

HEALTH INSURANCE CLAIM FORM

Worldwide Medical Assurance

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2813 Ex	kecutive	Park	Dr.	Center	fo
Suite#					
Aston	EI 33331	1			

(P)

APPROVED BY NATIONAL UN Page 1	IFORM CLAIM COMM . of 1 954				Suite# Weston	120 FL 33331			
1 MEDICARE MEDIC		CHAMPVA	GROUP HEALTH	PLAN FECA BLK LU (ID#)	OTHE	R 1a INSURED'S I.D. NUMB	BER	(Fo	PICA or Program in Item 1)
(Medicare#) (Medica		(Member ID#	(ID#)	-		31272			
2. PATIENT'S NAME (Last Na Frechilla-Orte	ga, Antoni	Initial) O	10 10	1962 ×	SEX F	4 INSURED'S NAME (Last Frechilla-Ort	tega, A	ame, Midd nton	le Initial) i O
5. PATIENT'S ADDRESS (No. 1643 Brickell			SeX Spo	ATIONSHIP TO IN	SURED Other	7 INSURED'S ADDRESS		pt 20	003
<mark>спу</mark> Иіаті		STATE	8. RESERVED F	OR NUCC USE		Miami			STATE FL
ZIP CODE 33129	786 253					ZIP CODE 33129			slude Area Code) 536433
9. OTHER INSURED'S NAME	(Last Name, First Name	e, Middle Initial) 1	0. IS PATIENT'S	CONDITION REL	ATED TO:	11. INSURED'S POLICY G	ROUP OR FEC	A NUMBE	R
a, OTHER INSURED'S POLIC	Y OR GROUP NUMBE	٦ .	a EMPLOYMEN	T? (Current or Prev	,	a INSURED'S DATE OF B	ІВТН 162	MX	SEX
b. RESERVED FOR NUCC US	BE	t	AUTO ACCIDE	YES X N	PLACE (State)				
c. RESERVED FOR NUCC US	Е		OTHER ACCID			c. INSURANCE PLAN NAM Worldwide Med	EORPROGRA	AM NAME	ance I TD
d. INSURANCE PLAN NAME (DR PROGRAM NAME	1	0d. CLAIM COD	ES (Designated by		d. IS THERE ANOTHER HE	EALTH BENEFI	T PLAN?	
12. PATIENT'S OR AUTHORIZ	ED PERSON'S SIGNA	FORE COMPLETING 8	ease of any medi	cal or other informat	ion necessary	YES NO 13. INSURED'S OR AUTHO payment of medical bene	PRIZED PERSO	N'S SIGN	
to process this claim. I also rebelow. SIGNATUI	RE ON FILE	rnment benefits either to		arty who accepts as		services described below	······································	FILE	
SIGNED 14. DATE OF CURRENT ILLNI 2 MM 15 2022	The state of the s	The state of the s	DATE HER DATE	MM DD	YY	SIGNED 16. DATES PATIENT UNAB MM DD	BLE TO WORK	IN CURRE	ENT OCCUPATION
12 L3 ZUZZ 17 NAME OF REFERRING PF	QUAL. 431 OVIDER OR OTHER S	QUAL 17a				FROM 18. HOSPITALIZATION DATA MM DD		то	
N Alejandro B			NP134629	1515		FROM DD	YY	TO MM	DD YY
19. ADDITIONAL CLAIM INFO	RMATION (Designated	by NUCC)				20. OUTSIDE LAB? YES X NO		\$ CHARG	ies
21, DIAGNOSIS OR NATURE			line below (24E)	ICD Ind. 0		22 RESUBMISSION CODE	ORIGINA	L REF. N	0
863.8X1A	_{B.} <u>S63.681</u>	_A		D				(C1(C1, 14)	O.
E. L.	F, L	G. L_		н. 🛌		23. PRIOR AUTHORIZATIO 220214-0034	N NUMBER		
24. A DATE(S) OF SERV From	To PLACE OF	(Explain	Unusual Circums		E DIAGNOSIS	F. DA	G. H. AYS EPSDT DB Family	l.	J. RENDERING
	DD YY SERVICE			MODIFIER	POINTER		ITS Plan QU		4195585 4195585
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				T - T			Ne	9	
25. FEDERAL TAX I D. NUMBE	R SSN EIN	26 PATIENT'S ACC	OUNT NO.	27. ACCEPT AS	1	28 TOTAL CHARGE	29. AMOUNT	PAID	30. Rsvd for NUCC Use
61642118 31. SIGNATURE OF PHYSICIA	N OR SUPPLIFE	BHS-16892 32 SERVICE FACIL	ITV I OCATION	YES L	NO	\$ 1970 \$0 33. BILLING PROVIDER INF		00 0	274262
INCLUDING DEGREES OR (I certify that the statements	CREDENTIALS	The Surger	v Cente	r at Dor	al	Badia Hand to			274263
a telly I thinkile that PA		3650 NW 82	2nd Aven	ue Suite	101	3650 NW 82nd . Doral FL 3316	Avenue		e 103 Ste
IGNATURE ON FI		a 13868218	17			a 1851560031	b.		



Worldwide Medical Assurance LTD 2813 Executive Park Dr. Center for Suite# 120 Weston FL 33331 **HEALTH INSURANCE CLAIM FORM** APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA Page	1 of 1 954	-533-6510		weston	FL 33331		PICA
MEDICARE MEDI- (Medicare#) (Medicare#)		CHAMPVA (Member ID	HEALTH PLAN	FECA OTHE BLK LUNG (ID#)	R 1a INSURED'S I.D. NUN 31272	IBER	(For Program in Item 1)
2. PATIENT'S NAME (Last N Frechilla-Ort	_{amo, First Name, Middle} ega, Antoni	Initial)	3 PATIENT'S BIRTH DA 10 196	TE SEX	4. INSURED'S NAME (LE Frechilla-O	rtega, An	ne, Middle Initial) tonio
5. PATIENT'S ADDRESS (NO 1643 Brickell	Ave Apt 20	03	6- PATIENT RELATIONS Sel Spouse	Child Other	7. INSURED'S ADDRESS		t 2003
cny Miami		STATE FL	8, RESERVED FOR NUC	CC USE	_{СІТҮ} Miami		STATE FL
ZIP CODE 33129	786)2530	the state of the s			ZIP CODE 33129		ONE (Include Area Code) 5 2536433
9. OTHER INSURED'S NAMI	E (Last Name, First Name	, Middle Initial)	10. IS PATIENT'S COND	ITION RELATED TO:	11. INSURED'S POLICY 755630	GROUP OR FECA	NUMBER
a, OTHER INSURED'S POLIC	CY OR GROUP NUMBER	3	a EMPLOYMENT? (Curi	rent or Previous)	a, INSURED'S DATE OF 10 10 11	_{ВІВТН} 962	SEX
b. RESERVED FOR NUCC L	JSE		b. AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (De	signated by NUCC)	
c. RESERVED FOR NUCC U	SE		c. OTHER ACCIDENT?	X NO	c INSURANCE PLAN NA Worldwide Me		
d INSURANCE PLAN NAME	OR PROGRAM NAME		10d, CLAIM CODES (Des	signated by NUCC)	d. IS THERE ANOTHER I		PLAN? plete items 9, 9a, and 9d.
RE 12. PATIENT'S OR AUTHORI to process this claim. I also	AD BACK OF FORM BE ZED PERSON'S SIGNAT request payment of gover	TURE I authorize the re	lease of any medical or otl	her information necessary		ORIZED PERSON	'S SIGNATURE I authorize igned physician or supplier for
below	JRE ON FILE			3 09 2022		TURE ON	FILE
14 DATE OF CURRENT ILLA 2 MM 15 2022	GUAL 431	NANCY (LMP) 15. O QUAI	THER DATE	DD YY	16. DATES PATIENT UNA MM DD FROM		CURRENT OCCUPATION MM DD YY O
17 NAME OF REFERRING P N Alejandro			NPI134629151	5	18. HOSPITALIZATION D. MM DD FROM		O CURRENT SERVICES MM DD YY
19. ADDITIONAL CLAIM INFO	DRMATION (Designated b	oy NUCC)			20 OUTSIDE LAB?	1	CHARGES
21. DIAGNOSIS OR NATURE \$63.8X1A	OF ILLNESS OR INJUR B S63.681		e line below (24E) ICI	o Ind. 0	22. RESUBMISSION CODE	ORIGINAL	REF. NO.
E. [F. L.	G		D	23, PRIOR AUTHORIZAT 220214-0034	ON NUMBER	
24. A. DATE(S) OF SERVENCE From MM DD YY MM		C D, PROCED (Explain	URES, SERVICES, OR S Unusual Circumstances) S MODIFIE	DIAGNOSIS	F.	G. H. I. DAYS EPSDT OR Family JNITS Plan QUAL	J. RENDERING PROVIDER ID. #
2 15 22 02	15 22 24	29845		АВ	3382 00	L NPI	1346291515
2 15 22 02	15 22 24	29999		АВ	4500 00	L NPI	1346291515
						NPI	
			1 1 1			NPI	4
·						NPI	
						NPI	
25. FEDERAL TAX I.D. NUMB 61642118	ER SSN EIN	26. PATIENT'S AC		CCEPT ASSIGNMENT? or govt. claims, see back) YES NO	28 TOTAL CHARGE \$ 7882 00	29. AMOUNT P. \$ 0	AID 30. Rsvd for NUCC Use
st, SIGNATURE OF PHYSICI INCLUDING DEGREES O (I certify that the statement] 은맛된 II 레마덴 리 딩요인다	R CREDENTIALS s on the reverse	The Surge	ry Center a 2nd Avenue 33166-6662	t Doral Suite 101	33. BILLING PROVIDER IT Badia Hand to 3650 NW 82nd Doral FL 331	Shoulde Ave Ste	5 2274263 er
IGNATURE ON F		a 1386821			a 1851560031	b	N.

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