



Olivia Ivory

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Montefiore Medical Center
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FAX

To: WWS

From: Olivia Ivory

Fax: 954-206-0014

Pages: 20 (including cover sheet)

Phone: 786-485-7447

Date: 02/22/2022

MEMO

Please see claims for patient Victoria E. Acosta Saladin Member ID #000965132.

Feb/22/2022 1:37:31 PM
MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

International Dept Montefiore 1671

2/20

38 PAT CNTRL #	MB110642114400	40 09022210	41 111
5 FED TAX NO.	131740114	6 STATEMENT COVERS PERIOD FROM	7 THROUGH 051121 051321

1 PATIENT NAME	ACOSTA SALADIN VICTORIA E	9 PATIENT ADDRESS	3411 WAYNE AVE, APT 11A	10 CITY	BRONX	11 STATE	NY	12 ZIP	10467
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13 BIRTHDATE	08131963	14 SEX	F	15 ADMISSION DATE	05112101	16 TYPE	I	17 SRC	4	18 DHR	1401	19 STAT	C5	20	21	22	23	24	25	26	27	28	29 AGDT STATE	30
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31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM	37 THROUGH	38 CODE	39 OCCURRENCE SPAN FROM	40 THROUGH	41 CODE
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42 WORLDWIDE SEGUROS	43 VALUE CODES AMOUNT	44 VALUE CODES AMOUNT	45 VALUE CODES AMOUNT
2813 EXECUTIVE PARK DRIVE CENTER FOR INT SUITE 120 WESTON, FL 33331 718-920-2582	01 7246	80 2	

46 REV CD	47 DESCRIPTION	48 HCPCS / RATE / HIPP CODE	49 SERV DATE	50 SERV UNITS	51 TOTAL CHARGES	52 NON COVERED CHARGES	53
0111	MED-SUR-GY/PVT	11200.00		1	1120000	000	
0121	MED-SUR-GY/2BED	10400.00		1	1040000	000	
0250	PHARMACY			156	18581	000	
0300	LAB			4	113400	000	
0301	LAB/CHEMISTRY			9	197700	000	
0302	LAB/IMMUNOLOGY			4	138400	000	
0305	LAB/HEMATOLOGY			6	96600	000	
0306	LAB/BACT-MICRO			3	66500	000	
0324	DX X-RAY/CHEST			1	35500	000	
0424	PHYS THERP/EVAL			1	53800	000	
0434	OCCUP THERP/EVAL			1	51300	000	
0444	SPEECH THERP/EVAL			1	91200	000	
0480	CARDIOLOGY			1	467000	000	
0610	MRT			2	809100	000	
0611	MRI/BRAIN			1	678400	000	
0730	EKG/ECG			1	59700	000	
0731	HOLTER MONT			2	212600	000	
0001	PAGE 1 OF 1	CREATION DATE	082421	TOTALS	5249781	000	

54 PAYER NAME	WORLDWIDE SEGUROS	55 HEALTH PLAN ID	98999	56 REL Y	57 ASG Y	58 PRIOR PAYMENTS	000	59 EST. AMOUNT DUE	4028735	60 NPI	1952476988	61	131740114
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62 INSURED'S NAME	ACOSTA SALADIN, VICTORIA	63 REL	18	64 INSURED'S UNIQUE ID	000965132	65 GROUP NAME	WWMA	66 INSURANCE GROUP NO.	755630
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67 TREATMENT AUTHORIZATION CODES	68 DOCUMENT CONTROL NUMBER	69 EMPLOYER NAME
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70 I63411 YZ87891 E785 YM069 YZ20822 Y	71	72	73
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74 ADMIT I63411	75 PATIENT REASON DX	76 PPS CODE	066	77 ECI	78						
79 PRINCIPAL PROCEDURE CODE	80 DATE	81 OTHER PROCEDURE CODE	82 DATE	83 OTHER PROCEDURE CODE	84 DATE	85 ATTENDING NPI	1295046092	86 QUAL	OB0028334	87 LAST CHENG	88 FIRST NATALIE T
89 OTHER PROCEDURE CODE	90 DATE	91 OTHER PROCEDURE CODE	92 DATE	93 OTHER PROCEDURE CODE	94 DATE	95 OPERATING NPI	1295046092	96 QUAL	OB00283347	97 LAST CHENG	98 FIRST NATALIE T

99 NYHCRA INDIGENT %: 9.63	100 B3282N00000X	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120
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P.O. Box 412510
Boston, MA 02241-2510

Account #	Total Charges	Current Balance
1106421144	\$52,497.81	\$40,287.35

Victoria Eugenia Acosta Saladin
3411 Wayne ave, apt 11A
BRONX, NY 10467

Guarantor ID: 3893926

Visit Coverages:

International Insurance - International Patient Elector List

This is an itemization of your hospital services for:

Patient: Acosta Saladin, Victoria Eugenia Admission Date: 05/11/21
Hospital Account: 1106421144 Discharge Date: 05/13/21

Current Hospital Account Balance: 40,287.35

ACCOUNT DETAILS

Hospital Charges

Rev Code	Description	Quantity	CPT/Charge Code	Amount	Service Date
0111	HC PRIVATE	1		11,200.00	05/11/2021
0121	HC SEMI-PRIVATE	1		10,400.00	05/12/2021
0250	ACETAMINOPHEN 325 MG TAB	2		0.11	05/11/2021
0250	ASPIRIN 325 MG TAB	2		0.48	05/11/2021
0250	ASPIRIN 81 MG TBEC	1		0.03	05/12/2021
0250	ASPIRIN 81 MG TBEC	1		0.03	05/13/2021
0250	ATORVASTATIN 20 MG TAB	1		0.68	05/11/2021
0250	ATORVASTATIN 80 MG TAB	1		1.07	05/12/2021
0250	DEXAMETHASONE PER 1 MG	4		2.64	05/11/2021
0250	DEXAMETHASONE PER 1 MG	4		2.64	05/11/2021
0250	ENOXAPARIN PER 10 MG	4		12.40	05/11/2021
0250	ENOXAPARIN PER 10 MG	4		12.40	05/12/2021
0250	ENOXAPARIN PER 10 MG	4		12.40	05/13/2021
0250	GADOBUTROL PER .1 ML	1		1.07	05/11/2021
0250	GADOBUTROL PER .1 ML	75		79.53	05/11/2021
0250	LACTATED RINGERS PER 1000 ML	1		20.00	05/11/2021
0250	LEVETIRACETAM PER 10 MG	50		39.60	05/11/2021
0250	PANTOPRAZOLE 40 MG TBEC	1		0.73	05/11/2021
0300	HC BLOOD TYPING ABO	1	86900	291.00	05/11/2021
0300	HC BLOOD TYPING RH (D)	1	86901	310.00	05/11/2021
0300	HC RBC ANTIBODY SCREEN	1	86850	425.00	05/11/2021
0300	HC URINALYSIS AUTO W/O SCOPE	1	81003	108.00	05/11/2021
0301	HC ASSAY OF BETA-2 PROTEIN	1	82232	228.00	05/13/2021
0301	HC ASSAY OF MAGNESIUM	1	83735	164.00	05/11/2021
0301	HC ASSAY OF PHOSPHORUS	1	84100	104.00	05/11/2021
0301	HC ASSAY THYROID STIM HORMONE	1	84443	340.00	05/12/2021
0301	HC COMPREHENSIVE METABOLIC PANEL	1	80053	317.00	05/11/2021

Rev Code	Description	Quantity	CPT/Charge Code	Amount	Service Date
0301	HC DRUG SCRIN QUAN LEVETIRACETAM	1	80177	137.00	05/11/2021
0301	HC GLYCOSYLATED HEMOGLOBIN TEST	1	83036	226.00	05/12/2021
0301	HC LIPID PANEL	1	80061	290.00	05/12/2021
0301	HC METABOLIC PANEL TOTAL CA	1	80048	171.00	05/12/2021
0302	HC BETA-2 GLYCOPROTEIN ANTIBODY	1	86146	264.00	05/13/2021
0302	HC BETA-2 GLYCOPROTEIN ANTIBODY	1	86146	264.00	05/13/2021
0302	HC CARDIOLIPIN ANTIBODY EA IG	2	86147	856.00	05/13/2021
0305	HC COMPLETE CBC W/AUTO DIFF WBC	1	85025	101.00	05/11/2021
0305	HC COMPLETE CBC W/AUTO DIFF WBC	1	85025	101.00	05/12/2021
0305	HC PROTHROMBIN TIME FOR LAB	1	85610	110.00	05/11/2021
0305	HC RUSSELL VIPER VENOM DILUTED	1	85613	396.00	05/13/2021
0305	HC THROMBOPLASTIN TIME PART (PTT);PLASMA/WHLE BLD	1	85730	129.00	05/11/2021
0305	HC THROMBOPLASTIN TIME PART (PTT);PLASMA/WHLE BLD	1	85730	129.00	05/13/2021
0306	HC BLOOD CULTURE FOR BACTERIA	1	87040	157.00	05/11/2021
0306	HC COVID-19 LAB TEST NON-CDC HIGH THROUGHPUT TECH	1	U0004	250.00	05/11/2021
0306	HC URINE CULTURE/COLONY COUNT	1	87086	258.00	05/11/2021
0324	HC X-RAY EXAM CHEST 1 VIEW	1	71045	355.00	05/11/2021
0424	HC PT EVAL LOW COMPLEX 20 MIN	1	97161	538.00	05/12/2021
0434	HC OT EVAL LOW COMPLEX 30 MIN	1	97165	513.00	05/13/2021
0444	HC EVALUATE SWALLOWING FUNCTION	1	92610	912.00	05/13/2021
0480	HC TTE W/DOPPLER COMPLETE	1	93306	4,670.00	05/12/2021
0610	HC MR ANGIOGRAPHY HEAD W/O DYE	1	70544	4,960.00	05/11/2021
0610	HC MR ANGIOGRAPHY NECK W/O DYE	1	70547	3,131.00	05/11/2021
0611	HC MRI BRAIN STEM W/O & W/DYE	1	70553	6,784.00	05/11/2021
0730	HC ELECTROCARDIOGRAM TRACING	1	93005	597.00	05/11/2021
0731	HC ECG MONIT/REPRT UP TO 48 HRS;RECORDING	1	93225	893.00	05/13/2021
0731	HC ECG MONIT/REPRT UP TO 48 HRS;SCANNING ANALYSIS	1	93226	1,233.00	05/13/2021

