FAX

CENTRAL INDIANA ORTHOPEDICS

Because life moves.

Anderson
2610 Enterprise Drive
Anderson, IN 46013
Phone: 765-683-4400
Fax: 765-642-7903

Elwood
St. Vincent Mercy Hospital
Medical Specialty Suites
1331 South A Street
Elwood, IN 46036
Phone: 765-552-4584

Fishers
14300 E 136th Street
Building B
Fishers, IN 46037
Phone: 317-773-4301
Fax: 765-608-3687

Marion
1389 North Baldwin Avenue
Marion, IN 46952
Phone: 765-664-2671
Fax: 765-664-3703

Muncie
3600 West Bethel Avenue
Muncie, IN 47304
Phone: 765-284-7738
Fax: 765-284-4266

Cover + Number of Pages: 27 Current Date: 2/21/2022

From: Karita

To: UHC

Fax Number: (954) 206-0014

☐ Urgent ☐ For Review ☐ Please Reply ☐ Please Comment

Message:

Refund to patient is being held up due to 11/4/2021 not being processed by UHC. Please process claim so we can finish patient refund. Claims, Eob and encouter bills from Central Indiana Orhtopedics and CIO Surgery Center LLC

765-213-3719 765-213-3718 FAX karita_tackett@cioecnter.com

If there are any problems with the transmission of this information, please contact:

Karita

Thank you.

1 CIO Surgery Center LLC
PO Box 1987
Muncie IN 47308-1987
7652133800

2 ASC CIO Muncie
3600 West Bethel Ave
Muncie IN 47304-5407

3a PAT. CNTL. # 000200030776
b. MED. REC. #
4 TYPE OF BILL 831
5 FED. TAX NO. 352033226
6 STATEMENT COVERS PERIOD FROM 062321 THROUGH 062321
7

8 PATIENT NAME a
b Perez, Jennifer

9 PATIENT ADDRESS a 9100 N Lonesome Dr
b Muncie c IN d 473029025 e

10 BIRTHDATE 03121964
11 SEX F
12 DATE
13 HR
14 TYPE
15 SRC 9
16 DHR
17 STAT 01
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
28 ADDT STATE
30

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

38 !!! COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 07/01/21 !!!
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025

39 VALUE CODES CODE AMOUNT
a 80 0 00
40 VALUE CODES CODE AMOUNT
AE 8,700 00
41 VALUE CODES CODE AMOUNT
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
0490	RECONSTRUCT SHOULDER JOINT	23472 RT	062321	1	35,280 00		
0278	Joint device (Implantable)	C1776	062321	1	8,700 00		
0001	PAGE 1 OF 1	CREATION DATE	02212022	TOTALS	43,980 00	0 00	

50 PAYER NAME: Jnited Healthcare Access
51 HEALTH PLAN ID
52 REL INFO Y
53 ASG BEN Y
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 1447260575
57 OTHER PRV ID

58 INSURED'S NAME: Perez, Jennifer
59 P REL 18
60 INSURED'S UNIQUE ID 168900936
61 GROUP NAME
62 INSURANCE GROUP NO. 33822

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME: Unemployed

66 DX M25.611
67
68
69

66 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1447260575 QUAL
LAST Surgery Center FIRST CIO
77 OPERATING NPI QUAL OTH000
LAST Waterman FIRST Scott
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS United Healthcare Access
PO Box 740372
Atlanta, GA 303740372

81CC a 261QA1903X
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 Printed on Recycled Paper NUBC Approval TFP2439H089 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Explanation of Benefits

UMR USNAS
PO BOX 30526
SALT LAKE CITY, UT 841300526

CENTRAL INDIANA ORTHOPEDICS SURGERY CENTER
3600 W BETHEL AVE
MUNCIE, IN 47304

Check/EFT #: 709174339
Check Date: 12/16/2021
Check Amt: 7355.35
NPI Provider#: 1447260575

Patient: PEREZ, JENNIFER
Insured: PEREZ, JENNIFER
HIN: 685000033822
Patient Control Number: 000200030776
ICN#: 21188153353
Status: Primary

Dates of Service	Units	CPT4/Mods	Billed	CoIns	Allwd	Deduct	Paid	Adj	Adj Cd
06/23/2021-06/23/2021	1	23472 RT	35280.00	607.40	8510.36	2436.39	5466.57	26769.64	CO45
06/23/2021-06/23/2021	1	C1776	8700.00	209.86	2090.64	0	1888.78	6601.36	CO45
Totals:			***43980.00***	***817.26***	***10609.00***	***2436.39***	***7355.35***	***33371.00***	

Reason Codes: CO45-26769.64; PR1-2436.39; PR2-607.4
Reason Codes: CO45-6601.36; PR2-209.86

HIPAAX12 Code List Summary:
CO45 - Charges exceed fee arrangement
PR1 - Patient Responsibility Deductible
PR2 - Coinsurance amount

Make Checks Payable To:

CIO Surgery Center, LLC
3600 W Bethel Ave
Muncie, IN 47304-5407
ENCOUNTER INVOICE 30776

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
Check Card Using For Payment		
☐ American Express ☐ Discover ☐ Mastercard ☐ Visa		
Card Number	CVV	Amount
Signature		Exp. Date

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	$0.00	17326
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
CIO Surgery Center, LLC
3600 W Bethel Ave
Muncie, IN 47304-5407
USA

☐ Please check box if above address is incorrect or insurance information has changed and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
06/15/21	Perez, Jennifer	Surgery Center, CIO	Chgest	Charge Estimated	$0.00
06/23/21	Perez, Jennifer	Surgery Center, CIO	23472	Total Shldr Arthroplasty	$35,280.00
06/23/21	Perez, Jennifer	Surgery Center, CIO	C1776	Joint device (implantable)	$8,700.00
06/15/21				Patient Payment Credit Card	-$4,773.92
06/15/21				Transfer Patient Payment	$716.09
09/16/21				Transfer Patient Payment	-$3,836.15
09/16/21				Transfer Patient Payment	-$219.68
12/15/21				Commercial Payment	-$5,466.57
12/15/21				Commercial Payment	-$1,886.76
12/15/21				Commercial Adjustment	-$26,769.64
12/15/21				Commercial Adjustment	-$6,601.86
02/16/22				Refund Patient	$584.50

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
17326	$43,980.00	-$11,193.50	-$32,786.50	$0.00	$0.00

MESSAGE:

Please Pay This AMOUNT >>>> $0.00

** PAYMENT DUE UPON RECEIPT *THANK YOU **

ENCOUNTER INVOICE

Printed by tackar (450) on 2/21/2022 9:28:40 AM

!!! COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 05/07/21

HEALTH INSURANCE CLAIM FORM

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

United Healthcare Access
PO Box 740372

Atlanta, GA 30374-0372

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 168900936

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Perez Jennifer

3. PATIENT'S BIRTH DATE: 03 12 1964 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 9100 N Lonesome Dr

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

7. INSURED'S ADDRESS (No., Street): 9100 N Lonesome Dr

CITY: Muncie STATE: IN

8. RESERVED FOR NUCC USE

CITY: Muncie STATE: IN

ZIP CODE: 47302-9025 TELEPHONE (Include Area Code): (617)901 7421

ZIP CODE: 47302-9025 TELEPHONE (Include Area Code): (617) 901 7421

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: 168900936

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 03 12 64 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 Healthcare Access

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.

PATIENT AND INSURED INFORMATION

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: 02/21/2022

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): 05 01 2020 QUAL.: 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN No Physician

17a.

17b. NPI 1174539076

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. Z96611 B. T8484XA C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 05062021	05062021	11		99203		A	228 00	1		NPI	207X00000X 1811049083
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 351709418 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 000101687060

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

28. TOTAL CHARGE: $ 228 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 228 00

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.)

Waterman MD, Scott M
02/21/2022
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Office CIO Muncie
3600 West Bethel Ave
Muncie IN 47304-5407

a. 1063422137 b.

33. BILLING PROVIDER INFO & PH #
Central Indiana Orthopedics, PC
3600 West Bethel Avenue
Muncie IN 47304-5407
(765) 284-7738

a. 1063422137 b. 193200000X

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

Explanation of Payment

Payer	Check/EFT Trace #	Payment
UMR USNAS PO BOX 30526 SALT LAKE CITY, UT 841300526 To Contact: UMR EDI TEAM TE: 8442518318 Technical Contact: UMR EDI TEAM EM: UMR-EDI-IT-TEAM_DL@DS.UHC.COM	723086646 (ACH)	$403.82 1/28/2022

Tax/NPI/Prov ID	Provider
01 1063422137 TJ 351709418	CENTRAL INDIANA ORTHOPEDICS 3600 W BETHEL AVE MUNCIE, IN 47304

Remittance Information Only

Provider Adjustments		
Reason	Tracking #	Amount
None		

Provider/POS					
Provider ID	POS	Fiscal Period	Total Claims	Total PIP Claims	Total PIP ADJ	Total Charge
None						

Provider	Procedure	Mods	Bld/Pd	DOS	POS		Total Charges	Allowed	Paid
001 Patient Control Number: 000101687060						Sub: JENNIFER PEREZ (685000033822)			
Pat: JENNIFER PEREZ Rend: SCOTT WATERMAN (1811049083) Claim Supplemental Information Amount							**$228.00**	$109.20	**$98.28**
Coverage Amount			228.00						
1811049083	99203		1/1	5/6/2021-5/6/2021	11		**$228.00**	$109.20	**$98.28**
Contractual Obligation: CO-45			Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement			$118.80			
						Less Contractual Obligation:	$118.80	**$109.20**	
Patient Responsibility: PR-2			Coinsurance Amount			$10.92			
						Less Patient Responsibility:	$10.92	**$98.28**	
						Total Paid:		**$98.28**	

Payer Claim Tracking #(ICN) 21132169341 **Claim Filing Indicator:** Mutually Defined
Claim Frequency Code: 1 - Admit Through Discharge Claim (a)

****Provider Identifiers**
1063422137 **(XX)** - Centers for Medicare and Medicaid Services National Provider Identifier
351709418 **(TJ)** - Federal Taxpayer's Identification Number

Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1687060

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
Check Card Using For Payment		
☐ American Express ☐ Discover ☐ Mastercard ☐ Visa		
Card Number	CVV	Amount
Signature		Exp. Date

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	-$98.28	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
05/06/21	Perez, Jennifer	Waterman, Scott	99203	New Patient Office Visit Detailed	$228.00
06/28/21				Commercial Payment	-$0.00
09/16/21				Transfer Patient Payment	-$109.20
01/27/22				Commercial Payment	-$98.28
06/28/21				Commercial Adjustment	-$118.80

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$228.00	-$207.48	-$118.80	$0.00	-$98.28

MESSAGE:
Thank you for your payment!

Please Pay This AMOUNT >>>> -$98.28

** PAYMENT DUE UPON RECEIPT *THANK YOU **
ENCOUNTER INVOICE
Printed by tackar (450) on 2/21/2022 9:30:38 AM

!!! COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 07/15/21

United Healthcare Global
PO Box 30526

Salt Lake City, UT 84130-0526

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 685000033822

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Perez Jennifer	03 12 1964 M [ ] F [X]	Perez Jennifer
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
9100 N Lonesome Dr	Self [X] Spouse [ ] Child [ ] Other [ ]	SAME
CITY: Muncie / STATE: IN	8. RESERVED FOR NUCC USE: X	CITY / STATE
ZIP CODE: 47302-9025 / TELEPHONE (Include Area Code): 617)901 7421		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
		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 12 64 M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] 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: 02/21/2022

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	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
05 01 2020 QUAL.		FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
Waterman Scott	1811049083	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. M25511 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 15D0960980

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 05122021	05122021	11		20610	RT	1	263 00	1		NPI	1902812639
2 05122021	05122021	11		77002		1	480 00	1		NPI	1902812639
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
351709418 [ ] [X]	000101689914	[X] YES [ ] NO	$ 743 00	$	743 00

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	33. BILLING PROVIDER INFO & PH #
Lillo MD, Robert A 02/21/2022 SIGNED DATE	Office CIO Muncie 3600 West Bethel Ave Muncie IN 47304-5407 a. b.	Central Indiana Orthopedics, PC 3600 West Bethel Avenue Muncie IN 47304-5407 (765) 284-7738 a. 1063422137 b. 193200000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Explanation of Payment

Payer	Check/EFT Trace #	Payment
UMR USNAS PO BOX 30526 SALT LAKE CITY, UT 841300526 To Contact: UMR EDI TEAM TE: 8442518318 Technical Contact: UMR EDI TEAM EM: UMR-EDI-IT-TEAM_DL@DS.UHC.COM	723086646 (ACH)	$403.62 1/28/2022

Tax/NPI/Prov ID	Provider
01 1063422137 TJ 351709418	CENTRAL INDIANA ORTHOPEDICS 3600 W BETHEL AVE MUNCIE, IN 47304
Remittance Information Only	

Provider Adjustments		
Reason	Tracking #	Amount
None		

Provider/POS					
Provider ID	POS	Fiscal Period	Total Claims	Total PIP Claims	Total PIP ADJ	Total Charge
None						

