

**Exhibit 27-12**

**SAMPLE REMITTANCE ADVICE – ADJUSTED FACILITY CLAIMS**

REPORT ID: FI04W400  
 PROGRAM ID: FI04L400  
 001549

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
 FACILITY REMITTANCE ADVICE - ACUTE  
 ADJUSTED CLAIMS - INVOICE DATE: 11/29/2003

PAGE: 6  
 RUN: 11/29/2003

BILLING PROVIDER: 654321 01 ARIZONA HOSPITAL  
 SERVICE PROVIDER: 654321 01 ARIZONA HOSPITAL

INVOICE NUMBER: A9800000000001  
 CHECK NUMBER: 48746  
 PAYMENT DATE: 12/02/2003

TAX ID: 999999999  
 FORM TYPE: INPATIENT

AHCCS ID RECIPIENT	NAME PATIENT ACCOUNT NUMBER	CRN STATUS DATE	DATES OF SERVICE	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS		
A12345678	OAKLEY, ANNIE	033100001001	10/20/2003	2,280.00	3.00	2,280.00	ALLOWED AMOUNT (*)
A12345678	0011617768-1	11/26/2003	10/23/2003	3.00		760.00-	PREVIOUSLY PAID
						1,520.00	NET PAID AMOUNT
PRICE EXPL: PDM *AHA							
A87654321	JANE, CALAMITY	033100001001	10/26/2003	2,280.00	2.00	1,520.00	ALLOWED AMOUNT (*)
A87654321	J4176027943-1	11/26/2003	10/29/2003	3.00		2,280.00-	PREVIOUSLY PAID
						760.00-	NET PAID AMOUNT
PRICE EXPL: PDM *AHA							

- New Allowed Amount is listed first
- Previously Paid Amount is “backed out” as negative
- Net Paid Amount shows the difference
- Net Paid Amount will be negative if the adjusted Allowed Amount is less than the original Allowed Amount
- Last page of Adjusted Claims section lists totals for

NUMBER OF CLAIMS: 2  
 TOTAL BILLED AMOUNT: 4,560.00  
 TOTAL REMIT AMOUNT: 760.00