Total hospital charges:**52,497.81****Hospital Payments and Adjustments**

Date	Description	Amount
08/24/21	International Insurance Adjustments	-12,210.46

Total hospital payments and adjustments:**-12,210.46**

Feb/22/2022 1:37:31 PM
MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

International Dept Montefiore 7187981671

5/20

34 FILL CNTL #	HB110644110602	OF BILL
35 MED REC #	09022210	131
5 FED. TAX NO.	131740114	6 STATEMENT COVERS PERIOD FROM 051421 THROUGH 051421

1 PATIENT NAME	a	9 PATIENT ADDRESS	s	3411 WAYNE AVE, APT 11A
2 ACOSTA SALADIN VICTORIA E	b	BRONX	c	NY d 10467

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACOT STATE	30
08131963	F	051421		3	1		01													
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37										

38 WORLDWIDE SEGUROS	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
2813 EXECUTIVE PARK DRIVE CENTER FOR INT SUITE 120 WESTON, FL 33331 718-920-2582						

42 REV. CD	43 DESCRIPTION	44 HCPCS / DATE / ICD-9 CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES	49
0300	LAB	86850	051421	1	42500	000	
0300	LAB	86900	051421	1	29100	000	
0300	LAB	86901	051421	1	31000	000	
0481	CARDIC CATH LAB	93312	051421	1	225168	000	
0481	CARDIC CATH LAB	93320TC	051421	1	225166	000	
0481	CARDIC CATH LAB	93325TC	051421	1	225166	000	
0636	N400409230517ML2	J2250	051421	2	172	000	
0636	N400409909422ML1	J3010	051421	1	250	000	
0637	DRUGS/SELF ADMIN		051421	1	270	000	

0001	PAGE 1 OF 1	CREATION DATE	082421	TOTALS	778792	000
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50 PAYER NAME	51 HEALTH PLAN ID	52 REL RPO	53 ASG REL	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1952476988
WORLDWIDE SEGUROS	98999	Y	Y	000	597652	57	131740114
						OTHER PRV ID	

58 INSURED'S NAME	59 REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
ACOSTA SALADIN, VICTORIA	18	000965132	WWMA	755630

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 I63511	I081	E785	Z87891	68
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69 ADMIT DX	70 PATIENT REASON DX	71 FPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 OTHER PROCEDURE CODE	77 ATTENDING NPI	78 QUAL
			1669567210	0B0024210
			LAST GARCIA	FIRST MARIO J
79 OTHER PROCEDURE CODE	80 OTHER PROCEDURE CODE	81 OTHER PROCEDURE CODE	77 OPERATING NPI	78 QUAL
			LAST	FIRST

82 NYHCRA INDIGENT %: 9.63	83 CC a	BB282N00000X	78 OTHER NPI	79 QUAL
	b		LAST	FIRST
	c		79 OTHER NPI	80 QUAL
	d		LAST	FIRST

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MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

International Dept Montefiore 7187981671

6/20

34 PAT. CNTRL # 09022210
5 FED. TAX NO. 131740114
6 STATEMENT COVERS PERIOD FROM 051721 THROUGH 051721
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3 PATIENT NAME ACOSTA SALADIN VICTORIA E
9 PATIENT ADDRESS 3411 WAYNE AVE, APT 11A
b BRONX c NY d 10467 e

10 BIRTHDATE 08131963 F 11 SEX 05172114 12 DATE 3 13 ADM. TYPE 2 14 SRC 01 15 DHR 16 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30

