HEALTH INSURANCE CLAIM FORM

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

PICA

 954-533-6510

Worldwide Medical Assurance LTD
2813 Executive Park Dr. Center for
Suite# 120
Weston FL 33331

(P)

CARRIER

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 31272

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Frechilla-Ortega, Antonio

3. PATIENT'S BIRTH DATE: 10 10 1962 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Frechilla-Ortega, Antonio

5. PATIENT'S ADDRESS (No., Street): 1643 Brickell Ave Apt 2003

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 1643 Brickell Ave Apt 2003

CITY: Miami STATE: FL

8. RESERVED FOR NUCC USE

CITY: Miami STATE: FL

ZIP CODE: 33129 TELEPHONE (Include Area Code): (786) 2536433

ZIP CODE: 33129 TELEPHONE (Include Area Code): (786) 2536433

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 755630

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH: 10 10 1962 SEX: M X F

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES NO X PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: Worldwide Medical Assurance LTD

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: 03 09 2022

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 02 15 2022 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Alejandro Badia

17a.

17b. NPI 1346291515

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S63.8X1A B. S63.681A C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 220214-0034

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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02	15	22	02	15	22	24		29845	AS	AB	845 50	1		NPI	1104195585
2 02	15	22	02	15	22	24		29999	AS	AB	1125 00	1		NPI	1104195585
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 261642118 SSN EIN X

26. PATIENT'S ACCOUNT NO.: BHS-16892

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 1970 $0

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

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.)

Kate I Macia PA

03 09 2022

SIGNED: SIGNATURE ON FILE DATE

32. SERVICE FACILITY LOCATION INFORMATION

The Surgery Center at Doral
3650 NW 82nd Avenue Suite 101
Doral FL 33166-6662

a. 1386821817 b.

33. BILLING PROVIDER INFO & PH # (305) 2274263

Badia Hand to Shoulder
3650 NW 82nd Avenue Suite 103 Ste
Doral FL 33166-6662

a. 1851560031 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA

 954-533-6510

Worldwide Medical Assurance LTD
2813 Executive Park Dr. Center for
Suite# 120
Weston FL 33331

(P)

CARRIER

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 31272

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Frechilla-Ortega, Antonio

3. PATIENT'S BIRTH DATE MM DD YY: 10 10 1962 — SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Frechilla-Ortega, Antonio

5. PATIENT'S ADDRESS (No., Street): 1643 Brickell Ave Apt 2003

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 1643 Brickell Ave Apt 2003

CITY: Miami — STATE: FL

8. RESERVED FOR NUCC USE

CITY: Miami — STATE: FL

ZIP CODE: 33129 — TELEPHONE (Include Area Code): (786) 2536433

ZIP CODE: 33129 — TELEPHONE (Include Area Code): (786) 2536433

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 755630

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 10 10 1962 — SEX: M X F

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES NO X — PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: Worldwide Medical Assurance LTD

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X — *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: 03 09 2022

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 15 2022 — QUAL. 431

15. OTHER DATE QUAL. — MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Alejandro Badia

17a.

17b. NPI 1346291515

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO X — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. S63.8X1A B. S63.681A C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 220214-0034

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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 15 22	02 15 22	24		29845		AB	3382 00	1		NPI	1346291515
2 02 15 22	02 15 22	24		29999		AB	4500 00	1		NPI	1346291515
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 261642118 — SSN EIN: EIN X

26. PATIENT'S ACCOUNT NO.: BHS-16891

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 7882 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

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.)

Alejandro Badia MD

03 09 2022

SIGNED: SIGNATURE ON FILE — DATE

32. SERVICE FACILITY LOCATION INFORMATION

The Surgery Center at Doral
3650 NW 82nd Avenue Suite 101
Doral FL 33166-6662

a. 1386821817 b.

33. BILLING PROVIDER INFO & PH # (305) 2274263

Badia Hand to Shoulder
3650 NW 82nd Ave Ste 103
Doral FL 33166-6662

a. 1851560031 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION