

ALTH INSURANCE CLAIM FORM

Page 1
Attn: MEDICARE-NY-DOWNSTATE

PO BOX 6703

FARGO ND 58108-6703

APPROVED BY	NATIO	NAL UN	IFORM	CLAIM	СОММІТ	TEE (NU	JCC) 02/12							ГР	INGO N	טו	0 100	-0703				
X X X PICA																			PI	ICA		
1. MEDICARI	E	MEDIC	AID	TRI	CARE		CHAMPV/	1	GROU	JP TH PLAN	E	CA K LUNG	OTHER	1a. INSURED'S I.D. N	UMBER			(For P	rogram in Ite	em 1)		
X (Medicare#	9 🔲	Medica	id#)	(ID#	/DoD#)		(Member II)	W)	(ID#)	TH PLAN		JK LUNG)#)	(ID#)	8J92TA2K	C00							
2. PATIENT'S I	NAME (L	ast Nar	ne, Firs	st Name,	Middle Ir	nitial)		3. PA	TIENT'S	BIRTH	QATE		SEX	4. INSURED'S NAME	(Last Name	e, Firs	t Name,	Middle In	nitial)			
CRACCHIOL	.O, RO	SARIO)						09 2			X	F	CRACCH	IOLO, RO	OSAF	RIO					
5. PATIENTS	Street)				6. PA	TIENT F	RELATIO	NSHIP T	OINSL	JRED	7. INSURED'S ADDRI	ESS (No., S	Street)								
51 BIRCHWOOD PARK DRIVE										Spouse	Chile		Other	51 BIRCH	4/V/OOD 1		K DDIV	/ =				
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SYOSSET NY TELEPHONE (Include Area Code)														SYOSSET		TEL	EDHON	E (laalus)	a Area Cada	NY		
ZIP CODE TELEPHONE (Include Area Code)														ZIP CODE TELEPHONE (Include Area Code)								
11791 (516) 972-7924														11791 (516) 972-7924								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									PATIEN	NT'S CO	NOITION	RELAT	FED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER								
CRACCHIOL	.O, FEI	LICET	TA											NONE								
a. OTHER INSURED'S POLICY OR GROUP NUMBER								a. EM	PLOYM	IENT? (C	urrent or	Previo	us)	a. INSURED'S DATE	OF BIRTH				SEX			
890156279										YES		X NO					М		F			
b. RESERVED	FOR N	UCC US	BE .					b. AU	TO ACC	CIDENT?		Р	LACE (State)	b. OTHER CLAIM ID	Designated	by N	UCC)					
										YES		X NO										
c. RESERVED FOR NUCC USE								c. OT	HER AC	CIDENT	7			c. INSURANCE PLAN	NAME OR	PRO	GRAM N	NAME				
										YES	Г	X NO		MEDICARI	E-NY-DO	WNS	TATE					
d. INSURANCE	PLAN	NAME (OR PRO	OGRAM	NAME			10d. 0	CLAIM C	CODES (UCC)	d. IS THERE ANOTHE				AN?				
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READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the it to process this claim. I also request payment of government benefits either it.									of any n	nedical or	other inf			 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for 								
to process to below.	his claim	. I also i	equest	paymen	t of govern	nment be	nefits either t	o myse	elf or to t	he party v	who acce	pts assi	gnment	services described	below.							
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SIGNED				ON FIL					DAT	re	/9/2023	3		SIGNEDS	IGNATU	KE U	N FILE					
MM DD I YY									DATE	М	M DI	3 1	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY								
			QUAL.				QUA	L						FROM TO								
17. NAME OF I	REFERE	ING PE	ROVIDE	ER OR C	THER S	OURCE	17a.							18. HOSPITALIZATION	N DATES F	ELAT	TED TO	CURREN	IT SERVICE	S		
DN TAT	IANA E	BARO	N				17b	NPI		17	909228	88		FROM			то	121101	00			
19. ADDITIONA	AL CLAII	M INFO	RMATI	ON (Des	signated b	y NUCC)							20. OUTSIDE LAB?			\$ C	HARGES	3			
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21. DIAGNOSIS	SORNA	ATURE	OF ILL	NESS O	R INJUR	Y Relate	A-L to servi	ce line	below (24E)	100 1-1	10		22. RESUBMISSION CODE	10000							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to servin											ICD Ind.	R94	5	CODE	1	ORIG	SINAL R	EF. NO.				
A	-		В.	-			С. Ц			_	D.			23. PRIOR AUTHORIZATION NUMBER								
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24. A. DAT	TE(S) O	F SERV	To		B. PLACE OF	C.	D. PROCEI			ICES, Of cumstance		LIES	E. DIAGNOSIS		G. DAYS	H. EPSDT	I.		J. RENDERI	NG		
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25. FEDERAL	TAXID	NUMB	ER	991	N EIN	26 D	ATIENT'S A	CCOLL	NT NO	2	7. ACCE	PT ASS	SIGNMENT?	28. TOTAL CHARGE	20	AMO	UNT PA	ND I	30. Rsvd for	NUCC Use		
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31. SIGNATUR				A		32. S	ERVICE FA	CILITY	LOCAT	ION INFO	ORMATI	ON		33. BILLING PROVIDE	ER INFO &	PH#	(516) 4	407-2727			
(I certify the						.NS	SDEA Nort	hShor	eDiab	etesEnd	docrine			PRINE Health M	edical Gr	Oun	PLIC	,				
apply to this							3 New Hy							1129 Northern B								
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Dr. Tatiana E	Baron			11/9/2	2023		,							MANHASSET N	1 11030-	JUZZ						
SIGNED				DATE		a.			b.					a. 1144790163	b.							



ALTH INSURANCE CLAIM FORM

Page 2
Attn: MEDICARE-NY-DOWNSTATE

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FARGO ND 58108-6703

APPROVE	BY NATIO	ONAL UN	IFORM	CLAIM	COMMIT	TEE (NU	JCC) 02/12							FAF	NGO N	נ טו	0100-	0703				
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1. MEDIO	CARE	MEDICA	AID	TRI	CARE		CHAMPV	A	GROU	JP TH PLAN	FEC/	UNG	THER	1a. INSURED'S I.D. NU	MBER			(For Program	n in Item 1)			
X (Medic	are#)	(Medical	d#)	(ID#	/DoD#)		(Member II.)#)	(ID#)	TH PLAN	(10#)	UNG 0	D#)	8J92TA2KC	00							
2. PATIEN	T'S NAME	(Last Nar	ne, Firs	t Name	Middle Ir	nitial)		3. PA	TENT'S	BIRTH	RATE	SEX		4. INSURED'S NAME (L	ast Name	e, First	t Name, I	Middle Initial)				
CRACCHIOLO, ROSARIO									09 2			X F		CRACCHIO	OLO, RO	OSAF	RIO					
5. PATIEN	TS ADDRE	SS (No.,	Street)				6. PA	TIENT	RELATIO	NSHIP TO I	NSURED		7. INSURED'S ADDRES	SS (No., S	Street)						
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SYOSSET NY ZIP CODE TELEPHONE (Include Area Code)														SYOSSET NY ZIP CODE TELEPHONE (Include Area Code)								
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	11791 (516) 972-7924 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								Th. 6 THE SEC.					11791 (516) 972-7924 11. INSURED'S POLICY GROUP OR FECA NUMBER								
			3	lame, Fi	rst Name,	Middle	Initial)	10.18	PATIE	NI'S CON	NOTION HE	ELATED TO:			GHOUP	OHE	EGA NU	MBER				
CRACCH				10020000								Total Color		NONE								
a. OTHER		S POLICY	YORG	ROUP	NUMBER			a. EM	PLOYN	IENT? (C	urrent or Pre	100		a. INSURED'S DATE OF	F BIRTH		1.0	SEX				
8901562			(A)							YES	X	NO					М		F			
b. RESER	VED FOR N	NUCC US	E					b. AU	TO ACC	CIDENT?	_	PLACE (S	State)	b. OTHER CLAIM ID (D	esignated	by N	UCC)					
										YES	X	NO										
c. RESERV	ED FOR N	IUCC US	E					c. OTI	HER AC	CIDENT	7			c. INSURANCE PLAN N	IAME OR	PRO	GRAM N	AME				
										YES	X	NO		MEDICARE-	NY-DO	WNS	TATE					
d. INSURA	NCE PLAN	NAME C	R PRO	OGRAM	NAME			10d. C	LAIM (CODES (D	Designated b	by NUCC)		d. IS THERE ANOTHER	HEALTH	BEN	EFIT PL	AN?				
UNITED	HEALTH	CARE						1						YES I	NO I	If yes,	complet	te items 9, 9a,	and 9d.			
							OMPLETING					Casterna	,	13. INSURED'S OR AUT	THORIZE	DPEF	RSON'S	SIGNATURE I	authorize			
							uthorize the							payment of medical services described b		o the u	undersign	ned physician o	or supplier for	1		
below.	ood tillo oldii	III. I aled I	oquosi	paymon	t or govern	IIII DO	Nonia on io	io inyao	ii 01 15 1	no party e	то досорь	assignment		Services described b	GIOW.							
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															NO			0.00				
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25. FEDER	RAL TAX I.I). NUMBI	ER	SSI	N EIN	26. F	PATIENT'S A	CCOU	NT NO.	27	7. ACCEPT	ASSIGNME	NT?	28. TOTAL CHARGE	29.	AMO	UNT PAI	D 30. Rs	vd for NUCC	Use		
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8326688					X		10VN1E74				X YES	NO		\$	\$							
31. SIGNA	TURE OF I			-		32. 8	SERVICE FA	CILITY	LOCAT	ION INFO	ORMATION			33. BILLING PROVIDER	R INFO &	PH#	(5	516) 407-2	2727			
	y that the s						SDEA Nort							PRINE Health Me			PLLC					
	o this bill ar					300	03 New Hy	de Pa	rk Roa	ad Suite	201			1129 Northern Blv								
						Ne	w Hyde Pa	ark NY	1104	2				MANHASSET NY	11030-	3022						
Dr. Tatiar	na Baron			11/9/	2023		0.00	-						. N. 1984		JUZZ						
SIGNED				DATE		a.			b.					a. 1144790163	b.							



HEALTH INSURANCE CLAIM FORM

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

Page 3 Attn: MEDICARE-NY-DOWNSTATE PO BOX 6703

FARGO ND 58108-6703

X X X PICA																			PICA	П		
1. MEDICAR	E	MEDIC	AID	TRI	CARE		CHAMP	VA	GRO	UP LTH PLAN	FE	CA K LUNG	OTHER	1a. INSURED'S I.	D. NUMBER			(For Pro	gram in Item 1)		
X (Medicarei	(4)	(Medica	id#)	(ID#	/DoD#)		(Member	ID#)	(ID#)	LIHPLAN	(ID)	#)	(ID#)	8J92TA	A2KC00							
2. PATIENT'S	NAME (Last Na	me, Firs	t Name	Middle I	nitial)		3. F	ATIENT'	S BIRTH D	ATE .	S	EX	4. INSURED'S NA	ME (Last Name	e, Firs	t Name,	Middle Initi	ial)			
CRACCHIO	LO, RO	DSARI	O					4		22 1950		X	F	CRAC	CHIOLO, R	OSAF	RIO					
5. PATIENTS	ADDRE	SS (No.	Street)	1				6. F	PATIENT	RELATION	SHIPTO	O INSUI	RED	7. INSURED'S AD	DRESS (No., S	Street)						
51 BIRCHW	OOD F	PARK [DRIVE						Self	Spouse	Child		Other	51 BII	RCHWOOD	PARI	K DRIV	/E				
СПУ				STATE	8. F	RESERVE	D FOR NU	CC USE	E		CITY					STATE						
SYOSSET NY														SYOSS	ET				N	1Y		
ZIP CODE TELEPHONE (Include Area Code)														ZIP CODE TELEPHONE (Include Area Code)								
1791			(516	972-	7924								11791			516	5) 972-	-7924			
OTHER INS	URED	S NAME	(Last N	ame, Fi	rst Name	, Middle	Initial)	10.	IS PATIE	NT'S CON	NOITION	RELATI	ED TO:	11. INSURED'S P	OLICY GROUP	ORF	ECA N	UMBER				
CRACCHIO	LO, FE	LICET	TA					1						NONE								
. OTHER INS	URED'S	POLIC	YORG	ROUP	NUMBER	t		a. E	EMPLOY	MENT? (Cui	rrent or I	Previous	s)	a. INSURED'S DA	TE OF BIRTH		100	8	EX			
90156279										YES	\rightarrow	NO N					M		F			
. RESERVED	FORN	IUCC U	SE					b. A	AUTO AC	CIDENT?		PL	ACE (State)	b. OTHER CLAIM	ID (Designated	by N	UCC)			1		
										YES	\rightarrow	NO										
. RESERVED	FOR N	UCC US	SE .					c. (OTHER A	CCIDENT?				c. INSURANCE P	LAN NAME OR	PRO	GRAM N	NAME				
										YES	>	NO		MEDIC	ARE-NY-DO	WNS	TATE					
I. INSURANCI	E PLAN	NAME	OR PRO	OGRAM	NAME			100	. CLAIM	CODES (De	esignate	d by NU	JCC)	d. IS THERE AND	THER HEALTH	BEN	EFIT PL	AN?				
JNITED HE	ALTH	CARE						1						YES	NO	If yes	, comple	ite items 9,	9a, and 9d.			
O DATICHTIC	OP AL									THIS FORM				13. INSURED'S O								
										medical or o the party wh				payment of me services descr	dical benefits to bed below.	o the i	undersig	ned physici	an or supplier	TOF		
below.																						
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4. DATE OF C	CURRE	NT ILLN	ESS, IN	JURY,	or PREGI	NANCY	(LMP) 15	. OTH	ER DATE	ММ	DD		YY	16. DATES PATIE	NTUNABLET	o wo	RK IN C	URRENT	CCUPATION	1		
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7. NAME OF	REFER	RING P	ROVIDE	RORC	THER S	OURCE	17	a						18. HOSPITALIZA	TION DATES	BELAT	TED TO	CURRENT	SERVICES			
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9. ADDITION	AL CLA	M INFO	RMATIC	ON (Des	signated t	y NUCC	()							20. OUTSIDE LA	3?		\$ C	HARGES				
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1. DIAGNOSI	SORN	ATURE	OF ILLI	NESS O	RINJUR	Y Relate	e A-L to ser	vice lin	ne below	(24E) IC	CD Ind.	0		22. RESUBMISSI	ON	001	DINIAL D	EE 110				
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5. FEDERAL	IAX I.D	. NUMB	ER	SSI	N EIN	26. I	PATIENT'S	ACCC	DUNTNO			. claims,	GNMENT? see back)	28. TOTAL CHAR	GE 29.	AMO.	UNT PA	טוו 30). Rsvd for NUC	JC Us		
32668818					X	CN	//0VN1E7	4388	9	>	YES		NO	\$	21.07 \$			0.00				
1. SIGNATUR										TION INFO	RMATIC	ON		33. BILLING PRO		PH#		1	07-2727			
(I certify the						N!	SDEA No	rthSh	oreDiah	etesEndo	crine			PRINE Healt	h Medical Cr	OLID.	`	,				
apply to thi										ad Suite 2				1129 Norther			LLC					
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Or. Tatiana E	Baron			11/9/:	2023		, 40 1	w. IV 1						MANHASSE		3022						
SIGNED				DATE		a.			t).				a. 1144790	163 b.							