Provider	Procedure	Mods	Bld/Pd	DOS	POS		Total Charges	Allowed	Paid
001 Patient Control Number: 000101689914					Sub: JENNIFER PEREZ (168900936)				
Pat: JENNIFER PEREZ									
Corrected Patient/Insured Name: N/A (685000033822)									
Rend: ROBERT LILLO (1902812639)							**$743.00**	$228.79	**$205.91**
Claim Supplemental Information Amount									
Coverage Amount			743.00						
1902812639	20610	RT	1/1	5/12/2021-5/12/2021			**$263.00**	$130.60	**$117.54**
Contractual Obligation: CO-45			Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement			$132.40			
					Less Contractual Obligation:	$132.40	**$130.60**		
Patient Responsibility: PR-2			Coinsurance Amount			$13.06			
					Less Patient Responsibility:	$13.06	**$117.54**		
					Total Paid:		**$117.54**		
1902812639	77002		1/1	5/12/2021-5/12/2021			**$480.00**	$98.19	**$88.37**
Contractual Obligation: CO-45			Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement			$381.81			
					Less Contractual Obligation:	$381.81	**$98.19**		
Patient Responsibility: PR-2			Coinsurance Amount			$9.82			
					Less Patient Responsibility:	$9.82	**$88.37**		
					Total Paid:		**$88.37**		

Payer Claim Tracking #(ICN) 21161009167 **Claim Filing Indicator:** Mutually Defined
Claim Frequency Code: 1 - Admit Through Discharge Claim (a)

****Provider Identifiers**
1063422137 (XX) - Centers for Medicare and Medicaid Services National Provider Identifier
351709418 (TJ) - Federal Taxpayer's Identification Number

Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1669914

IF PAYING BY CREDIT CARD, FILL OUT BELOW			
Check Card Using For Payment			
☐ American Express	☐ Discover	☐ Mastercard	☐ Visa
Card Number	CVV	Amount	
Signature		Exp. Date	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	-$205.91	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
05/12/21	Perez, Jennifer	Lillo, Robert	20610	Injection Aspiration Major Joint/Bursa	$263.00
05/12/21	Perez, Jennifer	Lillo, Robert	77002-77	Fluoroscopic Guidance & Needle Placement	$480.00
07/28/21				UHC Payment	$0.00
07/28/21				UHC Payment	$0.00
08/11/21				UHC Payment	$0.00
08/11/21				UHC Payment	$0.00
08/11/21				UHC Payment	$0.00
08/11/21				UHC Payment	$0.00
12/16/21				Transfer Patient Payment	-$130.60
12/16/21				Transfer Patient Payment	-$96.19
01/27/22				UHC Payment	-$117.54
01/27/22				UHC Payment	-$86.37
07/28/21				UHC Adjustment	$0.00
07/28/21				UHC Adjustment	$0.00
08/11/21				UHC Adjustment	$0.00
08/11/21				UHC Adjustment	$0.00
08/11/21				UHC Adjustment	$0.00
08/11/21				UHC Adjustment	$0.00
09/30/21				UHC Adjustment	-$132.40
09/30/21				UHC Adjustment	-$381.81

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$743.00	-$434.70	-$514.21	$0.00	-$205.91

MESSAGE:
Thank you for your payment!

Please Pay This AMOUNT >>>> -$206.91

** PAYMENT DUE UPON RECEIPT *THANK YOU **

ENCOUNTER INVOICE

Printed by tackar (450) on 2/21/2022 9:32:29 AM

III COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 05/26/21

HEALTH INSURANCE CLAIM FORM

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

United Healthcare Access
PO Box 740372
Atlanta, GA 30374-0372

CARRIER

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 168900936

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Perez Jennifer	03 12 1964	M [ ] F [X]	Perez Jennifer

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
9100 N Lonesome Dr	Self [X] Spouse [ ] Child [ ] Other [ ]	9100 N Lonesome Dr

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Muncie	IN		Muncie	IN

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
47302-9025	(617)901 7421	47302-9025	(617) 901 7421

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
		168900936
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 12 64 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 Healthcare Access
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.

