Electronic Claims Submission
Coordination of Benefits (COB) – Dental Examples

Aetna Service Options℠ for Health Care Professionals

We prepared this COB Dental Claim Examples document to work in conjunction with the Aetna COB Overview document and the COB Final Addenda, and will provide you with the following:

- Claim scenarios of dental COB claims – Example #1, on page 2, is a straightforward commercial payer-to-payer claim, while Example #2, on page 9, is a paper sample of a commercial payer-to-payer claim where the dental deductible is applied.
- Examples of 837 claim detail for the primary payer, which correspond with the presented claim scenarios
- Correlating 837examples of claim detail to secondary payer
- Notes to assist you with understanding how the 837 claim detail compares between the primary payer and the submission to the secondary payer

Note: This document contains technical language pertaining to 837 claim information. If you are not comfortable with 837 language, please refer to the Aetna COB Overview document for guidance to a variety of informative documents which will assist you. At a minimum, you should be familiar with information housed in the 837 HIPAA Implementation Guide, which can be downloaded from:

http://www.wpc-edi.com

The 837 data found in this document is derived from Version 4010-A1 examples.

Questions?

Please contact us by selecting "Email Us" from www.aetnadental.com.

COB Example #1 - Dental Format - Commercial Payers

This example is based on **Example 2 from HIPAA Dental Implementation Guide (added more services to the example)**

Scenario:

Coordination of benefits; patient is not the subscriber; payers are commercial health insurance companies, provider-to-payer COB model. Provider submits claims electronically and receives ERA from primary payer.

CASE: Patient received exam, X-rays and cleaning.
DOS= 2/9/99
POS=Office

SERVICES RENDERED and CHARGES:

ADA Code	Service Description	# of Units	Charges
D0120	Periodic Oral Exam	1	$ 40.00
D0222	Periapical X-rays	2	$ 25.00
D0274	Bitewing X-rays	4	$ 35.00
D1205	Prophylaxis w/Fluoride	1	$ 80.00
		Total:	**$180.00**

Payer A returned an electronic remittance advice (835) to the billing provider with the following amounts and Claim Adjustment Reason Codes:

SUBMITTED CHARGES (CLP03): $180.00
AMOUNT PAID (CLP04): $90.00
PATIENT RESPONSIBILITY (CLP05): 0.00

The primary payer's 835 ERA CAS at the line level was:
CAS*CO*42*16~
CAS*CO*42*11~
CAS*CO*42*24~
CAS*CO*42*39~

CAS indicates that the charges were reduced because they exceeded the plans contracted/negotiated rate that is allowed for each service.

On the following pages, you will find comparisons of 837 data for this claim example.

Column 1 is provider's 837 claim data sent to payer A.

Column 2 is provider's 837 claim data sent to payer B, which includes the primary carrier's adjustments, payments, etc.

Column 3 has notes on the differences between the claims, and (highlighted) comments on entries that would result in Aetna COB data capture screens.

Comparison of original claim and secondary claim, differences highlighted

Claim to Payer A	Claim to Payer B	Notes
2 BHT TRANSACTION SET HIERACHY AND CONTROL INFORMATION BHT*0019*00*0123*19990210*1023*CH~ 3 REF TRANMISSION TYPE INDENTIFICATION REF*87*004010X097~ 4 1000A SUBMITTER NM1 SUBMITTER NM1*41*2*PREMIER BILLING SERVICE*****46*567890~ 5 PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*7176149999~ 6 1000B RECEIVER NM1 RECEIVER NM1*40*2*KEY INSURANCE COMPANY*****46*999996666~ 7 2000A BILLING/PAY-TO PROVIDER HL LOOP Hierarchical Level 1 HL*1**20*1~ 8 2010AA BILLING PROVIDER NM1 BILLING PROVIDER NAME NM1*85*2*DENTAL ASSOCIATES***** XX*9998887771~ 9 N3 BILLING PROVIDER ADDRESS N3*234 SEAWAY ST~ 10 N4 BILLING PROVIDER CITY N4*MIAMI*FL*33111~ 11 REF BILLING PROVIDER SECONDARY IDENTIFICATION	2 BHT TRANSACTION SET HIERACHY AND CONTROL INFORMATION BHT*0019*00*0123*19990220*1023*CH~ 3 REF TRANMISSION TYPE INDENTIFICATION REF*87*004010X097~ 4 1000A SUBMITTER NM1 SUBMITTER NM1*41*2*PREMIER BILLING SERVICE*****46*567890~ 5 PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*7176149999~ 6 1000B RECEIVER NM1 RECEIVER NM1*40*2*GREAT PRAIRIES HEALTH*****46*123456789~ 7 2000A BILLING/PAY-TO PROVIDER HL LOOP Hierarchical Level 1 HL*1**20*1~ 8 2010AA BILLING PROVIDER NM1 BILLING PROVIDER NAME NM1*85*2*DENTAL ASSOCIATES***** XX*9998887771~ 9 N3 BILLING PROVIDER ADDRESS N3*234 SEAWAY ST~ 10 N4 BILLING PROVIDER CITY N4*MIAMI*FL*33111~ 11 REF BILLING PROVIDER SECONDARY IDENTIFICATION	

REF*EI*123456789~ 12 2000B SUBSCRIBER HL LOOP Hierarchical Level 2 HL*2*1*22*1~ 13 SBR SUBSCRIBER INFORMATION SBR*P*****6***CI~ 14 2010BA SUBSCRIBER NM1 SUBSCRIBER'S NAME **NM1*IL*1*SMITH*JANE****MI*JS0 0111223333~** 15 2010BB SUBSCRIBER/PAYER NM1 PAYER NAME **NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~** 16 2000C PATIENT HL LOOP Hierarchical Level 3 HL*3*2*23*0~ 17 PAT PATIENT INFORMATION PAT*19~ 18 2010CA PATIENT NM1 PATIENT'S NAME NM1*QC*1*SMITH*TED~ 19 N3 PATIENT'S ADDRESS N3*236 N MAIN ST~ 20 N4 PATIENT'S CITY N4*MIAMI*FL*33413~ 21 DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~ 22 2300 CLAIM CLM Health CLAIM INFORMATION CLM*26403774*200***11::1*Y**Y *Y~ 23 DTP DATE - SERVICE DATE DTP*472*D8*19990209~ 24 REF VAN CLAIM NUMBER	REF*EI*123456789~ 12 2000B SUBSCRIBER HL LOOP Hierarchical Level 2 HL*2*1*22*1~ 13 SBR SUBSCRIBER INFORMATION SBR*S*****1***CI~ 14 2010BA SUBSCRIBER NM1 SUBSCRIBER'S NAME **NM1*IL*1*SMITH*JACK****MI*T55 TY666~** 15 2010BB SUBSCRIBER/PAYER NM1 PAYER NAME **NM1*PR*2*GREAT PRAIRIES HEALTH*****PI*123456789~** 16 2000C PATIENT'S HL LOOP Hierarchical Level 3 HL*3*2*23*0~ 17 PAT PATIENT INFORMATION PAT*19~ 18 2010CA PATIENT NM1 PATIENT'S NAME NM1*QC*1*SMITH*TED 19 N3 PATIENT'S ADDRESS N3*236 N MAIN ST~ 20 N4 PATIENT'S CITY N4*MIAMI*FL*33413~ 21 DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~ 22 2300 CLAIM CLM Health CLAIM INFORMATION CLM*26403774*200***11::1*Y**Y *Y~ 23 DTP DATE - SERVICE DATE DTP*472*D8*19990209~ 24 REF VAN CLAIM NUMBER REF*D9*444333222111~	Subscriber is payer specific and usually changes from primary to secondary claim. Payer changes from primary to secondary claim.

REF*D9*111222333444~ 25 2310B RENDERING PROVIDER NM1 RENDERING PROVIDER'S NAME NM1*82*1*KILDARE*BEN****XX*11 23454321~ 26 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*122300000N~	25 2310B RENDERING PROVIDER NM1 RENDERING PROVIDER'S NAME NM1*82*1*KILDARE*BEN****XX*11 23454321~ 26 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*122300000N~ **27 2320 OTHER SUBSCRIBER INFORMATION** SBR SUBSCRIBER INFORMATION - OTHER PAYERS SBR*P*19*******CI~ 28 AMT COB - PAYER AMOUNT PAID ON CLAIM **AMT*D*90~** 30 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~ 31 OI OTHER INSURANCE COVERAGE INFORMATION OI***Y***Y~ 32 2300A OTHER INSURED NAME NM1 OTHER NAME **NM1*IL*1*SMITH*JANE****MI*JS0 0111223333~** **33 N3 OTHER SUBSCRIBER'S ADDRESS** **N3*236 N MAIN ST~** 34 N4 OTHER SUBSCRIBER'S CITY N4*MIAMI*FL*33413~ 35 2300B OTHER PAYER NAME NM1 OTHER PAYER NAME **NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~** 36 2400 SERVICE LINE	Information on primary payer's subscriber is sent to secondary payer. There were no claim level adjustments for the services. Indicates primary payer paid $90.00. Primary payer's subscriber name and address Other (primary) payer name

36 2400 SERVICE LINE LX SERVICE LINE NUMBER LX*1~ 37 SV3 DENTAL SERVICE SV3*AD:D00120*40****1~ 38 DTP DATE-SERVICE DTP*472*D8*19990209~	LX SERVICE LINE NUMBER LX*1~ 37 SV3 DENTAL SERVICE **SV3*AD:D0120*40****1~** 38 DTP DATE-SERVICE DTP*472*D8*19990209~ 39 SVD LINE ADJUDICATION INFORMATION **SVD*999996666*16*AD:D0120**1~** 40 CAS SERVICE ADJUSTMENT **CAS*CO*42*24~**	**Service line 1**: Indicates billed charge was $40.00. Payer A paid $16.00 for the service. Payer A adjusted the billed charge from $40.00 to $16.00 by contractual agreement. CAS*CO*42*24~ indicates a $24.00 contractual write-off.
LX SERVICE LINE NUMBER LX*2~ 41 SV3 DENTAL SERVICE SV3*AD:D00222*25****1~ 42 DTP DATE-SERVICE DTP*472*D8*19990209~	LX SERVICE LINE NUMBER LX*2~ 41 SV3 DENTAL SERVICE **SV3*AD:D0222*25****1~** 42 DTP DATE-SERVICE DTP*472*D8*19990209~ 43 SVD LINE ADJUDICATION INFORMATION **SVD*999996666*11*AD:D00222**1~** 44 CAS SERVICE ADJUSTMENT **CAS*CO*42*14~**	**Service line 2:** Indicates billed charge was $25.00. Payer A paid $11.00 for the service. Payer A adjusted the billed charge from $25.00 to $11.00 by contractual agreement. CAS*CO*42*14~ indicates a $14.00 contractual write-off.
LX SERVICE LINE NUMBER LX*3~ 45 SV3 DENTAL SERVICE SV3*AD:D00274*35****1~ 46 DTP DATE-SERVICE DTP*472*D8*19990209~	LX SERVICE LINE NUMBER LX*3~ 45 SV3 DENTAL SERVICE **SV3*AD:D0274*35****1~** 46 DTP DATE-SERVICE DTP*472*D8*19990209~ 47 SVD LINE ADJUDICATION	**Service line 3:** Indicates billed charge was $35.00.

	INFORMATION **SVD*999996666*24*AD:D00274**1~** 48 CAS SERVICE ADJUSTMENT **CAS*CO*42*11~**	Payer A paid $24.00 for the service. Payer A adjusted the billed charge from $35.00 to $24.00 by contractual agreement. CAS*CO*42*11~ indicates an $11.00 contractual write-off.
LX SERVICE LINE NUMBER LX*4~ 49 SV3 DENTAL SERVICE SV3*AD:D01205*80****1~ 50 DTP DATE-SERVICE DTP*472*D8*19990209~	LX SERVICE LINE NUMBER LX*4~ 49 SV3 DENTAL SERVICE **SV3*AD:D1205*80****1~** 50 DTP DATE-SERVICE DTP*472*D8*19990209~ 51 SVD LINE ADJUDICATION INFORMATION **SVD*999996666*39*AD:D01205**1~** 52 CAS SERVICE ADJUSTMENT **CAS*CO*42*41~**	**Service line 4:** Indicates billed charge was $80.00. Payer A paid $39.00 for the service. Payer A adjusted the billed charge from $80.00 to $39.00 by contractual agreement. CAS*CO*42*41~ indicates a $41.00 contractual write-off.

COB Example #2 - Dental Format – Commercial Payers

Example is based on a live paper claim example received at Aetna.

Scenario:

Coordination of benefits; patient is not the subscriber; payers are commercial health insurance companies, provider-to-payer COB model. Provider submits claims electronically and receives a paper remit from the primary payer.

