



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00001
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1												PICA						
1. MEDICARE <input 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 checked="" type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)												PICA						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				SEX				4. INSURED'S I.D. NUMBER (For Program in Item 1)						
CAVOLI BALBUENA, FRANCISCO				MM DD YY				M F				000986312						
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)										
CALLE LUIS F THOMEN 154				Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				CALLE LUIS F THOMEN 154										
CITY SANTO DOMINGO				STATE				CITY SANTO DOMINGO				STATE						
ZIP CODE		TELEPHONE (Include Area Code)						ZIP CODE		TELEPHONE (Include Area Code)								
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										
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				755630										
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)				a. INSURED'S DATE OF BIRTH MM DD YY										
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				M F										
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				b. OTHER CLAIM ID (Designated by NUCC)										
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								c. INSURANCE PLAN NAME OR PROGRAM NAME				INTL WORLDWIDE						
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.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
SIGNED SIGNATURE ON FILE DATE 04/05/2022												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE QUAL. MM DD YY				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 JORGE MANRIQUE SUCCAR				17a. _____				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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. M1712				B. Z96652				C. _____ D. _____				F. G. H. I. J. \$ CHARGES DAYS OR UNITS EPSDT Family Plan ID. RENDERING PROVIDER ID. #						
E. _____ F. _____				G. _____ H. _____				I. _____ L. _____				ZZ 207R00000X NPI 1457681165						
I. _____ J. _____				K. _____ L. _____								ZZ 207R00000X NPI 1457681165						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG				C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				E. DIAGNOSIS MODIFIER pointer						
1 04 01 22 04 01 22 11				97110 GP				AB				22400 2						
2 04 01 22 04 01 22 11				97112 GP				AB				11200 1						
3																		
4																		
5																		
6																		
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. P80117776650				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 33600				29. AMOUNT PAID \$ 000		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.) ROLANDO PEREZ SIGNED 04/05/22				32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609				33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009										
DATE				a. NPI				b. NPI				a. 1215989298 b. ZZ207R00000X						



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HEALTH INSURANCE CLAIM FORM

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

PICA

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER												1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
<input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#)			<input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#)			<input type="checkbox"/> BLK LUNG <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)			000986312					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CAVOLI BALBUENA, FRANCISCO												3. PATIENT'S BIRTH DATE MM DD YY 02 21 1961 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		
5. PATIENT'S ADDRESS (No., Street) CALLE LUIS F THOMEN 154												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
CITY SANTO DOMINGO			STATE			8. RESERVED FOR NUCC USE			7. INSURED'S ADDRESS (No., Street) CALLE LUIS F THOMEN 154					
ZIP CODE			TELEPHONE (Include Area Code) ()						CITY SANTO DOMINGO					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			STATE			ZIP CODE					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						TELEPHONE (Include Area Code) ()					
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)											
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)											
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.												11. INSURED'S POLICY GROUP OR FECA NUMBER 755630		
SIGNED SIGNATURE ON FILE DATE 04/05/2022												a. INSURED'S DATE OF BIRTH MM DD YY 02 21 1961 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.			15. OTHER DATE MM DD YY			b. OTHER CLAIM ID (Designated by NUCC)								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN JORGE MANRIQUE SUCCAR			17a. _____			c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			17b. NPI 1790223527			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
A. <u>M1712</u>	B. <u>Z96652</u>	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____	SIGNED SIGNATURE ON FILE		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS MODIFIER			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
1 04 04 22 04 04 22 11						97110 GP			AB			22400 2 ZZ 207R00000X		
2 04 04 22 04 04 22 11						97112 GP			AB			11200 1 ZZ 207R00000X		
3												NPI		
4												NPI		
5												NPI		
6												NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/>			26. PATIENT'S ACCOUNT NO. P80117776740			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 33600			29. AMOUNT PAID \$ 000		
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.) ROLANDO PEREZ			32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609						33. BILLING PROVIDER INFO & PH# (800) 2222273			CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009		
SIGNED 04/05/22 DATE			a. NPI			b. NPI			a. 1215989298			b. ZZ207R00000X		



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HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE <input 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 checked="" type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#) X (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000016241									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN, JESSICA					3. PATIENT'S BIRTH DATE MM DD YY 06 12 1990					4. INSURED'S NAME (Last Name, First Name, Middle Initial) CHAHIN, JESSICA									
5. PATIENT'S ADDRESS (No., Street) 4265 SW 179TH WAY					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) 4265 SW 179TH WAY									
CITY MIRAMAR			STATE FL		8. RESERVED FOR NUCC USE			CITY MIRAMAR			STATE FL								
ZIP CODE 33029		TELEPHONE (Include Area Code) ()					ZIP CODE 33029		TELEPHONE (Include Area Code) ()										
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									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX 06 12 1990 M F									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) 					b. OTHER CLAIM ID (Designated by NUCC) 									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
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.											13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
SIGNATURE ON FILE SIGNED DATE 04/05/2022											SIGNATURE ON FILE SIGNED 								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. L508					15. OTHER DATE MM DD YY QUAL. 1144396334					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 VESSELIN V DIMOV					17a. 					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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) L508											22. RESUBMISSION CODE ORIGINAL REF. NO. 001843434								
A. 	B. 	C. 	D. 	E. 	F. 	G. 	H. 	I. 	J. 	K. 	L. 	F. 	G. DAYS OR UNITS \$ CHARGES	H. EPDS/ Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04 04 22 04 04 22 11					B. PLACE OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) J2357					E. MODIFIER F. DIAGNOSIS POINTER 					ZZ 207R00000X NPI 1144396334				
1 04 04 22 04 04 22 11					A 1150825 60					ZZ 207R00000X NPI 1144396334									
2 04 04 22 04 04 22 11					A 24900 1					ZZ 207R00000X NPI 1144396334									
3															NPI				
4															NPI				
5															NPI				
6															NPI				
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177					26. PATIENT'S ACCOUNT NO. P80117776570					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 1175725		29. AMOUNT PAID \$ 000		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.) VESSELIN V DIMOV					32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609					33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009									
SIGNED 04/05/22 DATE					a. NPI b. 					a. 1215989298 b. ZZ207R00000X									



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
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TUL01 00004
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HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA

PAGE 1 OF 1

PICA												
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000050641			(For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DE LA CRUZ, ABELARDO, A			3. PATIENT'S BIRTH DATE MM DD YY 09 20 1966			SEX <input checked="" type="checkbox"/> X <input type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) DE LA CRUZ, ABELARDO, A					
5. PATIENT'S ADDRESS (No., Street) CALLE HELIOS			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) CALLE HELIOS						
CITY SANTO DOMINGO		STATE	8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO			STATE			
ZIP CODE	TELEPHONE (Include Area Code) ()					ZIP CODE	TELEPHONE (Include Area Code) ()					
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 09 20 1966			SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> F			
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			<i>If yes, complete items 9, 9a, and 9d.</i>			
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 04/05/2022								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.			15. OTHER DATE QUAL. MM DD YY			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 MAURICIO VELEZ			17a. _____			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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												
A. E119	B. Z941	C. I10	D. D849	22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____								
E. _____	F. _____	G. _____	H. _____	23. PRIOR AUTHORIZATION NUMBER								
I. _____	J. _____	K. _____	L. _____	F. _____	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS MODIFIER		27700	1	ZZ 207RA0001X NPI 1699069088
1 04 01 22	04 01 22	11	99214									
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	
25. FEDERAL TAX I.D. NUMBER 650003177			SSN EIN <input checked="" type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. P80117776950		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 27700	29. AMOUNT PAID \$ 000	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.) DAVID SNIPELISKY			32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609			33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009						
SIGNED 04/05/22 DATE			a. NPI			a. 1215989298 b. ZZ207RA0001X						

