

EOB Review Checklist

Step-by-step checklist for reviewing an Explanation of Benefits document

An EOB (Explanation of Benefits) is the payer's statement showing how a claim was processed. Review every EOB within 24–48 hours of receipt. Use this checklist to catch errors, underpayments, and denial issues before deadlines pass.

STEP 1 — IDENTIFY THE EOB

- Payer name matches the expected insurance company
- Patient name and date of birth match your records
- Date of service matches the claim submitted
- Claim number on the EOB matches your submitted claim
- CPT code(s) match what was billed

STEP 2 — REVIEW PAYMENT AMOUNTS

- Billed amount matches your fee schedule for each line
- Allowed amount (contracted rate) is correct per your contract / fee schedule
- Contractual adjustment = Billed – Allowed (should not include patient responsibility)
- Insurance paid amount is correct (Allowed – Patient Responsibility)
- Patient responsibility (copay, deductible, coinsurance) matches benefit plan terms
- No line items were incorrectly bundled or reduced without explanation
- Coordination of benefits amounts are correct if this is a secondary EOB

STEP 3 — CHECK CARC / RARC DENIAL CODES

Each adjustment line has a CARC (Claim Adjustment Reason Code) and often a RARC (Remittance Advice Remark Code). Look up any unfamiliar codes at www.wpc-edi.com/reference.

- CARC code(s) identified and looked up
- RARC code(s) identified and looked up
- Denial reason is legitimate — not a payer processing error
- Denial reason requires action (appeal, resubmission, or patient billing)
- Appeal deadline noted: most payers allow 90–180 days from denial date

STEP 4 — TAKE ACTION

- PAID IN FULL — Post payment and apply patient responsibility to account → *No further action needed*
- UNDERPAYMENT — Contractual rate not honored → Initiate claim underpayment appeal
- DENIAL — Document denial code → Determine if appealing or writing off

- PATIENT RESPONSIBILITY — Bill patient for remaining balance
- RESUBMIT — Correct and resubmit if denial was due to a billing error
- VOID / REVERSE — If duplicate payment received, notify payer and return overpayment

STEP 5 — POST THE PAYMENT

- Payment posted to correct patient account and date of service
- Contractual write-off posted as adjustment (not as patient balance)
- Patient responsibility balance posted for billing
- Denial / no-pay line items flagged for follow-up in denial tracker
- ERA / paper EOB filed or scanned to patient record

EOB REFERENCE — COMMON CARC CODES

CARC	Meaning & Action
CO-4	Modifier required — resubmit with appropriate modifier
CO-11	Diagnosis inconsistent with procedure — review DX/CPT pairing
CO-15	Authorization required — appeal or obtain retro auth
CO-18	Duplicate claim — verify original was paid; appeal if not
CO-22	COB — primary payer paid; review secondary claim
CO-29	Timely filing exceeded — appeal with proof of timely submission
CO-45	Charge exceeds contracted amount (contractual write-off — expected)
CO-50	Medical necessity — appeal with clinical documentation
CO-97	Bundled / not separately payable — review NCCI edits; appeal if applicable
PR-1	Deductible — patient owes; bill patient
PR-2	Coinsurance — patient owes; bill patient
PR-3	Copay — patient owes; bill patient