CASE: Patient has cavities; one on the occlusal surface of Tooth 18 and another on the buccal surface of Tooth 19. Both require fillings.
DOS=04/0204
POS=Office

SERVICES RENDERED and CHARGES

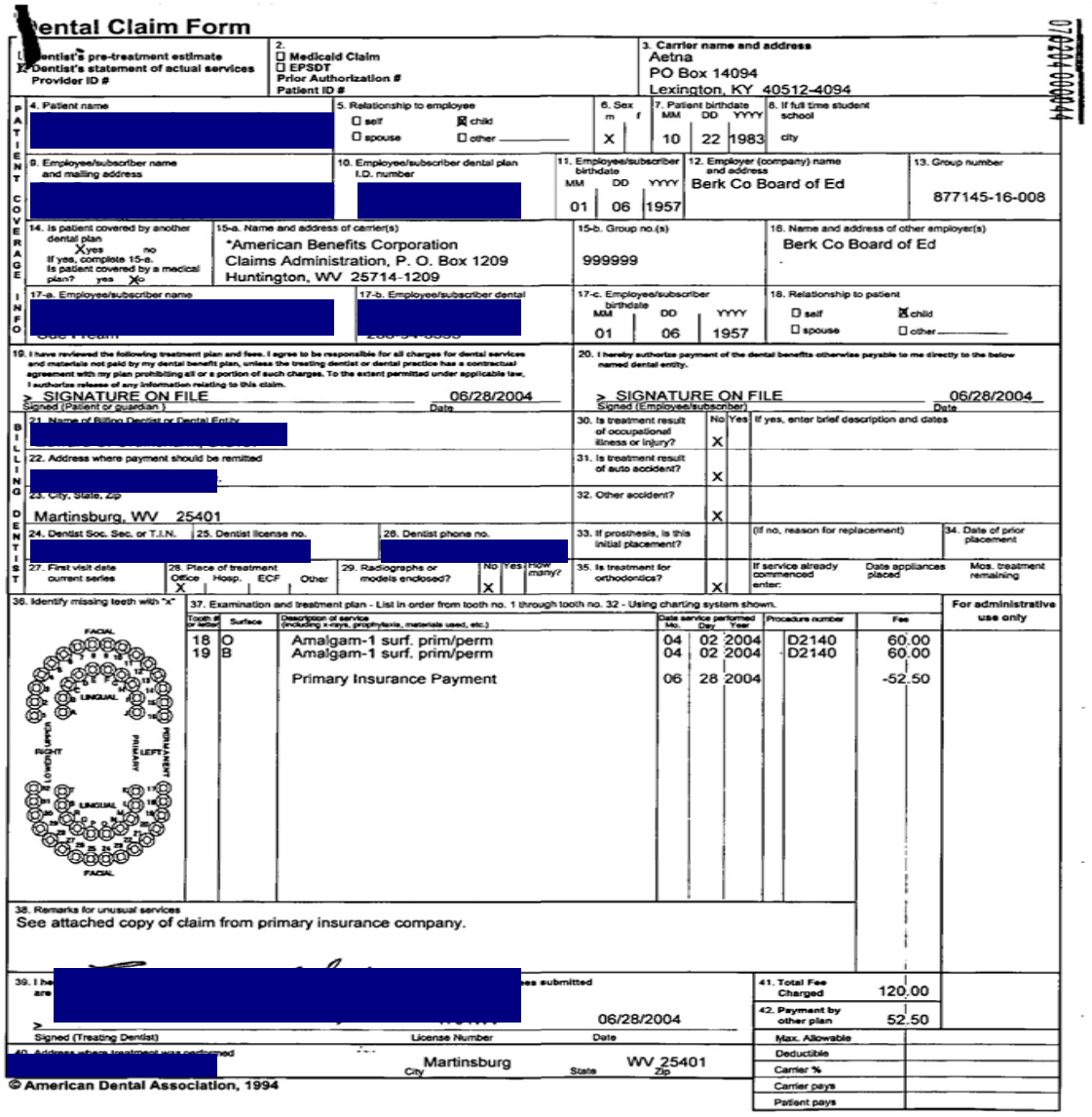
Tooth #	Surface	ADA Code	Service Description	# of Units	Charges
18	O	D2140	Amalgam – 1 surface	1	$ 60.00
19	B	D2140	Amalgam – 1 surface	1	$ 60.00
				Total:	**$120.00**

Payer A returned a paper remit to the billing provider with the following information:

Total Billed Amount: $120.00
Covered Charges: $120.00
Total Paid Amount: $52.50

Patient Responsibility Amounts:
Deductible (applied to service line 1 covered charge): $50.00
Coinsurance: 25%, after application of deductible. Patient is responsible for $17.50. ($120.00 - $50.00 = $70.00 x 25% = $17.50)

Provider then submitted dental claim to Payer B (Aetna) on paper. Below is the claim as received by Aetna:



[redacted]ental Claim Form

[redacted]entist's pre-treatment estimate
Dentist's statement of actual services
Provider ID #

2. ☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #

3. Carrier name and address: Aetna, PO Box 14094, Lexington, KY 40512-4094

PATIENT COVERAGE INFO

4. Patient name: [redacted]
5. Relationship to employee: ☐ self ☒ child ☐ spouse ☐ other
6. Sex: m ☐ f ☒
7. Patient birthdate MM DD YYYY: 10 22 1983
8. If full time student: school / city
9. Employee/subscriber name and mailing address: [redacted]
10. Employee/subscriber dental plan I.D. number: [redacted]
11. Employee/subscriber birthdate MM DD YYYY: 01 06 1957
12. Employer (company) name and address: Berk Co Board of Ed
13. Group number: 877145-16-008
14. Is patient covered by another dental plan? ☒ yes ☐ no. If yes, complete 15-a. Is patient covered by a medical plan? yes ☒ no
15-a. Name and address of carrier(s): *American Benefits Corporation, Claims Administration, P. O. Box 1209, Huntington, WV 25714-1209
15-b. Group no.(s): 999999
16. Name and address of other employer(s): Berk Co Board of Ed
17-a. Employee/subscriber name: [redacted]
17-b. Employee/subscriber dental: [redacted]
17-c. Employee/subscriber birthdate MM DD YYYY: 01 06 1957
18. Relationship to patient: ☐ self ☒ child ☐ spouse ☐ other

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
> SIGNATURE ON FILE — Signed (Patient or guardian) — 06/28/2004 Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
> SIGNATURE ON FILE — Signed (Employee/subscriber) — 06/28/2004 Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity: [redacted]
22. Address where payment should be remitted: [redacted]
23. City, State, Zip: Martinsburg, WV 25401
24. Dentist Soc. Sec. or T.I.N.: [redacted]
25. Dentist license no.
26. Dentist phone no.: [redacted]
27. First visit date current series
28. Place of treatment: Office X, Hosp., ECF, Other
29. Radiographs or models enclosed? No X Yes How many?
30. Is treatment result of occupational illness or injury? No X Yes — If yes, enter brief description and dates
31. Is treatment result of auto accident? No X Yes
32. Other accident? No X Yes
33. If prosthesis, is this initial placement? (If no, reason for replacement)
34. Date of prior placement
35. Is treatment for orthodontics? No X Yes — If service already commenced enter: / Date appliances placed / Mos. treatment remaining

36. Identify missing teeth with "x"

37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo.	Day	Year	Procedure number	Fee
18	O	Amalgam-1 surf. prim/perm	04	02	2004	D2140	60.00
19	B	Amalgam-1 surf. prim/perm	04	02	2004	D2140	60.00
		Primary Insurance Payment	06	28	2004		-52.50

For administrative use only

38. Remarks for unusual services: See attached copy of claim from primary insurance company.

39. I he[redacted] are [redacted] ees submitted
> Signed (Treating Dentist) — License Number — 06/28/2004 Date

40. Address where treatment was performed: [redacted] — Martinsburg City — WV State — 25401 Zip

41. Total Fee Charged: 120.00
42. Payment by other plan: 52.50
Max. Allowable
Deductible
Carrier %
Carrier pays
Patient pays

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Reminder:

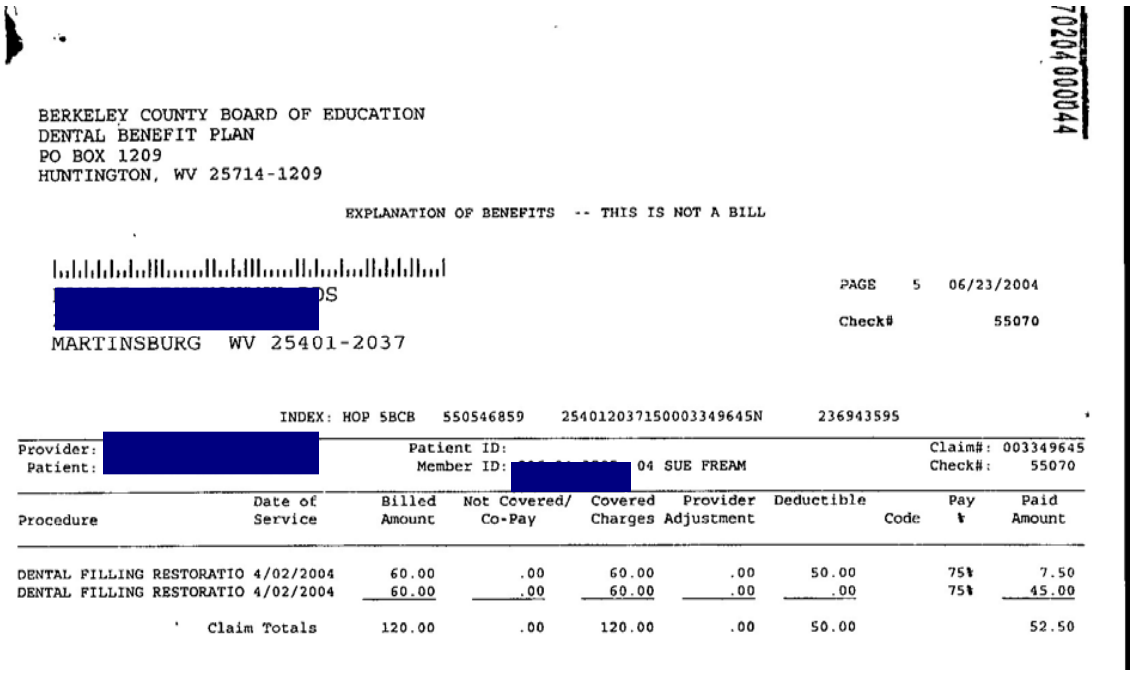
A paper copy of the previous payer's explanation of benefits (EOB) is not needed if you submit your COB claim data electronically. If COB claim data is sent electronically, sending a paper EOB will only result in Aetna rejecting the claim as a duplicate.

Helpful Hint:

Primary payer payment information should be sent using industry standard code values. When working with paper EOBs, please refer to our "Adjustment Reason and Adjustment Group Code Categorization Table". This table can assist you in converting payment information found on an EOB into industry standard coding.

It is possible your paper remittance may already contain standard code values. If so, please use the codes furnished by the primary payer.

Primary payer's paper remit (attached to the dental claim form) as received by Aetna:



BERKELEY COUNTY BOARD OF EDUCATION
DENTAL BENEFIT PLAN
PO BOX 1209
HUNTINGTON, WV 25714-1209

702040000044

EXPLANATION OF BENEFITS -- THIS IS NOT A BILL

[redacted]OS
MARTINSBURG WV 25401-2037

PAGE 5 06/23/2004
Check# 55070

INDEX: HOP 5BCB 550546859 25401203715000334964 5N 236943595

Provider: [redacted] Patient ID:
Patient: Member ID: [redacted] 04 SUE FREAM
Claim#: 003349645
Check#: 55070

Procedure	Date of Service	Billed Amount	Not Covered/ Co-Pay	Covered Charges	Provider Adjustment	Deductible	Code	Pay %	Paid Amount
DENTAL FILLING RESTORATIO	4/02/2004	60.00	.00	60.00	.00	50.00		75%	7.50
DENTAL FILLING RESTORATIO	4/02/2004	60.00	.00	60.00	.00	.00		75%	45.00
Claim Totals		120.00	.00	120.00	.00	50.00			52.50

On the following pages, you will find comparisons of 837 data for this claim example. Only those lines needed to illustrate points not shown in the prior example have been included.

Column 1 is selected lines from provider's claim to payer A as it *would have appeared if it had been sent electronically*.
Column 2 shows how these lines and additional lines created from information on TML paper remittance could have been used to send an EDI (837) claim to payer B (Aetna).

Column 3 has notes on the differences between the claims, and (highlighted) comments on entries that would result in Aetna COB data capture screens.

