NAME: **SS#:**

UFCW Unions and Participating Employers Health and Welfare Fund

EMPLOYER:	Shoppers Food	**LOCAL:**	400
DATE OF HIRE:	April 14, 2021	**STATUS:**	Part Time
PLAN:	Y30		

ISSUE: Hospital/Medical – Nonparticipating Provider #M25/103-1479

FUND RULE:
"**CareFirst PPO**

CareFirst PPO is a network of Hospitals, Physicians, and other health care providers which offers medical and Hospital services at discounted rates that are generally lower than usual provider fees. You must use a CareFirst provider to have coverage for Hospital, medical, or surgical benefits under the Fund (with the exception of: (1) services provided by pathologists, anesthesiologist, and radiologist at an in-network facility; (2) emergency admission; (3) emergency room services; and (4) emergency Ambulance Service)."
(Plan Y30 SPD, October 2017, Page 99)

SUMMARY:

Date(s) of Service:	September 19, 2024
Claim(s) Received:	February 24, 2025
Claim(s) Denied:	February 25, 2025
Appeal Received:	April 3, 2025

The **participant** is appealing for payment of a claim that was denied. The participant states, in summary, that she was informed this provider was in-network under her plan, and her insurance status was confirmed multiple times by the provider when scheduling her appointment. The participant further states that the charges have placed a significant financial burden on her, and she acted in good faith under the belief that the provider was in-network.

Fund records indicate Medical Imaging of Fredericksburg submitted a claim for an MRI performed on September 19, 2024. The claim was denied because Medical Imaging of Fredericksburg does not participate with CareFirst.

Fund records further indicate a phone call was received from this provider on September 18, 2024 regarding verifying active eligibility. However, there is no record of the provider's network status being discussed during that call. The Fund office received a phone call from the participant on March 19, 2025 regarding this claim, after it was denied, at which time she was advised of her appeal rights.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

3/28/2025

RE: Appeal of Claim Denial for Out-of-Network Services
Claim Numer: DCJT16
Member ID: (Group ; Prefix)
Date of Service: 9/19/2024

To whom it may concern,

I am writing to formally appeal the decision to deny coverage for my recent medical services, which were provided by Medical Imaging of North Stafford, as I was informed that this provider was in-network under my plan.

When scheduling my appointment, my insurance status was confirmed multiple times by the provider, leaving me no reason to believe that this provider was out-of-network. In fact, I trusted that the provider's services would be covered as in-network based on the information available to me at the time.

The out-of-network charges have placed a significant financial burden on me, as I acted in good faith under the belief that the provider was within the network. I acknowledge that there was an oversight or mistake on my part in confirming network status, and I sincerely apologize for the confusion. However, I respectfully request that you reconsider your decision and reprocess this claim as an in-network service, as this situation was based on a good faith belief that I was receiving care from an in-network provider.

I kindly ask that you review the circumstances surrounding this case and approve coverage for the services rendered, in line with my plan's network benefits. I highly appreciate your understanding and consideration of this appeal.

Please do not hesitate to contact me if you require any additional information or documentation. Thank you for your time and attention to this matter.

Sincerely,

MEDICAL IMAGING OF
FREDERICKSBURG LLC
2 MERIDIAN BLVD
3RD FLOOR
WYOMISSING, PA 19610-3202

RETURN SERVICE REQUESTED

Medical Imaging

RECEIVED
APR 03 2025
AA,LLC

Online Payment Options
- www.patientnotebook.com/256078
  Be sure to include /256078
- Text "PAY" to 877-909-1496
- Scan the QR code

Statement ID: **1584675561**
Account #:

SCAN ME

Billing Dept: **844-721-7231**
Patient Name:
Office Hours: **8:00am - 4:00pm EST M-F (Pay by Phone 24/7)**
Service Location: **MED IMG NORTH STAFFORD**

178319 - 25

0003 013580

Account Number	Due Date	Amount Due	Amount Paid
	04/10/2025	$2,528.98	$

PLEASE MAKE CHECKS PAYABLE AND REMIT TO:

Medical Imaging of Fredericksburg, LLC
PO BOX 371863
PITTSBURGH PA 15250-7863

]01584675561000025607800002528980009

Please detach and return top portion with payment. See reverse side for correspondence mailing address.

Statement Date	Due Date	Amount Due
03/11/2025	04/10/2025	$2,528.98

Date	Doctor	Code	Description	Amount
09/19/2024	JAKOB C L SCHUTZ MD	73721	MRI, ANY JOINT OF LOWER E	3,022.00
09/23/2024			SELF PAY TIME OF SERVICE	-164.34
10/23/2024			SELF PAY TIME OF SERVICE	-164.34
11/21/2024			SELF PAY TIME OF SERVICE	-164.34

This bill is your responsibility. If you have insurance to cover this balance, please call us with your insurance information.
Thank you.
Due within 30 days of statement date

Account:
Patient Name:
Billing Dept: **844-721-7231**
Office Hours: **8:00am - 4:00pm EST M-F**
Fax Number: **302-485-5373**
Fax ID: **54-1364028**
Service Location: **MED IMG NORTH STAFFORD**

Medical Imaging
MWHC Radiologic Associates of Fredericksburg

MEDICAL IMAGING OF FREDERICKSBURG LLC
PO BOX 830008
PHILADEPHIA, PA 19182-0008

178319-25 24782284

APR 03 2025

AA,LLC

Associated Administrators, LLC
911 Ridgebrook Rd.
Sparks MD 21152

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

Forwarding Service Requested

844-721-7231

UFCW Unions & Part. Emp. H&W

If you have any questions, please call
(800) 638-2972

Statement Date: 02/25/25

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	Procedure	Amount Charged	Not Covered	Remark Codes	Amount Allowed	Deductible	Type	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: DCJT16			Patient:						Patient Acct. #:		
Provider: IMAGING FREDERICKSBURG MED			Employee:						Employee #:		
09/19-09/19/2024	DIAG. LAB&X-RAY	3,022.00	3,022.00		0.00	0.00	M	0	0.00	0.00	3,022.00
	TOTALS	3,022.00	3,022.00		0.00	0.00			0.00	0.00	3,022.00

Total Plan Benefit	0.00
Total Plan Pays	0.00
Less COB Adjustment:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim	Line	Code	Description
DCJT16	00C	B1	YOUR PLAN DOES NOT COVER SERVICES RENDERED BY A NON-PARTICIPATING PROVIDER.

	Amount Charged	Not Covered	Amount Allowed	Deductible	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	3,022.00	3,022.00	0.00	0.00	0.00	0.00	3,022.00