PHYSICIAN OR SUPPLIER INFORMATION



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CARRIER

PICA		PAGE 1 OF 1						PICA						
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000986322 (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MIGUEL, EDITH			3. PATIENT'S BIRTH DATE MM DD YY 12 14 1966			SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) MIGUEL, EDITH							
5. PATIENT'S ADDRESS (No., Street) CALLE LUIS F			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) CALLE LUIS F								
CITY SANTO DOMINGO		STATE	8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE						
ZIP CODE	TELEPHONE (Include Area Code) ()					ZIP CODE	TELEPHONE (Include Area Code) ()							
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								
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 12 14 1966 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X								
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) 			b. OTHER CLAIM ID (Designated by NUCC)								
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE								
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 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 04/05/2022											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.			15. OTHER DATE QUAL. MM DD YY			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 YANIA VILARINO			17a. <input type="checkbox"/> 17b. NPI 1982376885			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0														
A. M5450	B. R531	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS MODIFIER		F. \$ CHARGES			G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 01 22	04 01 22	11	97110	GP		AB	33600	3	ZZ	2081P0004X		NPI	1588680821	
2												NPI		
3												NPI		
4												NPI		
5												NPI		
6												NPI		
25. FEDERAL TAX I.D. NUMBER 650003177		SSN EIN <input checked="" type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. P80117776480		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 33600	29. AMOUNT PAID \$ 000	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.) DANIEL GROBMAN		32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609		33. BILLING PROVIDER INFO & PH # (800) 2222273		CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009								
SIGNED 04/05/22		DATE		a. <input type="checkbox"/> b. <input type="checkbox"/>		a. 1215989298		b. ZZ2081P0004X						

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00006
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER 001030772 (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SALAZAR SIMO, MARTIN												3. PATIENT'S BIRTH DATE MM DD YY 01 20 1964		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SALAZAR SIMO, MARTIN	
5. PATIENT'S ADDRESS (No., Street) CALLE MADAME CURIE 20												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) CALLE MADAME CURIE 20			
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE		CITY SANTO DOMINGO		STATE									
ZIP CODE ()		TELEPHONE (Include Area Code) ()				ZIP CODE ()		TELEPHONE (Include Area Code) ()									
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 01 20 1964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____		b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE			
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 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.		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 04/05/2022		SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE QUAL. MM DD YY				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 GILBERTO ALEMAR				17a. _____				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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) K148												22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. <input type="checkbox"/> K148	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/> DAYS OR UNITS	H. <input type="checkbox"/> EPSDT Family Plan	I. <input type="checkbox"/> ID. QUAL.	J. <input type="checkbox"/> RENDERING PROVIDER ID. #	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER	E. DIAGNOSIS ICD Ind. 0	\$ CHARGES	A. <input type="checkbox"/>	39700	1	ZZ 207Y00000X						
1 04 04 22	04 04 22	11	99204					NPI 1538120779			NPI						
2											NPI						
3											NPI						
4											NPI						
5											NPI						
6											NPI						
25. FEDERAL TAX I.D. NUMBER 650003177		SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. P80117776440		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 39700		29. AMOUNT PAID \$ 000		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.) GILBERTO O ALEMAR												32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609		33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009			
SIGNED 04/05/22 DATE												a. <input type="checkbox"/> NPI b. <input type="checkbox"/>		a. 1215989298 b. ZZ207Y00000X			

1 CLEVELAND CLINIC FLORIDA 3100 WESTON ROAD WESTON 800222273		2 CLEVELAND CLINIC FLORIDA PO BOX 538021 FL 333313602ATLANTA GA 30353		3a PAT. CNTL # H200216646500001 b. MED. REC. # 6727317	4 TYPE OF BILL 0131			
8 PATIENT NAME a ACOSTA MEJIA, CARLOS		9 PATIENT ADDRESS a AV ANACAONA NO 46		6 STATEMENT COVERS PERIOD FROM THROUGH 7 650844880 033022 033022				
b SANTO DOMINGO		c d e DO						
10 BIRTHDATE 09041954	11 SEX M	12 DATE 3 2	ADMISSION 13 HR 14 TYPE 01	16 DHR	17 STAT 18 19 20 21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE SPAN FROM THROUGH		37	
a								
b								
38		39 CODE	40 CODE	41 CODE				
		VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT				
		a						
		b						
		c						
		d						
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1 0301	LAB/CHEMISTRY	82340	033022	1	61.00		1	
2 0301	LAB/CHEMISTRY	82507	033022	1	38.00		2	
3 0301	LAB/CHEMISTRY	82570	033022	1	88.00		3	
4 0301	LAB/CHEMISTRY	83945	033022	1	24.00		4	
5 0301	LAB/CHEMISTRY	84300	033022	1	90.00		5	
6 0301	LAB/CHEMISTRY	84560	033022	1	47.00		6	
7							7	
8							8	
9							9	
10							10	
11							11	
12							12	
13							13	
14							14	
15							15	
16							16	
17							17	
18							18	
19							19	
20							20	
21							21	
22							22	
23 0001 PAGE 1 OF 1	CREATION DATE 040522	TOTALS →	348.00				23	
50 PAYER NAME INTL WORLDWIDE	51 HEALTH PLAN ID PAPER	52 REL INFO Y	53 ASG BEN Y	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1083644033		
A						57 OTHER	A	
B						PRV ID	B	
C							C	
58 INSURED'S NAME ACOSTA MEJIA, CARLOS	59 P.REL 18	60 INSURED'S UNIQUE ID SWG160401068	61 GROUP NAME WORLDWIDE	62 INSURANCE GROUP NO.				
A							A	
B							B	
C							C	
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME						
A							A	
B							B	
C							C	
66 DX N200							68	
0								
69 ADMIT DX	70 PATIENT REASON DX N200	71 PPS CODE	72 ECI				73	
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI 1912170713	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 OTHER NPI	81 OTHER NPI	
DATE	DATE	LAST GEBRESELASSIE	FIRST SURAFEL					
C OTHER PROCEDURE CODE	d. OTHER PROCEDURE CODE	e. OTHER PROCEDURE CODE						
DATE	DATE	DATE						
80 REMARKS INTL WORLDWIDE 2813 EXECUTIVE PARK DR STE 120 WESTON FL 33331	B1CC a B3282N0000X	78 OTHER NPI	79 OTHER NPI	80 OTHER NPI	81 OTHER NPI	82 OTHER NPI	83 OTHER NPI	
		LAST		LAST		LAST		

CLEVELAND CLINIC FLORIDA 3100 WESTON ROAD WESTON 8002222273				CLEVELAND CLINIC FLORIDA PO BOX 538021 FL 333313602ATLANTA GA 30353				3a PAT. CNTL # b. MED. REC. #	H200216198420001 6396496	4 TYPE OF BILL 0131	
								5 FED.TAX NO. 6 STATEMENT COVERS PERIOD, FROM THROUGH	7		
								650844880 032522 032522			
8 PATIENT NAME a CAVOLI BALBUENA, FRANCISCO		9 PATIENT ADDRESS b SANTO DOMINGO		c	d	e	DO				
10 BIRTHDATE 02211961	11 SEX M	12 DATE 3 2	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR 17 STAT 01	18 19 20 21	CONDITION CODES 22 23 24 25 26 27 28	29 ACCT STATE 30				
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 CODE	OCCURRENCE SPAN FROM THROUGH	36 CODE	OCCURRENCE SPAN FROM THROUGH	37			
a	b	c	d	a	b	c	d				
38	39 CODE	40 CODE	41 CODE	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0312 PATHOL/HYSTOL	88305	032522 1							210.00		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49											
0001 PAGE 1 OF 1				CREATION DATE		040522	TOTALS ➔	210.00			
50 PAYER NAME A INTL WORLDWIDE		51 HEALTH PLAN ID PAPER		52 REL INFO Y	53 ASG BEN Y	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE	56 NPI 1083644033		
									57 OTHER		
									PRV ID		
58 INSURED'S NAME A CAVOLI BALBUENA, FRANCISC		59 PREL 18	60 INSURED'S UNIQUE ID 000986312		61 GROUP NAME		62 INSURANCE GROUP NO. 755630				
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME			
66 DX D485	C44219										68
0											73
69 ADMIT DX	70 PATIENT REASON DX D485	71 PPS CODE C44219		72 ECI a							
74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE		75	76 ATTENDING NPI 1518402353	JUL					
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE			LAST VISCONTI	FIRST PATRIZIA					
					77 OPERATING NPI	QUAL					
					LAST	FIRST					
80 REMARKS INTL WORLDWIDE 2813 EXECUTIVE PARK DR STE 120 WESTON FL 33331	B1CC a	B3282N0000X				78 OTHER NPI	QUAL				
	b					LAST	FIRST				
	c					79 OTHER NPI	QUAL				
	d					LAST	FIRST				

CLEVELAND CLINIC FLORIDA 3100 WESTON ROAD WESTON		CLEVELAND CLINIC FLORIDA PO BOX 538021 FL 333313602ATLANTA		GA 30353		3a PAT. CNTL # H200216761190001	4 TYPE OF BILL 0131			
						b. MED. REC. # 6727317				
						5 FED.TAX NO. 650844880	7 STATEMENT COVERS PERIOD, FROM 033122 THROUGH 033122			
8 PATIENT NAME a. ACOSTA MEJIA, CARLOS		9 PATIENT ADDRESS b. SANTO DOMINGO				s. d.	e. DO			
10 BIRTHDATE 09041954		11 SEX M	12 DATE 3 2	ADMISSION 13 HR 34	14 TYPE 01	15 SRC	16 DHR 17 STAT 18 19 20 21	18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28	29 ACDT 30 STATE	
31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE	36 OCCURRENCE SPAN FROM THROUGH	37 OCCURRENCE SPAN FROM THROUGH			
a.		b.	c.	d.	a.	b.	c.			
38		39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT						
a.		b.	c.	d.						
42 REV. CD.	43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1 0300	LABORATORY		36415		033122	1	16.00		1	
2 0301	LAB/CHEMISTRY		80061		033122	1	147.00		2	
3									3	
4									4	
5									5	
6									6	
7									7	
8									8	
9									9	
10									10	
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23	0001 PAGE 1 OF 1		CREATION DATE 040522		TOTALS →		163.00			
50 PAYER NAME	51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1083644033		
A INTL WORLDWIDE	PAPER		Y	Y			57 OTHER			
B							PRV ID			
C										
58 INSURED'S NAME	59 PREI	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.				
A ACOSTA MEJIA, CARLOS	18	SWG160401068		WORLDWIDE						
B										
C										
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME					
A										
B										
C										
66 DX E782 I739 E119 Z794 0										68
69 ADMIT DX	70 PATIENT REASON DX	E782	I739	E119	71 PPS CODE	72 ECI				73
74 PRINCIPAL PROCEDURE CODE	70 DATE	a. OTHER PROCEDURE CODE	71 DATE	b. OTHER PROCEDURE CODE	72 DATE	73				
c. OTHER PROCEDURE CODE	74 DATE	d. OTHER PROCEDURE CODE	75 DATE	e. OTHER PROCEDURE CODE	76 DATE					
80 REMARKS INTL WORLDWIDE	B1CC a. B3282N0000X	78 OTHER	NPI	79 OTHER	NPI	80 OTHER	NPI	LAST	FIRST	
2813 EXECUTIVE PARK DR STE 120 WESTON FL 33331	b. c. d.									

CLEVELAND CLINIC FLORIDA 3100 WESTON ROAD WESTON		CLEVELAND CLINIC FLORIDA PO BOX 538021 FL 333313602ATLANTA		GA 30353		3a PAT. CNTL # H200213814320001	4 TYPE OF BILL 0131	
8002222273						5 FED.TAX NO. 6 STATEMENT COVERS PERIOD, FROM THROUGH	7	
						650844880 033122 033122		
8 PATIENT NAME a		9 PATIENT ADDRESS a CALLE HELIOS						
b DE LA CRUZ, ABELARDO, A		b SANTO DOMINGO				c d e DO		
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28	CONDITION CODES 29 ACCT STATE 30	
09201966	M	3 2	01					
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE	36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH	
a	b	c	d	a	b	c	d	
38		39 CODE	40 CODE	41 CODE	42 REV. CD. 43 DESCRIPTION 44 HOPCS / RATE / HIPPS CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49		40 VALUE CODES AMOUNT 41 VALUE CODES AMOUNT	
1 0300 LABORATORY	36415	033122	1	16.00				
2 0301 LAB/CHEMISTRY	80053	033122	1	253.00				
3 0301 LAB/CHEMISTRY	80061	033122	1	147.00				
4 0301 LAB/CHEMISTRY	80197	033122	1	64.00				
5 0301 LAB/CHEMISTRY	83036	033122	1	88.00				
6 0301 LAB/CHEMISTRY	83735	033122	1	106.00				
7 0305 LAB/HEMATOLOGY	85025	033122	1	127.00				
8 0306 LAB/BACT-MICRO	87497	033122	1	515.00				
9 0307 LAB/UROLOGY	81001	033122	1	46.00				
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23 0001 PAGE 1 OF 1	CREATION DATE	040522	TOTALS →	1362.00				
50 PAYER NAME INTL WORLDWIDE		51 HEALTH PLAN ID PAPER	52 REL INFO Y	53 ASG BEN Y	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1083644033	57 OTHER PRV ID
A	B	C						
58 INSURED'S NAME DE LA CRUZ, ABELARDO, A	59 PREL 18	60 INSURED'S UNIQUE ID 000050641	61 GROUP NAME		62 INSURANCE GROUP NO. 755630			
A	B	C						
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME			
A	B	C						
66 DX Z941							68	
0								
69 ADMIT DX	70 PATIENT REASON DX Z941	71 PPS CODE	72 ECI				73	
74 PRINCIPAL PROCEDURE CODE	a. OTHER PROCEDURE CODE	b. OTHER PROCEDURE CODE	75	76 ATTENDING NPI 1457613861	JUL			
				LAST WILSON	FIRST SOPHIA			
c. OTHER PROCEDURE CODE	d. OTHER PROCEDURE CODE	e. OTHER PROCEDURE CODE		77 OPERATING NPI	QUAL			
				LAST	FIRST			
80 REMARKS INTL WORLDWIDE 2813 EXECUTIVE PARK DR STE 120 WESTON FL 33331	81CC a B3282N00000X b c d	78 OTHER NPI	QUAL					
		LAST	FIRST					
		79 OTHER NPI	QUAL					
		LAST	FIRST					



**INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331**

TUL01 00001
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000075372											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ABREU, FRANKLIN						3. PATIENT'S BIRTH DATE MM DD YY 09 14 1952						4. INSURED'S NAME (Last Name, First Name, Middle Initial) ABREU, FRANKLIN											
5. PATIENT'S ADDRESS (No., Street) CALLE JOSE A BREA PENA18						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) CALLE JOSE A BREA PENA18											
CITY SANTO DOMINGO			STATE			8. RESERVED FOR NUCC USE						CITY SANTO DOMINGO			STATE								
ZIP CODE			TELEPHONE (Include Area Code) ()									ZIP CODE			TELEPHONE (Include Area Code) ()								
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY SEX 09 14 1952 M <input checked="" type="checkbox"/> F <input type="checkbox"/>											
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____						b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 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.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
SIGNATURE ON FILE SIGNED _____ DATE 04/01/2022												SIGNATURE ON FILE SIGNED _____											
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 FERNANDO CABRERA						17a. _____ 17b. NPI 1891957080						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 11 2022 TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) N4289												22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. <input type="checkbox"/> N4289	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	ICD Ind. 0	23. PRIOR AUTHORIZATION NUMBER 10D0889158																		
E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	F. ZZ 207ZC0006X G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. # 1073532818															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. CPT/HCPCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. # ZZ 207ZC0006X NPI 1073532818					
1 03 11 22		03 11 22		21		88321		A		33600		1											
2																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. P80117653620						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 33600		29. AMOUNT PAID \$ 000		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.) PABLO BEJARANO 04/01/22												32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON HOSPITAL 3100 WESTON ROAD WESTON FL 33331-3602						33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009					
SIGNED DATE												a. <input type="checkbox"/> NPI b. <input type="checkbox"/>						a. 1215989298 b. ZZ207ZC0006X					



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00002
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

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PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000288181						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GADELOFF ABADI, ALBERTO										4. INSURED'S NAME (Last Name, First Name, Middle Initial) GADELOFF ABADI, ALBERTO						
5. PATIENT'S ADDRESS (No., Street) EDIF PACIFIC VILLAGE										7. INSURED'S ADDRESS (No., Street) EDIF PACIFIC VILLAGE						
CITY PANAMA CITY					STATE					CITY PANAMA CITY						
ZIP CODE		TELEPHONE (Include Area Code) ()								STATE		ZIP CODE			TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:						
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										11. INSURED'S POLICY GROUP OR FECA NUMBER 755657						
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.										a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>						
SIGNED SIGNATURE ON FILE DATE 04/01/2022										b. OTHER CLAIM ID (Designated by NUCC)						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE QUAL. MM DD YY					c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN MAUREEN WHITSETT										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										SIGNED SIGNATURE ON FILE						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. K766 B. R160 C. R161 D. D696 ICD Ind. 0										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. DIAGNOSIS MODIFIER POINTER										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
1 01 07 22 01 07 22 22 99205 ABCD 71600 1 NPI 340714585 2 _____ NPI 3 _____ NPI 4 _____ NPI 5 _____ NPI 6 _____ NPI										22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER						
25. FEDERAL TAX I.D. NUMBER SSN EIN 340714585 <input checked="" type="checkbox"/>										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. # EI 340714585 1558789511						
26. PATIENT'S ACCOUNT NO. P70581025620 27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 71600 29. AMOUNT PAID \$ 000 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.) MAUREEN WHITSETT MD SIGNED 04/01/22 DATE										32. SERVICE FACILITY LOCATION INFORMATION CCF CLEVELAND CLINIC MAIN 9500 EUCLID AVE CLEVELAND OH 44195-0001						
										33. BILLING PROVIDER INFO & PH # (800) 2232273 CLEVELAND CLINIC FOUNDATION PO BOX 931813 CLEVELAND OH 44193-1913						
										a. 1679525919 b. ZZ207RI0008X						



INTL WORLDWIDE
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TUL01 00003
SUB ID: 313260
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HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000288181							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GADELOFF ABADI, ALBERTO						3. PATIENT'S BIRTH DATE MM DD YY SEX 06 11 1986 M X F						4. INSURED'S NAME (Last Name, First Name, Middle Initial) GADELOFF ABADI, ALBERTO							
5. PATIENT'S ADDRESS (No., Street) EDIF PACIFIC VILLAGE						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) EDIF PACIFIC VILLAGE							
CITY PANAMA CITY			STATE			CITY PANAMA CITY			STATE										
ZIP CODE ()			TELEPHONE (Include Area Code) ()			ZIP CODE ()			TELEPHONE (Include Area Code) ()										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER 755657							
						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) ()						a. INSURED'S DATE OF BIRTH MM DD YY SEX 06 11 1986 M X F							
						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
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												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 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 IHAB HADDADIN				17a. NPI 1306854534				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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. K761 B. K7290 C. <input type="checkbox"/> D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>												22. RESUBMISSION CODE ORIGINAL REF. NO. 36D0656094							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS				E. DIAGNOSIS MODIFIER				F. G. DAYS OR UNITS H. EPSDT Family Plan I. I.D. J. RENDERING PROVIDER ID. #											
1	01	12	22	01	12	22	22	88307	26	AB	72900	1	EI	340714585					
2	01	12	22	01	12	22	22	88313	26	AB	26800	4	NPI	1215104369					
3													EI	340714585					
4													NPI						
5													NPI						
6													NPI						
25. FEDERAL TAX I.D. NUMBER 340714585 SSN EIN <input checked="" type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. P70581025390				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 99700 29. AMOUNT PAID \$ 000 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.) KEITH K LAI MD												32. SERVICE FACILITY LOCATION INFORMATION CCF MAIN CAMPUS OUTPATIENT 9500 EUCLID AVE CLEVELAND OH 44195-0001				33. BILLING PROVIDER INFO & PH# (800) 2232273 CLEVELAND CLINIC FOUNDATION PO BOX 931813 CLEVELAND OH 44193-1913			
SIGNED 04/01/22 DATE												a. <input type="checkbox"/> b. <input type="checkbox"/>				a. 1679525919 b. ZZ390200000X			

CARRIER ↑
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



INTL WORLDWIDE
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TUL01 00004
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HEALTH INSURANCE CLAIM FORM

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

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PICA

PICA																		
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000288181				(For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GADELOFF ABADI, ALBERTO							3. PATIENT'S BIRTH DATE MM DD YY 06 11 1986				SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) GADELOFF ABADI, ALBERTO						
5. PATIENT'S ADDRESS (No., Street) EDIF PACIFIC VILLAGE							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) EDIF PACIFIC VILLAGE							
CITY PANAMA CITY			STATE	8. RESERVED FOR NUCC USE				CITY PANAMA CITY			STATE							
ZIP CODE	TELEPHONE (Include Area Code) ()							ZIP CODE	TELEPHONE (Include Area Code) ()									
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 755657							
a. OTHER INSURED'S POLICY OR GROUP NUMBER							a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY 06 11 1986							
b. RESERVED FOR NUCC USE							b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE							
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
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 04/01/2022											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.							15. OTHER DATE QUAL. MM DD YY				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 DANIEL SULLIVAN							17a. <input type="checkbox"/> 17b. NPI 1366429375				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. K766 B. E782 C. Z23 D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/> ICD Ind. 0																		
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				E. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 13 22	01 13 22	22	99213				ABC	24700	1					EI 340714585				
2														NPI				
3														NPI				
4														NPI				
5														NPI				
6														NPI				
25. FEDERAL TAX I.D. NUMBER 340714585							SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. P70581025580			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 24700	29. AMOUNT PAID \$ 000	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.) DANIEL M SULLIVAN MD								32. SERVICE FACILITY LOCATION INFORMATION CCF CLEVELAND CLINIC MAIN 9500 EUCLID AVE CLEVELAND OH 44195-0001			33. BILLING PROVIDER INFO & PH # (800) 2232273 CLEVELAND CLINIC FOUNDATION PO BOX 931813 CLEVELAND OH 44193-1913							
SIGNED 04/01/22							DATE	a. <input type="checkbox"/> b. <input type="checkbox"/>			a. 1679525919		b. ZZ207R00000X					



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WESTON, FL 33331

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SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000288181			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GADELOFF ABADI, ALBERTO										3. PATIENT'S BIRTH DATE SEX MM DD YY 06 11 1986 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) EDIF PACIFIC VILLAGE										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY PANAMA CITY					STATE					7. INSURED'S ADDRESS (No., Street) EDIF PACIFIC VILLAGE			
ZIP CODE		TELEPHONE (Include Area Code) ()								CITY PANAMA CITY			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										8. RESERVED FOR NUCC USE			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										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	
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)			
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER 755657			
SIGNATURE ON FILE										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
SIGNED DATE 04/01/2022										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
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 MM DD YY FROM MM DD YY TO			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN JAMES BLACKBURN					17a. 17b. NPI 1831492859					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R918 B. K766 C. Z87891 D. ICD Ind. 0 E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. DIAGNOSIS MODIFIER					F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #								
1 01 11 22 01 11 22 22 99204 ABC 54800 1 2 3 4 5 6					EI 340714585 NPI NPI NPI NPI NPI								
25. FEDERAL TAX I.D. NUMBER SSN EIN 340714585 <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. P70581025490 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
28. TOTAL CHARGE \$ 54800					29. AMOUNT PAID \$ 000					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.) JAMES H BLACKBURN DO 04/01/22 DATE					32. SERVICE FACILITY LOCATION INFORMATION CCF CLEVELAND CLINIC MAIN 9500 EUCLID AVE CLEVELAND OH 44195-0001					33. BILLING PROVIDER INFO & PH # (800) 2232273 CLEVELAND CLINIC FOUNDATION PO BOX 931813 CLEVELAND OH 44193-1913 a. 1679525919 b. ZZ207RP1001X			



**INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331**

TUL01 00006
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000986322									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MIGUEL, EDITH					3. PATIENT'S BIRTH DATE SEX MM DD YY M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) MIGUEL, EDITH									
5. PATIENT'S ADDRESS (No., Street) CALLE LUIS F					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) CALLE LUIS F									
CITY SANTO DOMINGO			STATE		8. RESERVED FOR NUCC USE					CITY SANTO DOMINGO			STATE						
ZIP CODE ()			TELEPHONE (Include Area Code) ()							ZIP CODE ()			TELEPHONE (Include Area Code) ()						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE									
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.										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" 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.										SIGNATURE ON FILE									
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 YANIA VILARINO										17a. 17b. NPI 1982376885					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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M549 B. M5124 C. M5450 D. R531 E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS E. DIAGNOSIS MODIFIER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					23. PRIOR AUTHORIZATION NUMBER 2203180003														
1 03 25 22 03 25 22 11 97161 GP ABCD 36600 1 2 3 4 5 6					ZZ 2081P0004X NPI 1588680821 NPI NPI NPI NPI NPI														
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/> X					26. PATIENT'S ACCOUNT NO. P80117653700 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE \$ 36600 29. AMOUNT PAID \$ 000 30. Rsvd for NUCC Use (800) 2222273									
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.) DANIEL GROBMAN 04/01/22 DATE					32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609					33. BILLING PROVIDER INFO & PH # CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009 a. 1215989298 b. ZZ2081P0004X									



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00007
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

PICA												
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000016052 (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) VALLS, MARIA			3. PATIENT'S BIRTH DATE MM DD YY 09 08 1944			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) VALLS, MARIA					
5. PATIENT'S ADDRESS (No., Street) 1800 S OCEAN 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) 1800 S OCEAN DRIVE						
CITY HALLANDALE BEACH		STATE FL	8. RESERVED FOR NUCC USE			CITY HALLANDALE BEACH		STATE FL	ZIP CODE 33009			TELEPHONE (Include Area Code) ()
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 09 08 1944			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> X			
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			<i>If yes</i> , 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.												
SIGNATURE ON FILE						DATE 04/01/2022						
SIGNED			SIGNED			SIGNED			SIGNED			
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 NYDIA MARTINEZ			17a. <input type="checkbox"/> 17b. NPI 1528205937			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind. 0			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
A. J432	B. R0602	C. R768	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS MODIFIER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPDS/ Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. # ZZ 207RP1001X	
1 01 11 22	01 11 22	11	99215		ABC	36700	1			NPI	1528205937	
2										NPI		
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX I.D. NUMBER 650003177			SSN EIN <input checked="" type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. P80117653670	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 36700	29. AMOUNT PAID \$ 000	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.)			32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609			33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009						
NYDIA MARTINEZ 04/01/22			a. NPI <input type="checkbox"/> b. <input type="checkbox"/>			a. 1215989298 b. ZZ207RP1001X						

INTL WORLDWIDE
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STE 120
WESTON, FL 33331

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

<input type="checkbox"/> PICA MEDICARE <input 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 (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#) X (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000016052									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) VALLS, MARIA					3. PATIENT'S BIRTH DATE MM DD YY 09 08 1944					4. INSURED'S NAME (Last Name, First Name, Middle Initial) VALLS, MARIA									
5. PATIENT'S ADDRESS (No., Street) 1800 S OCEAN 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) 1800 S OCEAN DRIVE									
CITY HALLANDALE BEACH		STATE FL		8. RESERVED FOR NUCC USE					CITY HALLANDALE BEACH		STATE FL								
ZIP CODE 33009		TELEPHONE (Include Area Code) ()			ZIP CODE 33009		TELEPHONE (Include Area Code) ()												
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY 09 08 1944									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 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.																			
SIGNATURE ON FILE					DATE 04/01/2022					SIGNATURE ON FILE									
SIGNED _____					SIGNED _____														
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE QUAL. MM DD YY					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 NYDIA MARTINEZ					17a. _____ 17b. NPI 1528205937					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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0																			
A. J439		B. J449		C. _____		D. _____		E. _____											
E. _____		F. _____		G. _____		H. _____		I. _____											
I. _____		J. _____		K. _____		L. _____													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPSCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. MODIFIER					F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. #														
1 03 31 22 03 31 22 11 99214 AB 27700 1 ZZ 207RP1001X					NPI 1528205937														
2					NPI														
3					NPI														
4					NPI														
5					NPI														
6					NPI														
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/> X					26. PATIENT'S ACCOUNT NO. P80117653530 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					27. ACCEPT ASSIGNMENT? (For govt. claims, see back!) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 27700		29. AMOUNT PAID \$ 000		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.) NYDIA MARTINEZ 04/01/22					32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609					33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009									
SIGNED _____ DATE _____					a. NPI b. _____					a. 1215989298 b. ZZ207RP1001X									



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00009
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PICA

PAGE 1 OF 1

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER 000016052 (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) VALLS, MARIA					3. PATIENT'S BIRTH DATE MM DD YY 09 08 1944 M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) VALLS, MARIA		
5. PATIENT'S ADDRESS (No., Street) 1800 S OCEAN 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) 1800 S OCEAN DRIVE		
CITY HALLANDALE BEACH		STATE FL		8. RESERVED FOR NUCC USE					CITY HALLANDALE BEACH		STATE FL	
ZIP CODE 33009		TELEPHONE (Include Area Code) ()							ZIP CODE 33009		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					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					11. INSURED'S POLICY GROUP OR FECA NUMBER 755630		
					10d. CLAIM CODES (Designated by NUCC)					a. INSURED'S DATE OF BIRTH MM DD YY 09 08 1944 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		
d. INSURANCE PLAN NAME OR PROGRAM NAME										b. OTHER CLAIM ID (Designated by NUCC)		
										c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE		
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.					10e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" 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.		
SIGNATURE ON FILE					DATE 04/01/2022					SIGNATURE ON FILE		
SIGNED					14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE QUAL. MM DD YY			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 NYDIA MARTINEZ					17a. <input type="checkbox"/>		17b. NPI 1528205937			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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) J432										22. RESUBMISSION CODE ORIGINAL REF. NO.		
A. J432		B. <input type="checkbox"/>		C. <input type="checkbox"/>		D. <input type="checkbox"/>		E. <input type="checkbox"/>		F. G. H. J. \$ CHARGES DAYS EPDS/ Family RENDERING MODIFIER UNITS Plan PROVIDER ID. #		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS MODIFIER POINTER		F. G. H. J. \$ CHARGES DAYS EPDS/ Family RENDERING MODIFIER UNITS Plan PROVIDER ID. #				
1 03 31 22 03 31 22 11 94060				PLETHYSMOGRAPHY LUNG VOLUMES WWO AIRW		A 71600 1 ZZ 207RP1001X NPI 1255642831						
2 03 31 22 03 31 22 11 94726				DIFFUSING CAPACITY		A 18500 1 ZZ 207RP1001X NPI 1255642831						
3 03 31 22 03 31 22 11 94729						A 18300 1 ZZ 207RP1001X NPI 1255642831						
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER 650003177		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. P80117653760		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 108400		29. AMOUNT PAID \$ 000		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.) CHRISTOPHER LAU		32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609		33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009 a. 1215989298 b. ZZ207RP1001X								
SIGNED 04/01/22		DATE		a. <input type="checkbox"/> b. <input type="checkbox"/>								

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00010
SUB ID: 313260
CPIID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

PICA <input type="checkbox"/>																					
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000986312 (For Program in Item 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CAVOLI BALBUENA, FRANCISCO							3. PATIENT'S BIRTH DATE 02 21 1961 M <input checked="" type="checkbox"/> F <input type="checkbox"/>														
5. PATIENT'S ADDRESS (No., Street) CALLE LUIS F THOMEN 154							6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>														
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE					CITY SANTO DOMINGO		STATE										
ZIP CODE ()		TELEPHONE (Include Area Code) ()							ZIP CODE ()		TELEPHONE (Include Area Code) ()										
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY 02 21 1961 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE							b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____					b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE									
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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.							SIGNATURE ON FILE					SIGNATURE ON FILE									
SIGNED _____ DATE 04/04/2022																					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.			15. OTHER DATE QUAL. MM DD YY			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 PATRIZIA A VISCONTI							17a. _____			17b. NPI 1518402353			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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) C44219												22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. <input type="checkbox"/> C44219	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	F. <input type="checkbox"/> \$ CHARGES G. <input type="checkbox"/> DAYS OR UNITS H. <input type="checkbox"/> EPSDT Family Plan I. <input type="checkbox"/> ID. # J. <input type="checkbox"/> RENDERING PROVIDER ID. #																	
E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	ZZ 207ZC0006X																	
I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	NPI 1780600429																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS		E. MODIFIER		F. DIAGNOSIS POINTER		26. TOTAL CHARGE \$ 21300			29. AMOUNT PAID \$ 000		30. Rsvd for NUCC Use				
1 03 25 22	03 25 22	21	88305	26	A																
2															NPI						
3															NPI						
4															NPI						
5															NPI						
6															NPI						
25. FEDERAL TAX I.D. NUMBER 650003177				SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. P80117731310		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 21300			29. AMOUNT PAID \$ 000		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.) YASMIN JOHNSTON												32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON HOSPITAL 3100 WESTON ROAD WESTON FL 33331-3602					33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009				
SIGNED 04/04/22 DATE												a. <input type="checkbox"/> NPI b. <input type="checkbox"/> RDGJ01682L14F9G0F3J					a. 1215989298 b. ZZ207ZC0006X				

INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

<p>PICA <input type="checkbox"/></p> <p>1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)</p> <p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA MEJIA, CARLOS</p> <p>5. PATIENT'S ADDRESS (No., Street) AV ANACAONA NO 46</p> <p>CITY SANTO DOMINGO STATE ZIP CODE () TELEPHONE (Include Area Code) ()</p> <p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p> <p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p> <p>b. RESERVED FOR NUCC USE</p> <p>c. RESERVED FOR NUCC USE</p> <p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p> <p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>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.</p> <p>SIGNATURE ON FILE SIGNED DATE 04/04/2022</p> <p>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 15. OTHER DATE MM DD YY QUAL.</p> <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN JUSTIN DOLAN 17a. 1316213895 17b. NPI</p> <p>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p> <p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 Z8616 R9389 J849 A. 04 01 22 04 01 22 11 94010 B. ABC C. 32500 D. 1 E. PLETHYSMOGRAPHY LUNG VOLUMES WWO AIRW F. 04 01 22 04 01 22 11 94726 G. ABC H. 18500 I. DIFFUSING CAPACITY J. 04 01 22 04 01 22 11 94729 K. ABC L. 18300 </p> <p>24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPDS/ Family Plan I. ID. # J. RENDERING PROVIDER ID. # 1 04 01 22 04 01 22 11 94010 ABC 32500 1 ZZ 207RP1001X NPI 1255642831 2 04 01 22 04 01 22 11 94726 ABC 18500 1 ZZ 207RP1001X NPI 1255642831 3 04 01 22 04 01 22 11 94729 ABC 18300 1 ZZ 207RP1001X NPI 1255642831 4 5 6 </p> <p>25. FEDERAL TAX I.D. NUMBER 650003177 SSN EIN X 26. PATIENT'S ACCOUNT NO. P80117709860 27. ACCEPT ASSIGNMENT? X YES NO 28. TOTAL CHARGE \$ 69300 29. AMOUNT PAID \$ 000 30. Rsrd for NUCC Use</p> <p>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.) CHRISTOPHER LAU 04/04/22 DATE</p> <p>32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609</p> <p>33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009 a. 1215989298 b. ZZ207RP1001X</p>												<p>1a. INSURED'S I.D. NUMBER SWG160401068 (For Program in Item 1)</p> <p>4. INSURED'S NAME (Last Name, First Name, Middle Initial) ACOSTA MEJIA, CARLOS</p> <p>7. INSURED'S ADDRESS (No., Street) AV ANACAONA NO 46</p> <p>CITY SANTO DOMINGO STATE ZIP CODE () TELEPHONE (Include Area Code) ()</p> <p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p> <p>a. INSURED'S DATE OF BIRTH MM DD YY SEX 09 04 1954 M X F </p> <p>b. OTHER CLAIM ID (Designated by NUCC)</p> <p>c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE</p> <p>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO If yes, complete items 9, 9a, and 9d.</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNATURE ON FILE SIGNED DATE 04/04/2022</p> <p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM TO</p> <p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM TO</p> <p>20. OUTSIDE LAB? \$ CHARGES YES NO</p> <p>22. RESUBMISSION CODE ORIGINAL REF. NO.</p> <p>23. PRIOR AUTHORIZATION NUMBER</p>		
---	--	--	--	--	--	--	--	--	--	--	--	---	--	--



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00012
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) SWG160401068												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA MEJIA, CARLOS					3. PATIENT'S BIRTH DATE MM DD YY 09 04 1954					SEX M <input type="checkbox"/> F <input type="checkbox"/>												
5. PATIENT'S ADDRESS (No., Street) AV ANACAONA NO 46					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) AV ANACAONA NO 46												
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE					CITY SANTO DOMINGO		STATE											
ZIP CODE		TELEPHONE (Include Area Code) ()							ZIP CODE		TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER												
					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					a. INSURED'S DATE OF BIRTH MM DD YY 09 04 1954 M <input checked="" type="checkbox"/> F <input type="checkbox"/>												
					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)												
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE												
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 04/04/2022					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.												
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE MM DD YY QUAL.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN JUSTIN DOLAN					17a. <input type="checkbox"/> 17b. NPI 1316213895					14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)					ICD Ind. 0					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY												
A. J849		B. Z8616		C. <input type="checkbox"/>		D. <input type="checkbox"/>		E. <input type="checkbox"/>		F. <input type="checkbox"/>		G. <input type="checkbox"/>		H. <input type="checkbox"/>								
I. <input type="checkbox"/>		J. <input type="checkbox"/>		K. <input type="checkbox"/>		L. <input type="checkbox"/>		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. RESUBMISSION CODE		ORIGINAL REF. NO.										
22. PRIOR AUTHORIZATION NUMBER																						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY					B. PLACE OF SERVICE EMG		C. CPT/HCPSCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 04 01 22 04 01 22 22					71250		26		AB		23500		1		ZZ		2085R0202X					
2																			NPI			
3																			NPI			
4																			NPI			
5																			NPI			
6																			NPI			
25. FEDERAL TAX I.D. NUMBER 650003177					SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. P80117709790		27. ACCEPT ASSIGNMENT? For govt. claims, see back <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 23500		29. AMOUNT PAID \$ 000		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.) JACOB KIRSCH					32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON HOSPITAL-OUTPT 3100 WESTON ROAD WESTON FL 33331-3602		33. BILLING PROVIDER INFO & PH # (800) 2222273		CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009													
SIGNED 04/04/22					DATE		a. <input type="checkbox"/> b. <input type="checkbox"/>		a. 1215989298		b. ZZ2085R0202X											



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00013
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER SWG160401068 (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA MEJIA, CARLOS					3. PATIENT'S BIRTH DATE SEX 09 04 1954 M X F					4. INSURED'S NAME (Last Name, First Name, Middle Initial) ACOSTA MEJIA, CARLOS				
5. PATIENT'S ADDRESS (No., Street) AV ANACAONA NO 46					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) AV ANACAONA NO 46				
CITY SANTO DOMINGO			STATE		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO			STATE			
ZIP CODE			TELEPHONE (Include Area Code) ()					ZIP CODE			TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER				
					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					a. INSURED'S DATE OF BIRTH 09 04 1954 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE				
										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				
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.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNATURE ON FILE					DATE 04/04/2022					SIGNATURE ON FILE				
SIGNED								SIGNED						
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 JOSE CABRAL					17a. <input type="checkbox"/> 17b. NPI 1457314817					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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.				
A. E1165		B. E162		C. Z794		D. E782								
E. I10		F. J849		G. 		H. 		23. PRIOR AUTHORIZATION NUMBER						
I. 		J. 		K. 		L. 								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. CPT/HCPSC		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS MODIFIER		F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER ID. #
1 04 01 22 04 01 22 11						99204		ABDE		39700	1		ZZ	207R00000X
2 04 01 22 04 01 22 11						95251		ABDE		21200	1		NPI	1457314817
3													ZZ	207R00000X
4													NPI	1457314817
5													NPI	
6													NPI	
25. FEDERAL TAX I.D. NUMBER 650003177		SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. P80117710000		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 60900		29. AMOUNT PAID \$ 000		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.) JOSE M CABRAL		32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609		33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009										
SIGNED 04/04/22		DATE		a. NPI		b. 		a. 1215989298		b. ZZ207R00000X				



**INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331**

TUL01 00014
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

PICA												PICA								
PAGE 1 OF 1																				
1. MEDICARE MEDICAID TRICARE			CHAMPVA			GROUP HEALTH PLAN		FECA BLK LUNG		OTHER		1a. INSURED'S I.D. NUMBER (For Program in Item 1)								
<input type="checkbox"/> (Medicare#)	<input type="checkbox"/> (Medicaid#)	<input type="checkbox"/> (ID#/DoD#)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input checked="" type="checkbox"/> X (ID#)	<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	000986312									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE			SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
CAVOLI BALBUENA, FRANCISCO			MM	DD	YY	02	21	1961	M	X	F	CAVOLI BALBUENA, FRANCISCO								
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED						7. INSURED'S ADDRESS (No., Street)											
CALLE LUIS F THOMEN 154			Self	<input checked="" type="checkbox"/> X	Spouse	<input type="checkbox"/>	Child	<input type="checkbox"/>	Other	<input type="checkbox"/>		CALLE LUIS F THOMEN 154								
CITY SANTO DOMINGO			STATE			8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO			STATE								
ZIP CODE			TELEPHONE (Include Area Code) ()						ZIP CODE			TELEPHONE (Include Area Code) ()								
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								
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous)						755630								
						<input type="checkbox"/> YES	<input checked="" type="checkbox"/> X NO	b. AUTO ACCIDENT?						a. INSURED'S DATE OF BIRTH						
						<input type="checkbox"/> YES	<input checked="" type="checkbox"/> X NO	PLACE (State)	MM	DD	YY	M	X	F	b. OTHER CLAIM ID (Designated by NUCC)					
						c. OTHER ACCIDENT?						c. INSURANCE PLAN NAME OR PROGRAM NAME								
						<input type="checkbox"/> YES	<input checked="" type="checkbox"/> X NO							INTL WORLDWIDE						
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN?								
												<input type="checkbox"/> YES	<input checked="" type="checkbox"/> X NO	If yes, complete items 9, 9a, and 9d.						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
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.												14. SIGNED SIGNATURE ON FILE DATE 04/04/2022								
15. OTHER DATE						MM	DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
QUAL.									FROM	MM	DD	YY	TO	MM	DD	YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
DN JORGE MANRIQUE SUCCAR						17b. NPI	FROM						TO	MM	DD	YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES								
												<input type="checkbox"/> YES	<input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.								
A. Z01818	B. M1712	C. K219	D. F17290	ICD Ind.	0															
E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____							23. PRIOR AUTHORIZATION NUMBER						
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) E. CPT/HCPCS F. MODIFIER G. DIAGNOSIS H. POINTERS						F. \$ CHARGES G. DAYS OR UNITS H. ERSPOT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. #														
START TIME MDM STOP TIME MINUTES 03 07 22 03 07 22 11 99205						ABCD 52100 1 ZZ 207R00000X NPI 1689985517														
25. FEDERAL TAX I.D. NUMBER 650003177 SSN EIN <input checked="" type="checkbox"/> X						26. PATIENT'S ACCOUNT NO. P80117709540 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 52100 29. AMOUNT PAID \$ 000 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.) FREDERICK ROSS SIGNED 04/04/22 DATE						32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609						33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009								
						a. b.						a. 1215989298 b. ZZ207R00000X								



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
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TUL01 00015
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HEALTH INSURANCE CLAIM FORM

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

PICA

PAGE 1 OF 1

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER 001177772 (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ, IGNACIO										4. INSURED'S NAME (Last Name, First Name, Middle Initial) MARTINEZ, IGNACIO				
5. PATIENT'S ADDRESS (No., Street) PALMARECA 66										7. INSURED'S ADDRESS (No., Street) PALMARECA 66				
CITY PUNTA CANA					STATE					CITY PUNTA CANA				
ZIP CODE		TELEPHONE (Include Area Code) ()								STATE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous)		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										11. INSURED'S POLICY GROUP OR FECA NUMBER 755630				
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.										a. INSURED'S DATE OF BIRTH 04 13 1975 M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
SIGNED SIGNATURE ON FILE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				
DATE 04/04/2022										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN BRIAN LEO										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17a. <input type="checkbox"/> 17b. NPI 1376750265										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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.				
A. M25561	B. S83232A	C. S83272A	D. S83271A	ICD Ind. 0	23. PRIOR AUTHORIZATION NUMBER									
E. M25562	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY					B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS MODIFIER		F. G. H. I. J. \$ CHARGES DAYS OR UNITS EPDS/ Family Plan ID. RENDERING QUAL. PROVIDER ID. #			
1 04 01 22 04 01 22 11					99204		ABCD		39700 1		ZZ 207X00000X NPI 1376750265			
2														
3														
4														
5														
6														
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. P80117709800		27. ACCEPT ASSIGNMENT? For govt. claims, see back! <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 39700		29. AMOUNT PAID \$ 000		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.) BRIAN M LEO SIGNED 04/04/22					32. SERVICE FACILITY LOCATION INFORMATION CCF CORAL SPRINGS CLINIC 5701 N UNIVERSITY DR CORAL SPRING FL 33067-1703		33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009		a. 1215989298		b. ZZ207X00000X			
DATE					a. <input type="checkbox"/> b. <input type="checkbox"/>		a. <input type="checkbox"/> b. <input type="checkbox"/>		a. <input type="checkbox"/> b. <input type="checkbox"/>		a. <input type="checkbox"/> b. <input type="checkbox"/>			



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00016
SUB ID: 313260
CPIID: 4320

HEALTH INSURANCE CLAIM FORM

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

PAGE 1 OF 1

PICA

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 001177772								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ, IGNACIO						3. PATIENT'S BIRTH DATE MM DD YY 04 13 1975			SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) MARTINEZ, IGNACIO									
5. PATIENT'S ADDRESS (No., Street) PALMARECA 66						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) PALMARECA 66											
CITY PUNTA CANA			STATE			8. RESERVED FOR NUCC USE			CITY PUNTA CANA			STATE								
ZIP CODE ()			TELEPHONE (Include Area Code)						ZIP CODE ()			TELEPHONE (Include Area Code)								
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 04 13 1975 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE						PLACE (State)									b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE															c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
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 04/04/2022								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.						15. OTHER DATE QUAL.			MM DD YY			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 BRIAN M LEO						17a.			17b. NPI 1376750265			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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M170 B. Z98890 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												22. RESUBMISSION CODE ORIGINAL REF. NO.								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)						E. MODIFIER			F. \$ CHARGES			G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
1 04 01 22 04 01 22 11 73564 RT AB 41400 1															ZZ 2085R0202X					
2 04 01 22 04 01 22 11 73564 LT AB 41400 1															ZZ 2085R0202X					
3															NPI					
4															NPI					
5															NPI					
6															NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. P80117709690			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 82800		29. AMOUNT PAID \$ 000		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.) SIMON DORTON 04/04/22						32. SERVICE FACILITY LOCATION INFORMATION CCF CORAL SPRINGS CLINIC 5701 N UNIVERSITY DR CORAL SPRING FL 33067-1703			33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009											
34. DATE						a. NPI b.			a. 1215989298 b. ZZ2085R0202X											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331

TUL01 00017
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

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PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) SWG1411110583									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MORROBEL, ANGEL										3. PATIENT'S BIRTH DATE SEX MM DD YY 04 07 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) CESAR AUGUSTO ROQUE 30										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY SANTO DOMINGO					STATE					8. RESERVED FOR NUCC USE									
ZIP CODE		TELEPHONE (Include Area Code) ()																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX MM DD YY 04 07 1967 M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
SIGNATURE ON FILE										b. OTHER CLAIM ID (Designated by NUCC)									
SIGNED DATE 04/04/2022										c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE									
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 FERNANDO CABRERA										17a. 1891957080					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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. N401 B. R351 C. R350 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAY'S OR UNITS H. EPSDT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. #									
1 03 31 22 03 31 22 11 99204 ABC 39700 1										ZZ 208800000X NPI 1891957080									
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. P80117709240					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 39700		29. AMOUNT PAID \$ 000		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.) FERNANDO CABRERA					32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON CLINIC 2950 CLEVELAND CLINIC BLVD WESTON FL 33331-3609					33. BILLING PROVIDER INFO & PH# (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009									
SIGNED 04/04/22 DATE					a. <input type="checkbox"/> b. <input type="checkbox"/>					a. 1215989298 b. ZZ208800000X									



**INTL WORLDWIDE
2813 EXECUTIVE PARK DR
STE 120
WESTON, FL 33331**

TUL01 00018
SUB ID: 313260
CPID: 4320

HEALTH INSURANCE CLAIM FORM

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

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PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> BLK LUNG (ID#) <input checked="" type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000809752			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) UBEDA, RAFAEL												4. INSURED'S NAME (Last Name, First Name, Middle Initial) UBEDA, RAFAEL			
5. PATIENT'S ADDRESS (No., Street) CALLE DEL CARMEN												7. INSURED'S ADDRESS (No., Street) CALLE DEL CARMEN			
CITY SANTO DOMINGO				STATE				CITY SANTO DOMINGO				STATE			
ZIP CODE		TELEPHONE (Include Area Code) ()						ZIP CODE		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:			
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												11. INSURED'S POLICY GROUP OR FECA NUMBER			
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.												a. INSURED'S DATE OF BIRTH MM DD YY 06 01 1963 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
SIGNED SIGNATURE ON FILE												b. OTHER CLAIM ID (Designated by NUCC)			
DATE 04/04/2022												c. INSURANCE PLAN NAME OR PROGRAM NAME INTL WORLDWIDE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE QUAL. MM DD YY				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN HEYDI GAVIRIA												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												SIGNED SIGNATURE ON FILE			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) Z01818												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
A. Z01818				B. _____ C. _____ D. _____				17. NPI 1710653266				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. MODIFIER F. DIAGNOSIS POINTER												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
1 04 01 22 04 01 22 22 71046 26 A 9600 1 2 _____ 3 _____ 4 _____ 5 _____ 6 _____												22. RESUBMISSION CODE ORIGINAL REF. NO.			
25. FEDERAL TAX I.D. NUMBER SSN EIN 650003177 <input checked="" type="checkbox"/>												23. PRIOR AUTHORIZATION NUMBER			
26. PATIENT'S ACCOUNT NO. P80117709490 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												F. G. H. I. J. \$ CHARGES DAYS OR UNITS EPSDT Family Plan ID. RENDERING PROVIDER ID. # ZZ 2085R0202X NPI 1528070521			
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.) JACOBO KIRSCH												28. TOTAL CHARGE \$ 9600 29. AMOUNT PAID \$ 000 30. Rsvd for NUCC Use			
32. SERVICE FACILITY LOCATION INFORMATION CCF WESTON HOSPITAL - OUTPT 3100 WESTON ROAD WESTON FL 33331-3602												33. BILLING PROVIDER INFO & PH # (800) 2222273 CLEVELAND CLINIC FLORIDA PO BOX 538009 ATLANTA GA 30353-8009			
SIGNED 04/04/22 DATE												a. 1215989298 b. ZZ2085R0202X			