Comparison of original claim and secondary claim, differences highlighted

Claim to Payer A	Claim to Payer B	Notes
21 2300 CLAIM CLM Health CLAIM INFORMATION CLM*26403774*200***11::1*Y** Y*Y~ 22 DTP DATE - SERVICE DATE DTP*472*D8*19990209~ 23 REF VAN CLAIM NUMBER REF*D9*111222333444~ 24 2310B RENDERING PROVIDER NM1 RENDERING PROVIDER'S NAME NM1*82*1*KILDARE*BEN****XX*1 123454321~ 25 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*122300000N~	2300 CLAIM CLM Health CLAIM INFORMATION CLM*26403774*200***11::1*Y**Y *Y~ 22 DTP DATE - SERVICE DATE DTP*472*D8*19990209~ 23 REF VAN CLAIM NUMBER REF*D9*444333222111~ 24 2310B RENDERING PROVIDER NM1 RENDERING PROVIDER'S NAME NM1*82*1*KILDARE*BEN****XX*11 23454321~ 25 PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*122300000N~ 26 2320 OTHER SUBSCRIBER INFORMATION SBR SUBSCRIBER INFORMATION - OTHER PAYERS SBR*P*19*******CI~ 28 AMT COB - PAYER AMOUNT PAID ON CLAIM **AMT*D*52.50~** 29 AMT COB – PATIENT RESPONSIBILITY **AMT*F2*67.50~** 30 DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~ 31 OI OTHER INSURANCE COVERAGE INFORMATION OI***Y***Y~ 32 2300A OTHER INSURED NAME NM1 OTHER NAME **NM1*IL*1*SMITH*JANE****MI*JS0**	There were no claim level adjustments applied by the primary payer. The primary payer paid $52.50 for the claim. The patient's responsibility is $67.50 due to the deductible and coinsurance amounts applied to the services on the claim. Information on primary payer's subscriber is sent to secondary payer.

	0111223333~ 33 N3 OTHER SUBSCRIBER'S ADDRESS N3*236 N MAIN ST~ 34 N4 OTHER SUBSCRIBER'S CITY N4*MIAMI*FL*33413~ 35 2300B OTHER PAYER NAME NM1 OTHER PAYER NAME NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~	Other (primary) payer name Payer A made adjustments to the charges due to a deductible being applied to service line 1, and coinsurance being applied to each service.
36 2400 SERVICE LINE LX SERVICE LINE NUMBER LX*1~ 37 SV3 DENTAL SERVICE SV3*AD:D02140*60****1~ 38 TOO TOOTH NUMBER SURFACE(S) TOO*JP*18*O~ 39 DTP DATE-SERVICE DTP*472*D8*20040402~	36 2400 SERVICE LINE LX SERVICE LINE NUMBER LX*1~ 37 SV3 DENTAL SERVICE SV3*AD:D2140*60****1~ 38 TOO TOOTH NUMBER SURFACE(S) TOO*JP*18*O~ 39 DTP DATE-SERVICE DTP*472*D8*20040402~ 40 SVD LINE ADJUDICATION INFORMATION SVD*999996666*7.50*AD:D02140**1~ 41 CAS SERVICE ADJUSTMENT CAS*PR*1*50**2*2.50~	**Service line 1:** Indicates billed charge was $60.00. Payer A paid $7.50 for the service. Payer A considered the entire charge of $60.00, but adjusted the benefit amount because of the deductible ($50.00) and applied the 25% co-insurance to the remainder of the covered charge ($2.50). In CAS*PR*1*50**2*2.50~, code 1 indicates there is a deductible applied and code 2 indicates there was coinsurance applied.

LX SERVICE LINE NUMBER LX*2~ 42 SV3 DENTAL SERVICE SV3*AD:D2140*60****1~ 43 TOO TOOTH NUMBER SURFACE(S) TOO*JP*19*B~ 44 DTP DATE-SERVICE DTP*472*D8*19990209~	LX SERVICE LINE NUMBER LX*2~ 42 SV3 DENTAL SERVICE **SV3*AD:D2140*60****1~** 43 TOO TOOTH NUMBER SURFACE(S) TOO*JP*19*B~ 44 DTP DATE-SERVICE DTP*472*D8*19990209~ 45 SVD LINE ADJUDICATION INFORMATION **SVD*999996666*45*AD:D02140**1** ~ 46 CAS SERVICE ADJUSTMENT **CAS*PR*2*15~**	**Service line 2:** Indicates submitted charge was $60.00. Payer A paid $45.00 for the service. Payer A considered the entire charge of $60.00, but adjusted the benefit amount because the 25% coinsurance was applied to the covered charge. In CAS*PR*2*15~, code 2 indicates a coinsurance adjustment was applied.