31 OCCURRENCE DATE 32 OCCURRENCE DATE 33 OCCURRENCE DATE 34 OCCURRENCE DATE 35 OCCURRENCE DATE 36 OCCURRENCE DATE 37 OCCURRENCE DATE 38 OCCURRENCE DATE 39 OCCURRENCE DATE 40 OCCURRENCE DATE 41 OCCURRENCE DATE 42 OCCURRENCE DATE 43 OCCURRENCE DATE 44 OCCURRENCE DATE 45 OCCURRENCE DATE 46 OCCURRENCE DATE 47 OCCURRENCE DATE 48 OCCURRENCE DATE 49 OCCURRENCE DATE 50 OCCURRENCE DATE 51 OCCURRENCE DATE 52 OCCURRENCE DATE 53 OCCURRENCE DATE 54 OCCURRENCE DATE 55 OCCURRENCE DATE 56 OCCURRENCE DATE 57 OCCURRENCE DATE 58 OCCURRENCE DATE 59 OCCURRENCE DATE 60 OCCURRENCE DATE 61 OCCURRENCE DATE 62 OCCURRENCE DATE 63 OCCURRENCE DATE 64 OCCURRENCE DATE 65 OCCURRENCE DATE 66 OCCURRENCE DATE 67 OCCURRENCE DATE 68 OCCURRENCE DATE 69 OCCURRENCE DATE 70 OCCURRENCE DATE 71 OCCURRENCE DATE 72 OCCURRENCE DATE 73 OCCURRENCE DATE 74 OCCURRENCE DATE 75 OCCURRENCE DATE 76 OCCURRENCE DATE 77 OCCURRENCE DATE 78 OCCURRENCE DATE 79 OCCURRENCE DATE 80 OCCURRENCE DATE 81 OCCURRENCE DATE 82 OCCURRENCE DATE 83 OCCURRENCE DATE 84 OCCURRENCE DATE 85 OCCURRENCE DATE 86 OCCURRENCE DATE 87 OCCURRENCE DATE 88 OCCURRENCE DATE 89 OCCURRENCE DATE 90 OCCURRENCE DATE 91 OCCURRENCE DATE 92 OCCURRENCE DATE 93 OCCURRENCE DATE 94 OCCURRENCE DATE 95 OCCURRENCE DATE 96 OCCURRENCE DATE 97 OCCURRENCE DATE 98 OCCURRENCE DATE 99 OCCURRENCE DATE 100 OCCURRENCE DATE

38 WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER FOR INT
SUITE 120
WESTON, FL 33331
718-920-2582

42 REV. CD. 0300 LAB C9803 051721 1 5700 000
0306 LAB/BACT-MICRO U0004 051721 1 25000 000

0001 PAGE 1 OF 1 CREATION DATE 082421 TOTALS 30700 000

50 PAYER NAME WORLDWIDE SEGUROS 51 HEALTH PLAN ID 98999 52 REL INFO Y 53 ASG BEN Y 54 PRIOR PAYMENTS 000 55 EST. AMOUNT DUE 23559 56 NPI 1952476988 57 OTHER PRV ID 131740114

58 INSURED'S NAME ACOSTA SALADIN, VICTORIA 59 P.REL 18 60 INSURED'S UNIQUE ID 000965132 61 GROUP NAME WWMA 62 INSURANCE GROUP NO. 755630

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME

66 Z03818 Z20822 67 68

69 ADMIT DX 70 PATIENT REASON DX 71 PPS CODE 72 ECI 73
74 PRINCIPAL PROCEDURE CODE DATE 75 OTHER PROCEDURE CODE DATE 76 OTHER PROCEDURE CODE DATE 77 OTHER PROCEDURE CODE DATE 78 OTHER PROCEDURE CODE DATE 79 OTHER PROCEDURE CODE DATE 80 OTHER PROCEDURE CODE DATE 81 OTHER PROCEDURE CODE DATE 82 OTHER PROCEDURE CODE DATE 83 OTHER PROCEDURE CODE DATE 84 OTHER PROCEDURE CODE DATE 85 OTHER PROCEDURE CODE DATE 86 OTHER PROCEDURE CODE DATE 87 OTHER PROCEDURE CODE DATE 88 OTHER PROCEDURE CODE DATE 89 OTHER PROCEDURE CODE DATE 90 OTHER PROCEDURE CODE DATE 91 OTHER PROCEDURE CODE DATE 92 OTHER PROCEDURE CODE DATE 93 OTHER PROCEDURE CODE DATE 94 OTHER PROCEDURE CODE DATE 95 OTHER PROCEDURE CODE DATE 96 OTHER PROCEDURE CODE DATE 97 OTHER PROCEDURE CODE DATE 98 OTHER PROCEDURE CODE DATE 99 OTHER PROCEDURE CODE DATE 100 OTHER PROCEDURE CODE DATE

NYHCRA INDIGENT %: 9.63 B3282N00000X

7/20

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Montefiore

THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

P.O. Box 412510
Boston, MA 02241-2510

Account #	Total Charges	Current Balance
1106445072	\$40,512.76	\$31,089.89

Victoria Eugenia Acosta Saladin
3411 Wayne ave, apt 11A
BRONX, NY 10467

Guarantor ID: 3893926

Visit Coverages:

International Insurance - International Patient Elector List

This is an itemization of your hospital services for:

Patient: Acosta Saladin, Victoria Eugenia Admission Date: 05/18/21
Hospital Account: 1106445072 Discharge Date: 05/18/21

Current Hospital Account Balance: 31,089.89

ACCOUNT DETAILS

Hospital Charges

Rev Code	Description	Quantity	CPT/Charge Code	Amount	Service Date
0250	LIDOCAINE-EPINEPHRINE 1 %-1:100,000 SOLN	1		7.76	05/18/2021
0278	MONITOR ICM REVEAL LINQ SYSTEM	1	C1764	19,380.00	05/18/2021
0481	HC CARDIOLOGY: CARDIAC CATH LAB PER 30 MIN	1		21,125.00	05/18/2021

Total hospital charges: 40,512.76

Hospital Payments and Adjustments

Date	Description	Amount
08/24/21	International Insurance Adjustments	-9,422.87

Total hospital payments and adjustments: -9,422.87

Feb/22/2022 1:37:31 PM
MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

International Dept Montefiore 7187981671

9/20

3a CONTL #	09022210	OF BILL	131
5 FED. TAX NO.	131740114	6 STATEMENT COVERS PERIOD FROM	081621
		THROUGH	081621

1 PATIENT NAME a ACOSTA SALADIN VICTORIA E 9 PATIENT ADDRESS a PONCIO SABATER NO 6, TORRE RENN PISO 6
b NEW YORK c NY d 10150 e

10 BIRTHDATE 08131963 11 SEX F 12 DATE 081621 13 HR 10 14 TYPE 3 15 SRC 2 16 DHR 01 17 STAT GO 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30

31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH

38 WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER FOR INT
SUITE 120
WESTON, FL 33331
718-920-2582

39 CODE	40 VALUE CODES AMOUNT	41 CODE	42 VALUE CODES AMOUNT	43 CODE	44 VALUE CODES AMOUNT

45 REV. CD.	46 DESCRIPTION	47 HCPCS / RATE / RPPS CODE	48 SERV. DATE	49 SERV. UNITS	50 TOTAL CHARGES	51 NON COVERED CHARGES	52
0300	LAB	36415	081621	1	9800	000	
0301	LAB/CHEMISTRY	84443	081621	1	34000	000	

0001 PAGE 1 OF 1 CREATION DATE 022222 TOTALS 43800 000

53 PAYER NAME	54 HEALTH PLAN ID	55 REL INFO	56 ASG REQ	57 PRIOR PAYMENTS	58 EST. AMOUNT DUE	59 NPI	1952476988
WORLDWIDE SEGUROS	98999	Y	Y	000	28470	131740114	

60 INSURED'S NAME	61 REL	62 INSURED'S UNIQUE ID	63 GROUP NAME	64 INSURANCE GROUP NO.
ACOSTA SALADIN, VICTORIA	18	000965132	WWMA	755630

65 TREATMENT AUTHORIZATION CODES	66 DOCUMENT CONTROL NUMBER	67 EMPLOYER NAME

36 E02 37 38 39 40 41 42 43 44 45 46 47 48

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	1669567210	QUAL 080024210
		LAST GARCIA	FIRST MARIO J	

77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 OTHER NPI

81 CC a B3282N00000X b c d



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS

2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120

WESTON, FL 33331

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
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 checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE										3. PATIENT'S BIRTH DATE 08 13 1963 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A										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) 3411 WAYNE AVE, APT 11A										8. RESERVED FOR NUCC USE									
CITY BRONX										CITY BRONX									
STATE NY										STATE NY									
ZIP CODE 10467										TELEPHONE (Include Area Code) (646) 531-6542									
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)									
11. INSURED'S POLICY GROUP OR FECA NUMBER 755630										a. INSURED'S DATE OF BIRTH 08 13 1963 M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER CLAIM ID (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL-INTERNATIONAL									
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.									
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 05 11 2021										SIGNED SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNDELROY COLEMAN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 05 11 2021 TO 05 13 2021									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) G9389 A. B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9 CODE I. ID. QUAL J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER SSN EIN 131740114 <input type="checkbox"/> <input checked="" type="checkbox"/>									
26. PATIENT'S ACCOUNT NO. P1251746630										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ 65.00										29. AMOUNT PAID \$ 0.00									
30. Rsvd for NUCC Use										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SEYMOUR SPRAYREGEN MD SIGNED 05 17 2021 DATE									
32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 111 EAST 210TH STREET BRONX, NY 10467-2401 a. 1588859870 b.										33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X									



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS

2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120

WESTON, FL 33331

<input type="checkbox"/> PICA										<input type="checkbox"/> 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 <input type="checkbox"/> BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132																																																																																																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE										3. PATIENT'S BIRTH DATE 08 13 1963 M <input type="checkbox"/> F <input checked="" type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																																																																																																			
5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A										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) 3411 WAYNE AVE, APT 11A																																																																																																			
CITY BRONX										STATE NY										CITY BRONX										STATE NY																																																																																									
ZIP CODE 10467										TELEPHONE (Include Area Code) (646) 531-6542										ZIP CODE 10467										TELEPHONE (Include Area Code) (646) 531-6542																																																																																									
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 08 13 1963 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										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 INTERNATIONAL - INTERNATIONAL																																																																																																			
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.																																																																																																			
SIGNED SIGNATURE ON FILE DATE 05 18 2021																				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 DNMARIO J GARCIA										17a. NPI 1669567210										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																																																																																																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) I63511 ICD Ind. 0																				22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																			
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) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																																																																			
1 05 18 21 05 18 21 22 33285 A 25695.00 1 ZZ 390200000X 1073003497																				2																																																																																																			
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25. FEDERAL TAX I.D. NUMBER 131740114																				26. PATIENT'S ACCOUNT NO. P1257072110																				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																				28. TOTAL CHARGE \$25695.00																				29. AMOUNT PAID \$ 0.00																				30. Rsvd for NUCC Use																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) XIAODONG ZHANG MD SIGNED 06 28 2021 DATE																				32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 111 EAST 210TH STREET BRONX, NY 10467-2401 a. 1588859870 b.																				33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X																																																																															



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
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"/> (ID#) (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE										3. PATIENT'S BIRTH DATE 08 13 1963					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>																								
5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A										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) 3411 WAYNE AVE, APT 11A																			
CITY BRONX					STATE NY					CITY BRONX					STATE NY																								
ZIP CODE 10467					TELEPHONE (Include Area Code) (646) 531-6542					ZIP CODE 10467					TELEPHONE (Include Area Code) (646) 531-6542																								
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 08 13 1963																			
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 INTERNATIONAL - INTERNATIONAL																			
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 05 19 2021																				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 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 DNMARIO J GARCIA										17a. 1669567210										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) I63511										ICD Ind. 0										23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EFSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																							
1 05 19 21 05 19 21 11 99213 A 477.54 1 ZZ 207RC0000X NPI 1669567210																																							
2 05 19 21 05 19 21 11 93000 A 273.46 1 ZZ 207RC0000X NPI 1669567210																																							
3																																							
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER 131740114										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. P1252244950																			
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.) MARIO J GARCIA MD SIGNED 05 20 2021 DATE										32. SERVICE FACILITY LOCATION INFORMATION MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																			
28. TOTAL CHARGE \$ 751.00										29. AMOUNT PAID \$ 0.00										30. Rsvd for NUCC Use																			
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X																																							



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

<input type="checkbox"/> PICA										<input type="checkbox"/> 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 checked="" type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in item 1) 000965132									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE										3. PATIENT'S BIRTH DATE SEX 08 13 1963 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) PONCIO SABATER NO 6, TORRE R										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) PONCIO SABATER NO 6, TORRE REN										8. RESERVED FOR NUCC USE									
CITY NEW YORK										CITY NEW YORK									
STATE NY										STATE NY									
ZIP CODE 10150										ZIP CODE 10150									
TELEPHONE (Include Area 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									
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. SIGNED SIGNATURE ON FILE DATE 05 29 2021										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 QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNENRICO CASTELLUCCI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 05 18 2021 TO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) I63511 ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. # MM DD YY MM DD YY CPT/HCPCS MODIFIER										23. PRIOR AUTHORIZATION NUMBER 2105100021									
1 05 29 21 05 29 21 21 93227 A 235.00 1 ZZ 207RC0000X NPI 1952491821										2									
3										4									
5										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN 131740114 <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. P1280764770									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 235.00									
29. AMOUNT PAID \$ 0.00										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) KEVIN J FERRICK MD SIGNED 12 21 2021 DATE										32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 111 EAST 210TH STREET BRONX, NY 10467-2401 a. 1588859870 b.									
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X																			



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

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 checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE					3. PATIENT'S BIRTH DATE 08 13 1963		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		
5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A					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) 3411 WAYNE AVE, APT 11A		
CITY BRONX			STATE NY		CITY BRONX			STATE NY	
ZIP CODE 10467		TELEPHONE (Include Area Code) (646) 531-6542			ZIP CODE 10467		TELEPHONE (Include Area Code) (646) 531-6542		
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.									
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 06 16 2021					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 QUAL MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNKEVIN J FERRICK					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R002					22. RESUBMISSION CODE ORIGINAL REF. NO.				
24. A. DATE(S) OF SERVICE MM DD YY MM DD YY					25. F. \$ CHARGES				
B. PLACE OF SERVICE C. EMG					26. G. DAYS OR UNITS				
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					27. H. EPSON Family Plan				
E. DIAGNOSIS POINTER					28. I. ID. QUAL				
1 06 16 21 06 16 21 22 93298 A 245.00 1					29. J. RENDERING PROVIDER ID. #				
2 06 16 21 06 16 21 22 93298 A 245.00 1					30. Rsvd for NUCC Use				
3 06 16 21 06 16 21 22 93298 A 245.00 1					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.) KEVIN J FERRICK MD				
4 06 16 21 06 16 21 22 93298 A 245.00 1					32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720				
5 06 16 21 06 16 21 22 93298 A 245.00 1					33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514				
6 06 16 21 06 16 21 22 93298 A 245.00 1					34. a. 1063525152 b. ZZ282N00000X				
25. FEDERAL TAX I.D. NUMBER 131740114					26. PATIENT'S ACCOUNT NO. P1261720670				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 245.00				
29. AMOUNT PAID \$ 0.00					30. Rsvd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) KEVIN J FERRICK MD					32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720				
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514					34. a. 1063525152 b. ZZ282N00000X				



