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Attn: MEDICARE-NY-DOWNSTATE
PO BOX 6703

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FARGO ND 58108-6703

X <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/>									
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 8J92TA2KC00									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CRACCHIOLO, ROSARIO										3. PATIENT'S BIRTH DATE MM DD YY SEX 09 22 1950 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 51 BIRCHWOOD PARK DRIVE CITY STATE SYOSSET NY ZIP CODE TELEPHONE (Include Area Code) 11791 (516) 972-7924										4. INSURED'S NAME (Last Name, First Name, Middle Initial) CRACCHIOLO, ROSARIO 7. INSURED'S ADDRESS (No., Street) 51 BIRCHWOOD PARK DRIVE CITY STATE SYOSSET NY ZIP CODE TELEPHONE (Include Area Code) 11791 (516) 972-7924									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) CRACCHIOLO, FELICETTA a. OTHER INSURED'S POLICY OR GROUP NUMBER 890156279 b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME UNITED HEALTH CARE										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC) 1									
11. INSURED'S POLICY GROUP OR FECA NUMBER NONE a. INSURED'S DATE OF BIRTH MM DD YY SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE-NY-DOWNSTATE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE DATE 11/9/2023									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 11/9/2023										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 15. OTHER DATE MM DD YY QUAL 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN TATIANA BARON 17a. NPI 1790922888 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 0.00 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 R945 A. E1121 B. I10 C. E785 D. R945 E. Z23 F. G. H. I. J. K. L. 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 33D0928417									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 10 19 23 10 19 23 11 99214 25 ABCD 389.55 1 N NPI 1790922888																			
2 10 19 23 10 19 23 11 95251 A 103.17 1 N NPI 1790922888																			
3 10 19 23 10 19 23 11 81003 A 5.62 1 N NPI 1790922888																			
4 10 19 23 10 19 23 11 82043 A 14.45 1 N NPI 1790922888																			
5 10 19 23 10 19 23 11 82570 A 12.95 1 N NPI 1790922888																			
6 10 19 23 10 19 23 11 83036 A 24.27 1 N NPI 1790922888																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 832668818 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. CM0VN1E743889									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Dr. Tatiana Baron 11/9/2023 SIGNED DATE										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use									
32. SERVICE FACILITY LOCATION INFORMATION .NSDEA NorthShoreDiabetesEndocrine 3003 New Hyde Park Road Suite 201 New Hyde Park NY 11042										33. BILLING PROVIDER INFO & PH # (516) 407-2727 PRINE Health Medical Group, PLLC 1129 Northern Blvd Suite 101 MANHASSET NY 11030-3022									
a. NPI										b. 1144790163									



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5. PATIENT'S ADDRESS (No., Street) 51 BIRCHWOOD PARK DRIVE										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 51 BIRCHWOOD PARK DRIVE																																							
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1 10 19 23 10 19 23 11 82985 A 41.90 1 N NPI 1790922888										2 10 19 23 10 19 23 11 84681 A 52.02 1 N NPI 1790922888										3 10 19 23 10 19 23 11 83525 A 28.57 1 N NPI 1790922888																																							
4 10 19 23 10 19 23 11 80053 C 26.40 1 N NPI 1790922888										5 10 19 23 10 19 23 11 80061 C 33.47 1 N NPI 1790922888										6 10 19 23 10 19 23 11 83721 59 C 26/25 1 N NPI 1790922888																																							
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1 10 19 23 10 19 23 11 36415 ABCD 10.00 1 N NPI 1790922888																			
2 N470461012304 FLUAD QUADRIVALENT 2023-2 ML0.50 10 19 23 10 19 23 11 90662 E 152.45 1 N NPI 1790922888																			
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CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION