**DE: CLAIM ERROR DETAIL REPORT**

| Patient Name | Patient Ctrl No | HIC | Submit Date | Claim Charges |
|---|---|---|---|---|
| PATIENT, ONE P | A2345678091 | H123456 | mm/dd/yyyy | 105,987.00 |

| Code | Field Name | Value | Description |
|---|---|---|---|
| 37056 | Release for Transmission | Y | Description goes here. |
| ELGSEX | Patient Sex | M | Description goes here. |
| ELDHMO | Payer Name | Medicare | Description goes here. |

| Patient Name | Patient Ctrl No | HIC | Submit Date | Claim Charges |
|---|---|---|---|---|
| PATIENT, TWO P | A09876543 | H098765 | mm/dd/yyyy | 4,098.00 |

| Code | Field Name | Value | Description |
|---|---|---|---|
| 37056 | Release for Transmission | Y | Description goes here. |