PATIENT AND INSURED INFORMATION

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 02/21/2022

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.	431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
05 01 2020				

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN Waterman Scott M		1811049083	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES [ ] NO [X]	$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	ICD Ind.	0	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. M25511 B. Z96611 C. M19011 D.				
E. F. 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	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 05252021	05252021	11		99214		A	202 00	1		NPI	207X00000X 1811049083
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
351709418	[ ]	[X]	000101697113	YES [X] NO [ ]	$ 202 00	$	202 00

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	33. BILLING PROVIDER INFO & PH #
Waterman MD, Scott M 02/21/2022 SIGNED DATE	Office CIO Muncie 3600 West Bethel Ave Muncie IN 47304-5407 a. 1063422137 b.	Central Indiana Orthopedics, PC 3600 West Bethel Avenue Muncie IN 47304-5407 (765) 264-7738 a. 1063422137 b. 193200000X

Explanation of Payment

Payer	Check/EFT Trace #	Payment
UMR USNAS PO BOX 30526 SALT LAKE CITY, UT 841300526 To Contact: UMR EDI TEAM TE: 8442518318 Technical Contact: UMR EDI TEAM EM: UMR-EDI-IT-TEAM_DL@DS.UHC.COM	723086646 (ACH)	$403.62 1/28/2022

Tax/NPI/Prov ID	Provider
01 1063422137 TJ 351709418	CENTRAL INDIANA ORTHOPEDICS 3600 W BETHEL AVE MUNCIE, IN 47304

Remittance Information Only

Provider Adjustments

Reason	Tracking #	Amount
None		

Provider ID	Provider/POS POS	Fiscal Period	Total Claims	Total PIP Claims	Total PIP ADJ	Total Charge
None						

Provider	Procedure	Mods	Bld/Pd	DOS	POS	Total Charges	Allowed	Paid
001 Patient Control Number: 000101697113					Sub: JENNIFER PEREZ (685000033822)			
Pat: JENNIFER PEREZ Rend: SCOTT WATERMAN (1811049083) Claim Supplemental Information Amount						**$202.00**	$110.48	**$99.43**
Coverage Amount			202.00					
1811049083	99214		1/1	5/25/2021-5/25/2021	11	**$202.00**	$110.48	**$99.43**
Contractual Obligation: CO-45			Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement		$91.52			
				Less Contractual Obligation:	$91.52	**$110.48**		
Patient Responsibility: PR-2			Coinsurance Amount		$11.05			
				Less Patient Responsibility:	$11.05	**$99.43**		
				Total Paid:		**$99.43**		

Payer Claim Tracking #(ICN) 21149217115 **Claim Filing Indicator:** Mutually Defined
Claim Frequency Code: 1 - Admit Through Discharge Claim (a)

****Provider Identifiers**
1063422137 (XX) - Centers for Medicare and Medicaid Services National Provider Identifier
351709418 (TJ) - Federal Taxpayer's Identification Number

Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1697113

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
Check Card Using For Payment		
☐ American Express ☐ Discover ☐ Mastercard ☐ Visa		
Card Number	CVV	Amount
Signature		Exp. Date

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	-$99.43	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9026
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
05/25/21	Perez, Jennifer	Waterman, Scott	99214	Established Patient Visit Detailed	$202.00
07/07/21				Commercial Payment	-$0.00
09/16/21				Transfer Patient Payment	-$110.48
01/27/22				Commercial Payment	-$99.43
07/07/21				Commercial Adjustment	-$91.52

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$202.00	-$209.91	-$91.52	$0.00	-$99.43

MESSAGE:
Thank you for your payment!

Please Pay This AMOUNT >>>> -$99.43

** PAYMENT DUE UPON RECEIPT "THANK YOU **

ENCOUNTER INVOICE

Printed by tackar (460) on 2/21/2022 9:33:18 AM

HEALTH INSURANCE CLAIM FORM

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

III COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 07/15/21

United Healthcare Global
PO Box 30526

Salt Lake City, UT 84130-0526

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 685000033822

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Perez Jennifer	03 12 1964 M [ ] F [X]	Perez Jennifer
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
9100 N Lonesome Dr	Self [X] Spouse [ ] Child [ ] Other [ ]	SAME
CITY: Muncie / STATE: IN	8. RESERVED FOR NUCC USE: X	CITY / STATE
ZIP CODE: 47302-9025 / TELEPHONE (Include Area Code): (617)901 7421		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: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 12 64 M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] 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: 02/21/2022

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	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
05 01 2020 QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI 1174539076	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
No Physician		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [X] NO / $ CHARGES
Request Documentation		

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. M25611 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 15D0945752

PHYSICIAN OR SUPPLIER INFORMATION

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 06232021	06232021	24		23472	22 RT	1	13,204 00	1		NPI	1811049083
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
351709418 [ ] [X]	000101707512	[X] YES [ ] NO	$ 13,204 00	$	13,204 00

