Hospital for Special Surgery Fax Cover Sheet

To: Seguros Worldwide To Fax: 954-206-0014

From: Liz Cobena, HSS NPI 1598703019

Phone: 917-260-3033 Fax: 917-260-4933

Date/Time: Wednesday, February 23, 2022

Pages: 06

Comments:

RE: ID: 685001190352 CARMEN J. FINKE DE YUNEN MRN #2567708

Dear team,
Please advise on status.

Thank you,
Liz

Patient: Finke de Yunen, Carmen Josefina
Medical Record #: 2567708

Insurance Information:
(1) UnitedHealth Care (UT), Pol# 685001190352, Grp# 1190352

Explanation of Benefits

Services Provided				Insurance Responsibility			Patient Responsibility						
Provider	**Description**	**Visit Date**	**Charges**	**Insurance Allowance**	**Insurance Payments**	**Insurance Balance**	**Deductible**	**Co-Ins**	**NYS Surcharge**	**Other**	**Patient Payment**	**Patient Balance**	**TOTAL BALANCE**
Hospital													
HSS	X-rays	18-Oct-21	$611.00	($313.00)	$0.00	$298.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$298.00
HSS	X-rays	11-Jan-22	$298.00	$0.00	$0.00	$298.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$298.00
Subtotal for Hospital:			$909.00	($313.00)	$0.00	$596.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$596.00
Professional													
HSS Radiologists		18-Oct-21	$500.00	$0.00	$0.00	$500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$500.00
HSS Radiologists		11-Jan-22	$50.00	$0.00	$0.00	$50.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00
Subtotal for Professional:			$550.00	$0.00	$0.00	$550.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$550.00
Grand Total:			**$1,459.00**	**($313.00)**	**$0.00**	**$1,146.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$1,146.00**

HOSPITAL FOR SPECIAL SURG
535 EAST 70TH STREET
NEW YORK NY 100214823
2126061784

HOSPITAL FOR SPECIAL SURG
P.O. BOX 29174
NEW YORK NY100879174

3a PAT. CNTL #: NY100220103970
b. MED. REC. #: 2567708
4 TYPE OF BILL: 0131
5 FED. TAX NO.: 820957570
6 STATEMENT COVERS PERIOD FROM: 011122 THROUGH: 011122

8 PATIENT NAME: FINKE DE YUNEN CARMEN J
9 PATIENT ADDRESS: HSS INTERNATIONAL SERVICES 525 E 71 ST, NEW YORK, NY 10021

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
03181956	F			3	2		01

31 OCCURRENCE CODE	DATE
11	011122

UNITEDHEALTHCARE INTER
PO BOX 740372

ATLANTA, GA 30374

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0320	RADIOLOGY - DIAGNOSTIC -	73060LT	011122	1	64200	000
0001	PAGE 1 OF 1	CREATION DATE	022322	TOTALS	64200	000

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
UNITEDHEALTHCARE INTER		Y	Y	000	64200	1598703019

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FINKE DE YUNEN, CARMEN JO		685001190352	UNITED HEALTHC	755630

63 TREATMENT AUTHORIZATION CODES

64 DOCUMENT CONTROL NUMBER

65 EMPLOYER NAME

67: S42342D 0

69 ADMIT DX

70 PATIENT REASON DX: S42342D

74 PRINCIPAL PROCEDURE CODE DATE

76 ATTENDING NPI: 1881612422 LAST: RICCI FIRST: WILLIAM M

77 OPERATING NPI: 1881612422 LAST: RICCI FIRST: WILLIAM M

78 OTHER NPI LAST FIRST

79 OTHER NPI LAST FIRST

80 REMARKS: NYHCRA SURCHARGES NOT INCLUDED

81 CC: a B3282N00000X

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

HOSPITAL FOR SPECIAL SURG
535 EAST 70TH STREET
NEW YORK NY 100214823
2126061784

HOSPITAL FOR SPECIAL SURG
P.O. BOX 29174
NEW YORK NY100879174

3a PAT. CNTL #: 10021288084803
b. MED. REC. #: 2567708
4 TYPE OF BILL: 0131
5 FED. TAX NO.: 131624135
6 STATEMENT COVERS PERIOD FROM: 101821 THROUGH: 101821

