Freedom Life Insurance Company of America
300 Burnett St. Suite 200
Fort Worth, TX 76102

DPS$$$PKG 2513516852

[redacted]

The document you are holding is a payment for services provided. The attached check and Explanation of Benefit(s) is sent to you for services rendered on behalf of Freedom Life Insurance Company of America who has partnered with Optum Financial® to process their payments. If you have questions regarding Optum Financial®, please contact us at 1-888-477-0230. If you have questions regarding the payment amount or benefits, please contact Freedom Life Insurance Company of America at 1-866-745-8744 (Providers) or 1-866-780-8744 (Consumers).

Claim ID:
Client Reference ID:
VP Trans ID:

Date:
Amount:
Check Number:

[redacted]

IMPORTANT HIPAA NOTICE - The information contained in this Optum Financial® communication contains data considered Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is transmitted subject to HIPAA privacy rules and subsequent penalties for improper use. If the information contained in this communication does not pertain to a current patient at this facility, please (1) notify Optum Financial® immediately at **(877) 399-5917** and provide the VP Trans ID shown (2) destroy this communication and all attached information.

Freedom Life Insurance Company of America
300 Burnett St. Suite 200
Fort Worth, TX 76102

Key Bank
Columbus, OH

VOID AFTER 180 DAYS

DATE: 08/06/2024

0315112054

6-103/410

PAY: ******FORTY FOUR AND 72/100 DOLLARS

$44.72

PAY TO THE ORDER OF

[redacted]

MEMO: [redacted]

[redacted]

Freedom Life Insurance Company of America
300 Burnett St. Suite 200
Fort Worth, TX 76102

FII

EXPLANATION OF BENEFITS

[redacted]

INSURED: [redacted]
POLICY/CERTIFICATE:
PLAN:
CLAIMANT:
PATIENT ID:
SETTLEMENT DATE: 08/06/2024

CLAIM #: [redacted]

PROVIDER DESCRIPTION	DATE(S) OF SERVICE	TOTAL CHARGE	PROVIDER DISCOUNT	EXCLUDED CHARGES	BENEFIT AMOUNT	PAID AT	AMOUNT PAID BY PLAN	REMARK CODE
TGH FAMILY CARE CENTER KENNEDY PHYSICIAN	07/31/24 - 07/31/24	$187.00	$131.72	$0.00	$100.00	100%	$100.00	JG
Total		**$187.00**	**$131.72**	**$0.00**	**$100.00**		**$100.00**	

Summary of Claim	AMOUNT CHARGED BY PROVIDER	DISCOUNT	AMOUNT PAID	PAYEE	AMOUNT YOU MAY OWE
Total	**$187.00**	**$131.72**	**$55.28**	**TGH FAMILY CARE CENTER KENNEDY**	**$0.00**
			$44.72	[redacted]	

REMARK CODE	DESCRIPTION
JG	UnitedHealthcare Choice Plus-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Patient is not responsible for this amount.
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of the policy/certificate. Any expenses erroneously applied to a deductible or copay, if applicable, or paid under any section or provision of the policy/certificate shall not constitute a waiver or modification of any conditions, terms, definitions, or limitations contained in the policy/certificate.

Appeal Notice: If you believe that a claim has been wrongfully denied, you have the right to appeal. To file an appeal, please contact customer service at 1-866-780-8744 or write to Freedom Life Insurance Company of America at 300 Burnett Street, Suite 200, Fort Worth, TX 76102. For more information relating to the internal appeal process, please refer to your coverage materials.

THIS IS NOT A BILL