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	33. BILLING PROVIDER INFO & PH #
Waterman MD, Scott M 02/21/2022 SIGNED DATE	ASC CIO Muncie 3600 West Bethel Ave Muncie IN 47304-5407 a. 1447260575 b.	Central Indiana Orthopedics, PC 3600 West Bethel Avenue Muncie IN 47304-5407 (765) 284-7738 a. 1063422137 b. 193200000X

Explanation of Benefits

UMR USNAS
PO BOX 30526
SALT LAKE CITY, UT 841300526

CENTRAL INDIANA ORTHOPEDICS
3600 W BETHEL AVE
MUNCIE, IN 47304

Check/EFT #: 706246682
Check Date: 12/08/2021
Check Amt: 2385.16
NPI Provider#: 1063422137

Patient: PEREZ, JENNIFER
Insured: PEREZ, JENNIFER
HIN: 695000033822
Patient Control Number: 000101707512
ICN#: 21185105215
Status: Primary

Dates of Service	Units	CPT4/Mods	Billed	CoIns	Allwd	Deduct	Paid	Adj	Adj Cd
06/23/2021-06/23/2021	1	23472 22 RT	13204.00	265.02	2650.18	0	2385.16	10553.82	CO45
Totals:			*13204.00*	*265.02*	*2650.18*	*0*	*2385.16*	*10553.82*	

Reason Codes: CO45-10553.82; PR2-265.02

HIPAAX12 Code List Summary:
CO45 - Charges exceed fee arrangement
PR2 - Coinsurance amount

Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1707512

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
Check Card Using For Payment		
☐ American Express ☐ Discover ☐ Mastercard ☐ Visa		
Card Number	CVV	Amount
Signature		Exp. Date

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	-$218.21	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
06/15/21	Perez, Jennifer	Waterman, Scott	CHGEST	Charge Estimated	$0.00
06/23/21	Perez, Jennifer	Waterman, Scott	[illegible]	Total Shoulder Arthroplasty	$13,204.00
06/15/21				Transfer Patient Payment	-$716.09
07/26/21				Transfer Patient Payment	-$716.09
07/26/21				Transfer Patient Payment	$716.09
08/11/21				UHC Payment	-$2,000
08/16/21				UHC Payment	$0.00
12/08/21				UHC Payment	-$8,185.16
12/16/21				Transfer Patient Payment	$232.86
08/11/21				UHC Adjustment	-$0.00
08/16/21				UHC Adjustment	$0.00
12/08/21				UHC Adjustment	-$10,553.82

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$13,204.00	-$2,868.39	-$10,553.82	$0.00	-$218.21

MESSAGE:
Thank you for your payment!

Please Pay This
AMOUNT >>>> -$218.21

** PAYMENT DUE UPON RECEIPT *THANK YOU **
ENCOUNTER INVOICE
Printed by tackar (450) on 2/21/2022 9:21:08 AM

!!! COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 06/29/21

United Healthcare Access
PO Box 740372
Atlanta, GA 30374-0372

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 168900936

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Perez Jennifer	03 12 1964 M [ ] F [X]	Perez Jennifer
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
9100 N Lonesome Dr	Self [X] Spouse [ ] Child [ ] Other [ ]	9100 N Lonesome Dr
CITY: Muncie / STATE: IN	8. RESERVED FOR NUCC USE	CITY: Muncie / STATE: IN
ZIP CODE: 47302-9025 / TELEPHONE (Include Area Code): 617)901 7421		ZIP CODE: 47302-9025 / TELEPHONE (Include Area Code): (617) 901 7421

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
		168900936
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 12 64 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 Healthcare Access
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature On File DATE: 02/21/2022

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	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
05 01 2020 QUAL. 431		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
DN No Physician	1174539076	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

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

A. M25611 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 (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 06232021	06232021	24		23472	AS RT	A	2,641 00	1		NPI	363A00000X 1811029572
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
351709418	[X]	000101715050	X YES [ ] NO	$ 2,641 00	$	2641 00

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.)
Waterman PA, Jennifer J
02/21/2022
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ASC CIO Muncie
3600 West Bethel Ave
Muncie IN 47304-5407
a. 1447260575 b.

33. BILLING PROVIDER INFO & PH #
Central Indiana Orthopedics, PC
3600 West Bethel Avenue
Muncie IN 47304-5407
(765) 284-7738
a. 1063422137 b. 193200000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Explanation of Benefits

UMR USNAS
PO BOX 30526
SALT LAKE CITY, UT 841300526

CENTRAL INDIANA ORTHOPEDICS
3600 W BETHEL AVE
MUNCIE, IN 47304

Check/EFT #: 702359754
Check Date: 11/26/2021
Check Amt: 0.00
NPI Provider#: 1063422137

Patient: PEREZ, JENNIFER
Insured: PEREZ, JENNIFER
HIN: 685000033822
Patient Control Number: 000101715050
ICN#: 21185105216
Status: Primary

Dates of Service	Units	CPT4/Mods	Billed	CoIns	Allwd	Deduct	Paid	Adj	Adj Cd
06/23/2021-06/23/2021	1	23472 AS RT	2641.00	0	0	0	0	0	
Totals:			*2641.00*	*0*	*0*	*0*	*0*	*0*	

Remark Codes: N130
Reason Codes: PR96-2641

HIPAAX12 Code List Summary:
PR96 - Non-covered charge(s)

Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1715050

IF PAYING BY CREDIT CARD, FILL OUT BELOW			
Check Card Using For Payment			
☐ American Express	☐ Discover	☐ Mastercard	☐ Visa
Card Number	CVV	Amount	
Signature		Exp. Date	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	$0.00	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
06/23/21	Perez, Jennifer	Waterman PA, Jennifer	23472AS	Total Shoulder Arthroplasty	$2,641.00
11/29/21				Commercial Payment	$0.00
11/29/21				Commercial Adjustment	$0.00
12/03/21				Commercial Adjustment	-$2,641.00

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$2,641.00	$0.00	-$2,641.00	$0.00	$0.00

MESSAGE:
Thank you for your payment!

Please Pay This
AMOUNT >>>> $0.00

** PAYMENT DUE UPON RECEIPT *THANK YOU **
ENCOUNTER INVOICE
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Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1719351

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
Check Card Using For Payment		
☐ American Express ☐ Discover ☐ Mastercard ☐ Visa		
Card Number	CVV	Amount
Signature		Exp. Date

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	$0.00	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
07/06/21	Perez, Jennifer	Waterman, Scott	99024	Postoperative Follow Up	$0.00

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$0.00	$0.00	$0.00	$0.00	$0.00

MESSAGE:
Thank you for your payment!

Please Pay This
AMOUNT >>>> $0.00

** PAYMENT DUE UPON RECEIPT *THANK YOU **

ENCOUNTER INVOICE

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!!! COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 08/04/21

HEALTH INSURANCE CLAIM FORM

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

United Healthcare Global
PO Box 30526

Salt Lake City, UT 84130-0526

CARRIER

PICA

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 685000033822

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Perez Jennifer

3. PATIENT'S BIRTH DATE: 03 12 1964 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 9100 N Lonesome Dr

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

7. INSURED'S ADDRESS (No., Street): SAME

CITY: Muncie STATE: IN

8. RESERVED FOR NUCC USE: X

CITY: STATE:

ZIP CODE: 47302-9025 TELEPHONE (Include Area Code): (617)901 7421

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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 03 12 64 SEX: M [ ] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] 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: 02/21/2022

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): 05 01 2020 QUAL:

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Waterman Scott

17a.

17b. NPI 1811049083

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. M25511 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 15D0960980

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	08	03	2021	08	03	2021	11		73030	RT	1	165 00	1		NPI	1811049083
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 351709418 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 000101734854

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

28. TOTAL CHARGE: $ 165 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 165 00

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.)
Waterman MD, Scott M
02/21/2022
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Office CIO Muncie
3600 West Bethel Ave
Muncie IN 47304-5407
a. b.

33. BILLING PROVIDER INFO & PH #
Central Indiana Orthopedics, PC
3600 West Bethel Avenue
Muncie IN 47304-5407
(765) 284-7738
a. 1063422137 b. 193200000X

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Explanation of Benefits

UMR USNAS
PO BOX 30526
SALT LAKE CITY, UT 841300526

CENTRAL INDIANA ORTHOPEDICS
3600 W BETHEL AVE
MUNCIE, IN 47304

Check/EFT #: 709165331
Check Date: 12/16/2021
Check Amt: 36.60
NPI Provider#: 1063422137

Patient: PEREZ, JENNIFER
Insured: PEREZ, JENNIFER
HIN: 685000033822
Patient Control Number: 000101734854
ICN#: 21219177835
Status: Primary