8 PATIENT NAME: FINKE DE YUNEN CARMEN J
9 PATIENT ADDRESS: HSS INTERNATIONAL SERVICES 525 E 71 ST, NEW YORK, NY 10021

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
03181956	F			3	2		01

31 OCCURRENCE CODE	DATE
11	101821

UNITEDHEALTHCARE INTER
PO BOX 740372

ATLANTA, GA 30374

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0001	PAGE 1 OF 1	CREATION DATE	022322	TOTALS	61100	000

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
UNITEDHEALTHCARE INTER		Y	Y	000	61100	1598703019

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
FINKE DE YUNEN, CARMEN JO		685001190352	UNITED HEALTHC	755630

63 TREATMENT AUTHORIZATION CODES / 64 DOCUMENT CONTROL NUMBER / 65 EMPLOYER NAME

67 S42342A
0
70 PATIENT REASON DX: S42342A

76 ATTENDING NPI: 1881612422 LAST: RICCI FIRST: WILLIAM M
77 OPERATING NPI: 1881612422 LAST: RICCI FIRST: WILLIAM M

80 REMARKS: NYHCRA SURCHARGES NOT INCLUDED
81CC a: B3282N00000X

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

HEALTH INSURANCE CLAIM FORM

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

UNITED HEALTHCARE GLOBAL
P.O. BOX 30526

SALT LAKE CITY, UT 84130-0526

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 685001190352

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FINKE DE YUNEN, CARMEN, J

3. PATIENT'S BIRTH DATE: 03 18 1956 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): HSS INTERNATIONAL SERVICES 5
CITY: NEW YORK STATE: NY
ZIP CODE: 10021 TELEPHONE (Include Area Code): (829)645-7585

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

7. INSURED'S ADDRESS (No., Street): HSS INTERNATIONAL SERVICES 525
CITY: NEW YORK STATE: NY
ZIP CODE: 10021 TELEPHONE (Include Area Code): (829)645-7585

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. OTHER ACCIDENT? [ ] YES [X] NO
10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: 76570101
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED HEALTH-UNITED HEALTHC
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] 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 02 23 2022

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNWILLIAM M RICCI
17a.
17b. NPI 1881612422

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES 000

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. S42342D B. C. 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 CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	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		73060	26 LT	A	50.00	1		NPI	1295742765
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 251917907 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: AA1043481171

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

28. TOTAL CHARGE: $ 50.00

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.)
ROBERT SCHNEIDER MD
SIGNED DATE 02 23 2022

32. SERVICE FACILITY LOCATION INFORMATION
HOSPITAL FOR SPECIAL SURGE
535 E 70TH STREET
NEW YORK, NY 10021-4823
a. 1598703019 b.

33. BILLING PROVIDER INFO & PH # (866)689-8865
HSS RADIOLOGISTS
PO BOX 5058
NEW YORK, NY 10087-5058
a. 1255777488 b.

HEALTH INSURANCE CLAIM FORM

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

UNITEDHEALTHCARE INTER
PO BOX 740372

ATLANTA, GA 30374

PICA

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4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): HSS INTERNATIONAL SERVICES 5
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): P.O. BOX 740372

CITY: NEW YORK STATE: NY
8. RESERVED FOR NUCC USE
CITY: ATLANTA STATE: GA

ZIP CODE: 10021 TELEPHONE (Include Area Code): (829)645-7585
ZIP CODE: 30374-0372 TELEPHONE (Include Area Code): (829)645-7585

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 755630

a. OTHER INSURED'S POLICY OR GROUP NUMBER:
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 03 18 1956 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE:
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):
b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED HEALTH-UNITED HEALTHC

d. INSURANCE PLAN NAME OR PROGRAM NAME:
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

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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: 02 23 2022

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14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

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A. S42302D B. C. D. E. F. G. H. I. J. K. L.
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2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 251917907 SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO.: AA1041488421
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 50.00
29. AMOUNT PAID: $ 0.00
30. Rsvd for NUCC Use

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a 1598703019 b

33. BILLING PROVIDER INFO & PH #: (866)689-8865
HSS RADIOLOGISTS
PO BOX 5058
NEW YORK, NY 10087-5058
a 1255777488 b

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION