



Anderson 2610 Enterprise Drive Anderson, IN 46013 Phone: 765-663-4400 Pax: 765-642-7903 St. Vincent Mercy Hospital Medical Specialty Suites 1331 South A Street Elwood, IN 46036 Phone: 765-552-4584 Flahers , 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 , Muncle 3600 West Bethel Avenue Muncle, IN 47304 Phone: 765-284-7738 Fax: 765-284-4266

Cover+ Number of Pag	ges: 27	Current Date:	2/21/2022
From: Karita	Name and the state of the state		
To: UHC			,
Fax Number: (954)) 206-0014		
Urgent	For Review	Please Reply	Please Comment
Message:			
Refund to patient is being patient refund. Claims, Ed	heid up due to 11/4/2021 no bb and encouter bills from Co	ot being processed by UHC entral Indiana Orhtopedics	. Please process claim so we can finish and CIO Surgery Center LLC
765-213-3719 765-213-37	18 FAX karlta_tackett@cioe	cnter.com	
If there are any problem Karita	lems with the transmi	ssion of this informat	tion, please contact:
Thank you.			

Please note:

This message is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this message in error, please notify us immediately by telephone, and return the original message to us via the U.S. Postal Service. Thankyou.

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Explanation of Benefits

UMR USNAS PO BOX 30526 SALT LAKE CITY, UT 941300526

Page 1.

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	Unite	CPT4/Mods	Billed	CoIns	Allwd	Deduct	Paid	Adj	Adj	Cđ
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Reason Codes: CO45-26769.64; PR1-2436.39; PR2-607.4

Reason Codes: CO45-6601.36; PR2-209.66

HIPAAX12 Code List Summary:

CO45 - Charges exceed fee arrangement

PR1 - Patient Responsibility Deductible

PR2 - Coinsurance amount

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

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

Signature

PAY THIS AMOUNT

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REMIT TO: Idel) adultation adultation adult CIO Surgery Center, LLC 3600 W Beihel 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 si	de

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

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17	7326	\$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

Page: 1 of 1



HEALTH INSURANCE CLAIM FORM

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

United Healthcare Access PO Box 740372

Atlanta, GA 30374-0372

APPROVED BY NATIONAL UNIFORM GLAIM COMMITTEE (NUCC) 02/12 PIÇA PICA ITT OTHER 1a. INSURED'S I.D. NUMBER CHAMPVA 1. MEDICARE MEDICAID TRICARE (For Program in Item 1) BEXTURE (Madjoara#) (Madicaid#) (ID#/DoD#) (Member IDH) (HOH) 168900936 2. PATIENT'S NAME (Lest Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 03 | 12 | 1964 4. INGURED'S NAME (Last Name, First Name, Middle Initial) SEX Perez Jennifer Perez Jennifer 7. INSURED'S ADDRESS (No., Street) 6. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 9100 N Lonesome Dr -9100 N Lonesome Dr Self X Spouse Child A. RESERVED FOR NUCC USE CITY STATE STATE PATIENT AND INSURED INFORMATION IN Muncle Muncie ZIP CODE TELEPHONE (include Area Code) ZIP CODE TELEPHONE (Include Area Code) (617) 901 7421 (617)901 7421 47302-9025 |47302-9025 11. INBURED'S POLICY GROUP OR FECA NUMBER 9, OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10, IS PATIENT'S CONDITION RELATED TO: 168900936 1 INSURED'S DATE OF BIRTH a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) FX b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES NÔ 6. INSURANCE PLAN NAME OR PROGRAM NAME 6. RESERVED FOR NUCC USE 6. OTHER ACCIDENT? United Healthcare Access YES X No d. INBURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 10d, CLAIM CODES (Designated by NUGC) 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 requise payment of government benefits either to myself or to the party who accepte assignment 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE Signature On File 02/21/2022 14- DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 05 01 2020 QUAL. 431 16. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION pp ΥY QUAL. FROM ΫÖ 17, NAME OF REFERRING PROVIDER OR OTHER SOURCE 176 8. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES NPI 11174539076 DN No Physician 17b. FROM TO 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES X NO YES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 22, RESUBMISSION ICD Ind. ORIGINAL REF. NO. A LZ96611 8. T8484XA Ď. 23. PRIOR AUTHORIZATION NUMBER e. l ř. G. DATE(8) OF SERVICE D. PROCEDUAES, SERVICES, OR SUPPLIES SUPPLIER INFORMATION (Explain Unusual Circumstances)
T/HCPCS | MODIFIER From PENDERING DI ACE N DIAGNOSIS (D MM CPT/HCPCS **S CHARGES** PROVIDER ID. ממ SERVICE POINTER DD 207X00000X 1811049083 05062021 05062021 11 99203 228 00 NPI NP NP 80 NP NP NPI 29. AMOUNT PAID 88N EIN 26. PATIENT'S ACCOUNT NO 26. TOTAL CHARGE 30. Bayd for NUCC Use 26. FEDERAL TAX LD. NUMBER 27. ACCEPT ASSIGNMENT? 000101687060 228 00 228 00 351709418 X YES 33 BILLING PROVIDER INFO & PH# Central Indiana Orthopedics, PC 3600 West Bethel Avenue 31. BIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION Office CIO Muncie (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 3600 West Bethel Ave Muncie IN 47304-5407 (765) 284-7738 Muncie IN 47304-5407 Waterman MD. Scott M 02/21/2022 1063422137 1063422137 193200000X SIGNED

Explanation of Payment

Payer		Check/EFT Trace	#	Payment
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TE: 8442518318				·
Technical Contact: UMR Et				
EM: UMR-EDI-IT-TEAM_DI	L@DS.UHC.COM	erstädelstädelstädendelsdelsdelsdelsdelsdelsdelsdelsdelsdels	determination and the service of	

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	MUNCIE, IN	,		,	•	• '
	47304					
Remittance Information Only						

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				Total Paid:		\$98.28		
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^{**}Provider Identifiers
1063422137 (XX) - Centers for Medicare and Medicaid Services National Provider Identifier
351709416 (TJ) - Federal Taxpayer's Identification Number

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

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

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MESSAGE:

Thank you for your payment!

Please Pay This AMOUNT >>>> -\$98,28



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

United Healthcare Global PO Box 30526

HEALTH INSURANCE CLAIM FORM

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

Salt Lake City, UT 84130-0526

PIÇA										_									PIGA
1. MEDICARE (Medicares)	MEDICAID (Medicald#)	-	AICARE A/DaD#)	Γ	CHAMPV (Momber l	A D#1 [X]	DROUP HEALTH I	PLÆN [-	喊	LUNG P	OTHE! 		. INGUREQ:					(For Progr	am in Item 1)
2. PATIENTS NAM Perez Jennif	E (Last Name, I			initial)	1 1,,,,,,,,,,		INT'S BIF			9E.		4.		NAME	(Lest Nam	e, Fire	t Name,	, Middle Inilial)	**************************************
6. PATIENT'S ADD		et)		·····	***********		ENT REL			INBURI			inguned's			Sireel)		**********	**********
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Muncie					<u> IN</u>						X	ļ							
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7302-9025 9. OTHER INSURE	D'A NAME (I ac	617)901		Initial	10 (8 0	ATIENT'S	CONDI	TION D	E ATE	3 T/3:	+-	. INSUPED	2 00/10	ov agaili		()	·····
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b. RESERVED FOI	NUCC USE					b, AUTO	ACCIDE	NT7		7	CE (State)	b. (OTHER CLA	AIM ID (etengleed)	d by N	UCC)		
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c. RESERVED FOR	NUCC USE					C. OTHE	DIODA FI		9	ماما		0.1	INSURANCE	∄ PI.AN	NAME OF	PRO	GRAM	VAME	
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	READ B	ACK OF	FORM DE	PORE	OMPLETING	i & BIQNI	NG THIS	FORM.				13.	INGURED'S		uthorize	D PE	190119	BIGNATURE	i authorize
(2. PATIENT'S OF to process this cl below.	AUTHORIZED I sim. I also reque	ei bayme ERSON	'S SIGNA	TURE I	avinoriza ina :	to etacler	any medic	any who	accepte	a assigni			services da	ecribed	l below.			ined physician	or supplier fo
Signed			*******		a		DATE	02/2	1/20	022			SIGNED,	*********	ature c		**********		
14. DATE OF CURF	RENT ILLNESS.	INJURY,	or PREG	INANCY	(LMP) 18.4 QU/	OTHER D AL.	ATE 	MM (QQ) YY	1	18.	. DATES PA MM FROM	TIENT	RNABLE 1	owo	rk in c To	UPRENT OC	CUPATION
17. NAME OF REFE			*****					ii		<u> </u>	 	18.		IZATIO	N DATES I	RELAT		CURRENT SE	PVICES
Vaterman S	cott					NPI 18	5110 4	9083				-	FROM	ים ו	D Y	Y	TO) · · •
19. ADDITIONAL CI	AIM INFORMA	TION (De	petengle	by NUC	D)		 	*************************************		******		20.	OUTGIDE I	AB?	_	*	\$ ¢	HARGES	
													YES		NO				
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apply to this bill s	ind are made a												3600 West Bethel Avenue Muncie IN 47304-5407						
illo MD, Rob 2/21/2022	ert A						T		p		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(7	65) 284	-773	8	· + '	********	******************************	******
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LIMA brotomation		- 11 - 1-1 -					I MADE				in the second		A	DDDA	317EB /3	LAP.	AAA.	LIOZ EODA	Linna /m/

Explanation of Payment

	Check/EFT Trace #	Payment
	723086646	\$403.62
	(ACH)	
SALT LAKE CITY, UT		
641300526		1/26/2022
To Contact: UMR EDI TEAM	4	
TE: 0442518318	-	,-
Technical Contact: UMR EDI TEAM		
EM: UMR-EDI-IT-TEAM_DL@DS.UHC.COM		

p		~~~~		***************************************	may y y a principal paragraph paragraph of the paragraph of the principal
Tax/NPI/Prov ID	Provider			Provider Adjustme	
01 1063422137	CENTRAL INDIANA ORTHOPEDICS	*********	Reason	Tracking	# Amaunt
TJ 351709418	3600 W BETHEL AVE		None	***************************************	**************************************
	'MUNCIE, IN '			•	•
	47304				
Remittance Information (nlv vlnt				

KT112	Provide	' ID	····	POS	ovider/Pi Fiscal Pe		otal Claima	Total PIP Claims	Total PIP ADJ	Total Charg
None Provider	Procedure	Mods	Bid/Pd		ÓS	POS		Total Charges	Allowed	Pal
	trol Number: 0001						ÉÑNIFER PER	EZ (168900936)	Fr.1 - Fr	
Pat: JENNIFER								(,		
	lent/Insurad Name: I		0033822)							
	T LILLO (190261263							\$743.00	\$228.79	\$205.9
Coverage A	mental Information A	nigunt	743.00							
1902812639	20610	RT		5/12/2021	-5/12/2021			\$263.00	\$130.60	\$117.5
	Contractual Obligat	ion:CO-45	Charge exceed					•	•	•
			allowable or co	intracted/l	egislated fe	E	*****			
			arrangement	ас Маненса	tual Obligat	Meson e	\$132,40 \$132,40			
	Patient Responsibil	Itv: PR-2	Coinsurance A		ran oniha	HWIII.	\$13.06			
		,			Responsib	Ilty:	\$13.06	*117.54		
						al Paid:		\$117,54		
1902812639	77002	land of the later			5/12/2021			\$460.00	\$98.19	\$88.3
	Contractual Obligat	ion:CO-45	Charge exceed allowable or co							•
			arrangement	. iri madami .	+M.m.m.m.n	1944	\$301.01			
			Ĺ#		tual Obligat	ion:	\$301.01			
	Patient Responsibil	ity:PR-2	Coinsurance A		*************	illia va	\$9.62			
			L.	ess Pacient	Responsib	ıncy: :al Pald:	\$9,62	\$88.37 \$88.37		
Paver Claim	Tracking #(ICN) 2:	116100916	7		101			stor: Mutually Dafin	ed	

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

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

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

IF PA	YING B	Y CREDIT CARE	, Fi	LL OUT BELOW	***************
	Che	ck Card Using F	or F	ayment	
American Exp	28910	Discover	May	□ Mastercard	VISA Visa
Card Number			CV	["	
Signature		and the second s		Exp. Date	
STATEMENT DATE	PA	Y THIS AMOUNT		ACCOUN	T NBR
02/21/2022		-\$205.91		5827	'96
		SHOW AMO PAID HERE			•

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAM		VIDER	SERVICE		TION OF SERVICE	AMOUNT
05/12/21	Perez, Jennifer	Lillo, Robert		20610	Injection Aspiration	i Major Joint/Bursa anca:Neadle/Placement	\$263.00
107/28/21					UHC Payment		. \$0.00
08/11/21					UHC Pavment		\$0.00 \$0.00
08/11/21					UHC Payment UHC Payment		00.00 00.00
108/11/24%					UHC Payment J.		
12/16/21					Transfer Patient Pr	ayment	-\$130.60 07:303-413 1114-145-413114
01/27/22		aria, or regola do reixo area area canto a mante de la compositiva de la compositiva de la compositiva de la c La follocativo rei do reixo area a mante de la compositiva de la compositiva de la compositiva de la compositi	O CONTRACTO DE LA CONTRACTO DE LA CONTRACTO DE LA CONTRACTO DE LA CONTRACTO DE LA CONTRACTO DE LA CONTRACTO D La contracto de la contracto d		UHC Payment		-\$117.54
07/28/21					UHC Adjustment		\$0.00
07/2 8/ 24 08/11/21		Angeria di Kampangan (Ka			ulilGrån(ustment) UHC Adjustment		10.00 50.00
108/11/243					UHO Adiusiment :		
08/11/21 08/44/24N					UHC Adjustment		\$0. 00 0.000
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Accou	nt Number	Charges	Paymen	te l	Refunds	Estimated Balance Due	Balance Due
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	32796	\$743.00	-\$434.7				-\$205,91

MESSAGE:

Thank you for your payment!

Please Pay This AMOUNT >>>> -\$205.91



HEALTH INSURANCE CLAIM FORM

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

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

United Healthcare Access PO Box 740372

Atlanta GA 30374-0372

PICA								PICA
1. MEDICARE MEDICAID (Medicare#) (Medicaid#)	TRICARE (ID#/OoD#)	V9MAHQ N sedmeM)		PLAN () FER WING	OJHER (ID#)	18. INSURED'S I.D. NUMBER 168900936	* (601,610	gram in item 1)
2. PATIENT'S NAME (Last Name, I	L	ابدبيبا	8. PATIENT'S BIF	ATH QATE 6	EX	4, INSURED'S NAME (Lact Nam	e, First Name, Middle Init	lal)
Perez Jennifer		·	03 12	1964 м□	F X	Perez Jennifer		
6. PATIENT'S ADDRESS (No., Sire	101)		6. PATIENT REL	ATIONSHIP TO INSU	RED	7. INSURED'S ADDRESS (No.,		
9100 N Lonesome Dr			Self X Spor	uae Child	Other	9100 N Lonesome I	Or .	
CITY		STATE	e. RESERVED FO	or nücc üse		OITY		STATE
Muncie ZIP CODE	TELEPHONE (Inaly	IN				Muncie	TELEPHONE (Include	IN Area Cortes
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17302-9025 9. OTHER INSURED'S NAME (Les	(617)901		IO IS PATIENT'S	CONDITION RELAT	En To	47302-9025 11, INSURED'S POLICY GROUP		1 7421
e. Offich insolves a revise (cas	rivanio, riigrivanio	, Middle millery	IO. IST ATENTO	CONDITION HUGHI	LU 101	168900936		
B. OTHER INSURED'S POLICY OF	A GROUP NUMBER	 	A, EMPLOYMEN'	T7 (Current or Previou	I #)	a INSUREDIS DATE OF BIRTH	8	EX
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, RESERVED FOR NUCC USE	*****************	······································	b. AUTO ACCIDE	! !! !NIT'9	ACE (State)	b. OTHER CLAIM ID (Designate	d by NUCC)	
				YES X NO	L			
O. RESERVED FOR NUCC USE			6. OTHER ACCID			c. INSURANCE PLAN NAME OF	PROGRAM NAME	
				AE6 X NO		United Healthcare A		
d, INSURANCE PLAN NAME OR P	MOGRAM NAME		10d. CLAIM COD	E9 (Deelgnaled by Ni	100)	d. 18 THERE ANOTHER HEALT		
***************************************	126 22 22 2				~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	YES X NO	// yee, complete items 9,	
PATIENT'S OR AUTHORIZED I to process this cisim. I also reque	PERSON'S SIGNAT		release of any medic	cal or other information		13. INSURED'S OR AUTHORIZE payment of medical benefits services described below.		
_{signeo} Signature On I	File		DATE _	02/21/2022		BIGNED SIGNATUI	RE ON FILE	
A DATE OF CURRENT ILLNESS,	INJURY, or PHEGI	YANCY (LMP) 18.	OTHER DATE	MM i DD i	ΥΥ	16. DATES PATIENT UNABLE T	9 WORK IN CURRENT	2CCUPATION
05 01 2020 au	u.: 431	QU	AL			FROM	TQ	i
7. NAME OF REFERRING PROVI			1 1	to the state of the same of th		18. HOSPITALIZATION DATES		SERVICES DD YY
N Waterman Scot			. NPI 181104	19083	·····	FROM	TO i	<u></u>
9. ADDITIONAL CLAIM INFORMA	TION (Designated t	by NUCC)				20. OUTSIDE LAST	CHARGES	
21. DIAGNOSIS OR NATURE OF II	I NESS OD IN ILIO	V Balata A.I In garv	ee line helour (24F)	, , , , , , , , , , , , , , , , , , ,	***************************************			****
,	₅ Z96611		W19011	CD Ind.		22, RESUBMISSION CODE	ORIGINAL REF. NO.	
			VITOUTT	O. L		23, PRIOR AUTHORIZATION N	JMBER	
E. Landerstein	f J	G.L. K.L.	**************************************	H. L	***************************************	'		
24. A. DATE(S) OF SERVICE	1 197	C. D. PROCE	ounes, aenvice	9, OR SUPPLIES	E	F. Q	H. I.	J.
From To MM DD YY MM DD			in Unusual Circums CS 1	signices) MODIFIER	DIAGNOSIS POINTER	F. Q DAYS OR \$ CHARGES UNITS	Famey IU. Plan QUAL. PI	RENDERING ROVIDER ID. #
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	<u> </u>					j [NPI	
5. FEDERAL TAX I.O. NUMBER	SSN EIN	26. PATIENT'S A		27. ACCEPT ASS			AMOUNT PAID 90). Playd for NUCC Us
51709418		000101697			NO	s 202 00 s		202 00
11. SIGNATURE OF PHYSICIAN O INCLUDING DEGREES OR CRI	EDENTIAL6		CILITY LOCATION CIO Muncie			33. BILLING PROVIDER INFO & Central Indiana Orth	PH# (lopedics: PC	
(I carlify that the statements on t apply to this bill and are made a	he reverse	3600 V	Vest Bethel	Ave		3600 West Bethel A	venue	
Vaterman MD, Scott I		Muncie	IN 47304-	5407		Muncie IN 47304-5 (765) 284-7738	407	
2/21/2022		8 400045	inan- ib.	A 111	·~**		402000000	7 17
BIGNED	DATE	105342	2137	, ,	1 1 1	° 1063422137 °	193200000X	بسيرت بيسرداني

Explanation of Payment

Payer	aki e di espesi kalanda i espeken pengahijih espeki api nahiya ada	Check/EFT Trace #		Payment
UMR USNAS	······································	723066646	Andrew Company of the	\$403.62
PO BOX 30526		(ACH)		
SALT LAKE CITY, UT		•		
641300526				1/28/2022
To Contact: UMR EDI TEAM		4		
TE: 8442518318		*		
Technical Contact: UMR EDI Te				
EM: UMR-EDI-IT-TEAM_DL@D	S,UHC,COM	······································	• · · · · · · · · · · · · · · · · · · ·	
		,	**************************************	

Tax/NPI/Prov ID	Provider		Provider Adjustments	
01 1063422137	CENTRAL INDIANA ORTHOPEDICS	Reason	Tracking #	Amount
TJ 351709418	3600 W BETHEL AVE	None		··· ······
'	MUNCIE, IN	•	•	•
	47304			
Remittance Information	Only			
	_	- 		
		manufalan / m/sc		1

P	rovider Procedure Mode	Bld/Pd	DOS	POS	•	Total Charges	Allowed	Pale
	atient Control Number: 00010169711				NIFER PEREZ	(685000033822)	4-10-10-10-10-10-10-10-10-10-10-10-10-10-	
	at: JENNIFER PEREZ	-					•	
	end: SCOTT WATERMAN (1811049083)					\$202.00	\$110.48	\$99.4
Ç	laim Supplemental Information Amount							
-5	Coverage Amount	202.00	78 W 78 8 W 7 W W 78	#:##:#:#:#:#:#:#:#:#:#:#:#:#:#				
14	811049083 99214		/25/2021-5/25/2			\$202.00	\$110.48	\$99.4
	Contractual Obligation: CO-45		: fee schedule/ma itracted/legislated					
		arrangement	iri acten) ie Biziatei	1 166	\$91,52			
			s Contractual Obl	antion:	\$91.52	\$110,48		
	Patient Responsibility: PR-2	Coinsurance Am		- AND THE	\$11.05	********		
	•	Les	s Patient Respon	sibility;	\$11.05	699,43		
				Total Paid:		\$99,43		

^{**}Provider Identifiers
1063422137 (XX) - Centers for Medicare and Medicald Services National Provider Identifier
351709416 (TJ) - Federal Taxpayer's Identification Number

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

IF PAY	ING BY CREDIT C	ARD, FILI	LOUT BELOW	
	Check Card Usi	ng For Pa	yment	
American Exp	ress Dieco	over Part	Mastercard	VSA Visa
Card Number	······································	¢W	Amount	······································
Signature		,	Exp. Date	
STATEMENT DATE	PAY THIS AMOU	INT	ACCOUN	TNBR
02/21/2022	-\$99.43		5827	96
1	SHÖW. PAID HI	AMOUNT Ere \$		

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

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DATE	PATIENT			VIDER	SERVICE		PTION OF SERVICE	AMOUNT
05/25/21	Perez, Jennifei	rancarandera	Waterman,∶ Baselaiduwa	Scott	99214	Established Patier	nt Visit Detailed Ient	\$202.00
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MESSAGE:

Thank you for your paymentl

Please Pay This AMOUNT >>> -\$99.43



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

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Explanation of Benefits

UMR USNAS PO BOX 30526 SALT LAKE CITY, UT 041300526

Page 1

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 Co	oIns Allwd	Deduct	Paid	Adj Adj Cd
06/23/2021-06/23/2021 1	23472 22 RT	13204.00	265.02 2650.11	9 0	2385.16	10553.820045
Totals:		13204.00	265.022650.	18 0	2385.16	10553.82
Reason Codes: CO45-10553.82;	PR2-265.02					<u> </u>

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

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

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

, IF PAY	ING BY CREDIT C	ARD, FILL	OUT BELOW	······································
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02/21/2022	-\$218.21		5827	'9 8
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REMIT TO: Ideal Industrial Industrial Industrial Central Indiana Orthopedics 3600 West Bethel Avenue Muncie, IN 47304-5407 USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

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DATE	PATIENT NAME	PROVIDER	SERVICE	I	TION OF SERVICE	AMOUNT
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58	2796 \$13	,204.00 -\$2,8	368.39	\$10,553.82	\$0.00	-\$218.21

MESSAGE:

Thank you for your payment!

Please Pay This AMOUNT >>> -\$218.21



III COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 06/29/21 ★

United Healthcare Access PO Box 740372

HEALTH INSURANCE CLAIM FORM

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

Atlanta, GA 30374-0372

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2. PATIENT'S NAME (Last Name, Perez Jennifer	' اسسا		Initial)		[/ ['8 BIRTH 0/ 12 196		SEX		4. INSURED'S NAME		ė, Firal	l Name,	Middle initial)	+ ************************************
6. PATIENT'S ADDRESS (No., Str						RELATIONS		FX	Щ	Perez Jennife 7. INSURED'S ADDRE		Zirool\			
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Explanation of Benefits

UMR USNAS PO BOX 30526 SALT LAKE CITY, UT 841300526

Page 1.

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	Ö	0	0	Q	
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HIPAAX12 Code List Summary: PR96 - Non-covered charge(s)

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

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STATEMENT DATE	PAY THIS AMOUNT		ACCOUNT NBR
02/21/2022	\$0.00		582796
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REMIT TO: Idullar Indiana Orthopedics 3600 West Bethel Avenue Muncle, IN 47304-5407 USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

									
DATE	PATIENT I			VIDER	SERVICE		PTION OF SERVI		AMOUNT
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MESSAGE:

Thank you for your payment!

Please Pay This AMOUNT >>>> \$0.00

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

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

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

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MESSAGE:

Thank you for your payment)

Please Pay This AMOUNT >>>> \$0.00



HEALTH INSURANCE CLAIM FORM

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

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

United Healthcare Global PO Box 30526

Salt Lake City, UT 84130-0526

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Explanation of Benefits

UMR USNAS PO BOX 30526 SALT LAKE CITY, UT 841300526

Page 1

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	Deduot	Paid	Adj Adj Cd
08/03/2021~08/03/2021 1	73030 RT	165.00	4.07	40.67	O	36.60	124.33 CO45
Totals:		165.00	4.07	40.67	o	36.60	124.33
Reason Codes: CO45-124.33; PE	R2-4.07	······································	·····				

HIPAAX12 Code List Summary:

CO45 - Charges exceed fee arrangement

PR2 - Coinsurance amount

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

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE		TION OF SERVICE	AMOUNT
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MESSAGE:

Thank you for your payment!

Please Pay This AMOUNT >>>> \$0.00

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

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

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REMIT TO: Idealizabilidade Indialidade III. Central Indiana Orthopedics 3600 West Bethel Avenue Muncle, IN 47304-5407 USA

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

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MESSAGE: Thank you for your payment! Please Pay This AMOUNT >>>> \$0.00



HEALTH INSURANCE CLAIM FORM

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

III COPY OF ARCHIVED ELECTRONIC CLAIM PROCESSED ON 11/05/21

United Healthcare Global PO Box 30526

Salt Lake City, UT 84130-0526

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