Dates of Service	Units	CPT4/Mods	Billed	CoIns	Allwd	Deduct	Paid	Adj	Adj Cd
08/03/2021-08/03/2021	1	73030 RT	165.00	4.07	40.67	0	36.60	124.33	CO45
Totals:			***165.00***	***4.07***	***40.67***	***0***	***36.60***	***124.33***	

Reason Codes: CO45-124.33; PR2-4.07

HIPAAX12 Code List Summary:
CO45 - Charges exceed fee arrangement
PR2 - Coinsurance amount

Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1734854

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
Check Card Using For Payment		
☐ American Express ☐ Discover ☐ Mastercard ☐ Visa		
Card Number	CVV	Amount
Signature		Exp. Date

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	$0.00	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
08/03/21	Perez, Jennifer	Waterman, Scott	99024	Postoperative Follow Up	$0.00
08/03/21	Perez, Jennifer	Waterman, Scott	73030	X-Ray Shoulder Minimum 2 Views	$165.00
12/14/21				UHC Payment	-$36.60
12/15/21				Transfer Patient Payment	-$4.07
12/14/21				UHC Adjustment	-$124.33

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$165.00	-$40.67	-$124.33	$0.00	$0.00

MESSAGE:
Thank you for your payment!

Please Pay This AMOUNT >>>> $0.00

** PAYMENT DUE UPON RECEIPT *THANK YOU **

ENCOUNTER INVOICE

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Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1760533

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
Check Card Using For Payment		
☐ American Express ☐ Discover ☐ Mastercard ☐ Visa		
Card Number	CVV	Amount
Signature		Exp. Date

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	$0.00	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
09/16/21	Perez, Jennifer	Waterman, Scott	99024	Postoperative Follow Up	$0.00

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$0.00	$0.00	$0.00	$0.00	$0.00

MESSAGE:
Thank you for your payment!

Please Pay This AMOUNT >>>> $0.00

** PAYMENT DUE UPON RECEIPT *THANK YOU **
ENCOUNTER INVOICE
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HEALTH INSURANCE CLAIM FORM

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

United Healthcare Global
PO Box 30526

Salt Lake City, UT 84130-0526

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 685000033822

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Perez Jennifer

3. PATIENT'S BIRTH DATE (MM DD YY): 03 12 1964 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 9100 N Lonesome Dr

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

7. INSURED'S ADDRESS (No., Street): SAME

CITY: Muncie | STATE: IN

8. RESERVED FOR NUCC USE: X

CITY | STATE

ZIP CODE: 47302-9025 | TELEPHONE (Include Area Code): (617)901 7421

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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH (MM DD YY): 03 12 64 SEX: M [ ] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

PATIENT AND INSURED INFORMATION

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: 02/21/2022

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): 05 01 2020 QUAL.

15. OTHER DATE QUAL. (MM DD YY)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: No Physician

17a.

17b. NPI 1174639076

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. M6281 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 15D0960980

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 11042021	11042021	11		99213		1	144 00	1		NPI	1811049083
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 351709418 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO: 000101786568

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

28. TOTAL CHARGE: $ 144 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use: 144 00

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.)
Waterman MD, Scott M
02/21/2022
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Office CIO Muncie
3600 West Bethel Ave
Muncie IN 47304-5407
a. b.

33. BILLING PROVIDER INFO & PH #
Central Indiana Orthopedics, PC
3600 West Bethel Avenue
Muncie IN 47304-5407
(765) 284-7738
a. 1063422137 b. 193200000X

Make Checks Payable To:

Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
ENCOUNTER INVOICE 1786668

IF PAYING BY CREDIT CARD, FILL OUT BELOW			
Check Card Using For Payment			
☐ American Express	☐ Discover	☐ Mastercard	☐ Visa
Card Number	CVV	Amount	
Signature		Exp. Date	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
02/21/2022	$0.00	582796
	SHOW AMOUNT PAID HERE $	

ADDRESSEE:
Perez, Jennifer
9100 N Lonesome Dr
Muncie, IN 47302-9025
USA

REMIT TO:
Central Indiana Orthopedics
3600 West Bethel Avenue
Muncie, IN 47304-5407
USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
11/04/21	Perez, Jennifer	Waterman, Scott	99213	Established Patient Visit Expanded	$144.00

Account Number	Charges	Payments	Refunds Adjustments	Estimated Balance Due From Insurance	Balance Due From Patient
582796	$144.00	$0.00	$0.00	$144.00	$0.00

MESSAGE:
Thank you for your payment!

Please Pay This AMOUNT >>>> $0.00

** PAYMENT DUE UPON RECEIPT *THANK YOU **
ENCOUNTER INVOICE
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