02/06/2024				Payment for Todays Service	MC/VISA **********1189	**$112.50**
03/06/2024	02/06/2024	99214		MATTHEW DHIEUX	Other	CHECK 2447	**$52.50**
Total Payment Amount							**$165.00**