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

<input type="checkbox"/> PICA										<input type="checkbox"/> 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 checked="" type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE										3. PATIENT'S BIRTH DATE 08 13 1963										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																																							
5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A										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) 3411 WAYNE AVE, APT 11A																																							
CITY BRONX										STATE NY										CITY BRONX										STATE NY																													
ZIP CODE 10467										TELEPHONE (Include Area Code) (646) 531-6542										ZIP CODE 10467										TELEPHONE (Include Area Code) (646) 531-6542																													
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 08 13 1963																																							
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 INTERNATIONAL-INTERNATIONAL																																							
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.																																																											
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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 DNLUIGI DI BIASE										17a. 1891045837										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R002										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) CPT/HCPCS E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID QUAL J. RENDERING PROVIDER ID #																																							
1 07 17 21 07 17 21 22 93298 A 245.00 1 ZZ 207RC0000X										1891045837										2 3 4 5 6																																							
25. FEDERAL TAX I.D. NUMBER 131740114										26. PATIENT'S ACCOUNT NO. P1263496300										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 245.00										29. AMOUNT PAID \$ 0.00										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) LUIGI DI BIASE MD 08 16 2021 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.										33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X																																							



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX LUNG <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE										3. PATIENT'S BIRTH DATE 08 13 1963 M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A										7. INSURED'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A									
CITY BRONX					STATE NY					CITY BRONX					STATE NY				
ZIP CODE 10467					TELEPHONE (Include Area Code) (646) 531-6542					ZIP CODE 10467					TELEPHONE (Include Area Code) (646) 531-6542				
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)									
11. INSURED'S POLICY GROUP OR FECA NUMBER 755630										a. INSURED'S DATE OF BIRTH 08 13 1963 M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL- INTERNATIONAL									
d. INSURANCE PLAN NAME OR PROGRAM NAME										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 DATE 08 16 2021										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 QUAL MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R002 B. I63511 C. M05711 ICD Ind. 0 D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 08 16 21 08 16 21 11 99214 ABC 636.77 1 ZZ 207RC0000X 1669567210										2 NPI									
3 NPI										4 NPI									
5 NPI										6 NPI									
25. FEDERAL TAX I.D. NUMBER 131740114										26. PATIENT'S ACCOUNT NO. P1264186190									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 636.77									
29. AMOUNT PAID \$ 0.00										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MARIO J GARCIA MD SIGNED 08 20 2021 DATE										32. SERVICE FACILITY LOCATION INFORMATION MMC MEDICAL ARTS PAVILION 3400 BAINBRIDGE AVENUE BRONX, NY 10467-2404 a. 1346435682 b.									
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X																			



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

<input type="checkbox"/> PICA										<input type="checkbox"/> 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 checked="" type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE										3. PATIENT'S BIRTH DATE 08 13 1963										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																																																	
5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A										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) 3411 WAYNE AVE, APT 11A																																																	
CITY BRONX										STATE NY										CITY BRONX										STATE NY																																							
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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 08 13 1963																																																	
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 INTERNATIONAL-INTERNATIONAL																																																	
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SIGNED SIGNATURE ON FILE DATE 09 17 2021																				SIGNED SIGNATURE ON FILE																																																	
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNLUGI DI BIASE										17a. NPI 1891045837										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																																																	
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1 09 17 21 09 17 21 22 93298 A 245.00 1										24. FEDERAL TAX I.D. NUMBER 131740114										25. PATIENT'S ACCOUNT NO. P1270538470										26. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										27. TOTAL CHARGE \$ 245.00										28. AMOUNT PAID \$ 0.00										29. Rsvd for NUCC Use									
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HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000965132	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE		3. PATIENT'S BIRTH DATE 08 18 1963	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		5. PATIENT'S ADDRESS (No., Street) 3411 WAYNE AVE, APT 11A	
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) 3411 WAYNE AVE, APT 11A	
8. RESERVED FOR NUCC USE		CITY BRONX	
STATE NY		CITY BRONX	
ZIP CODE 10467		STATE NY	
TELEPHONE (Include Area Code) (646) 531-6542		ZIP CODE 10467	
TELEPHONE (Include Area Code) (646) 531-6542		CITY BRONX	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		STATE NY	
10. IS PATIENT'S CONDITION RELATED TO:		CITY BRONX	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		STATE NY	
b. RESERVED FOR NUCC USE		ZIP CODE 10467	
c. RESERVED FOR NUCC USE		TELEPHONE (Include Area Code) (646) 531-6542	
d. INSURANCE PLAN NAME OR PROGRAM NAME		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 08 18 1963	
SIGNATURE ON FILE		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
DATE 10 18 2021		b. OTHER CLAIM ID (Designated by NUCC)	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL-INTERNATIONAL	
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 10 18 2021		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 DNLUGI DI BIASE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R002		22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	
25. FEDERAL TAX I.D. NUMBER 131740114		B. PLACE OF SERVICE EMG	
26. PATIENT'S ACCOUNT NO. P1275909020		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		D. DIAGNOSIS POINT	
28. TOTAL CHARGE \$ 245.00		E. DAYS OR UNITS 1	
29. AMOUNT PAID \$ 0.00		F. \$ CHARGES	
30. Rsvd for NUCC Use		G. DAYS OR UNITS	
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.) LUIGI DI BIASE MD		H. EPST Family Plan	
32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720		I. ID. NO.	
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514		J. RENDERING PROVIDER ID #	
SIGNED 11 16 2021 DATE		K. NPI	
a. 1962704650		L. NPI	
b. 1063525152		M. NPI	
c. ZZ282N00000X		N. NPI	
d. ZZ207RC0000X		O. NPI	
e. 1891045837		P. NPI	
f. 1891045837		Q. NPI	
g. 1891045837		R. NPI	
h. 1891045837		S. NPI	
i. 1891045837		T. NPI	
j. 1891045837		U. NPI	
k. 1891045837		V. NPI	
l. 1891045837		W. NPI	
m. 1891045837		X. NPI	
n. 1891045837		Y. NPI	
o. 1891045837		Z. NPI	



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

<input type="checkbox"/> PICA		<input type="checkbox"/> 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 checked="" type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S ID NUMBER (For Program in Item 1) 000965132	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ACOSTA SALADIN, VICTORIA EUGE		3. PATIENT'S BIRTH DATE 08 13 1963 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) PONCIO SABATER NO 6, TORRE R		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) PONCIO SABATER NO 6, TORRE REN		8. RESERVED FOR NUCC USE	
CITY NEW YORK STATE NY		CITY NEW YORK STATE NY	
ZIP CODE 10150 TELEPHONE (Include Area Code) ()		ZIP CODE 10150 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 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. SIGNED SIGNATURE ON FILE DATE 11 18 2021		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	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNKEVIN J FERRICK		17a. 1952491821 17b. NPI	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R002		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. CUA J. RENDERING PROVIDER ID #		23. PRIOR AUTHORIZATION NUMBER	
11 18 21 11 18 21 22 93298 A 245.00 1		ZZ 207RC0000X 1952491821	
25. FEDERAL TAX I.D. NUMBER 131740114 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. P1280764760	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 245.00	
29. AMOUNT PAID \$ 0.00		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) KEVIN J FERRICK MD SIGNED 12 21 2021 DATE		32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X		33. BILLING PROVIDER INFO & PH #	



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

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 <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S ID NUMBER (For Program in Item 1) 000965132																																																																															
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5. PATIENT'S ADDRESS (No., Street) PONCIO SABATER NO 6, TORRE R										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) PONCIO SABATER NO 6, TORRE REN																																																																					
CITY NEW YORK										STATE NY										CITY NEW YORK										STATE NY																																																											
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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 08 13 1963																																																																					
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 INTERNATIONAL-INTERNATIONAL																																																																					
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MM DD YY QUAL										MM DD YY QUAL										FROM MM DD YY TO MM DD YY																																																																					
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17b. NPI										17c.										FROM MM DD YY TO MM DD YY																																																																					
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R002																				23. PRIOR AUTHORIZATION NUMBER																																																																					
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE										C. D. PROCEDURES, SERVICES, OR SUPPLIES										E. DIAGNOSIS										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSDT Family Plan										I. ID.										J. RENDERING PROVIDER ID #									
From To										MM DD YY MM DD YY										CPT/HCPCS MODIFIER										POINTER										\$ CHARGES										DAYS OR UNITS										EPSDT Family Plan										ID.										RENDERING PROVIDER ID #									
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25. FEDERAL TAX I.D. NUMBER 131740114										SSN EIN <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. P1286150310										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 245.00										29. AMOUNT PAID \$ 0.00										30. Rsvd for NUCC Use																													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) XIAODONG ZHANG MDPHD 02 01 2022																				32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.																				33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X																																																	