Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

Olivia Ivory
Financial Manager
Montefiore Medical Center
Phone: (718) 920-2586
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Email: oivory@montefiore.org

FAX

To: WWS **From: Olivia Ivory**

Fax: 954-206-0014 **Pages: 11 (including cover sheet)**

Phone: 786-485-7447 **Date: 02/22/2022**

MEMO

Please see claims for patient Juan Ferrua Member ID #000966282.

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

3a PAT. CNTL # HB160500704502 | TYPE OF BILL
b. MED. REC. # 03628902 | 131

5 FED. TAX NO. 131740114 | 6 STATEMENT COVERS PERIOD FROM 072121 THROUGH 072121 | 7

PATIENT NAME a FERRUA JUAN | 9 PATIENT ADDRESS a BRISTOL PLAZA 210 E. 65TH ST
b NEW YORK c NY d 10065 e

10 BIRTHDATE 11301964 | 11 SEX M | 12 DATE | ADMISSION 13 HR 07212111 | 14 TYPE 3 | 15 SRC 2 | 16 DHR | 17 STAT 01 | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT 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 WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331
718-920-2582

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a
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
0300	LAB	36415	072121	1	9800	000	
0301	LAB/CHEMISTRY	80048	072121	1	17100	000	
0301	LAB/CHEMISTRY	80061	072121	1	29000	000	
0301	LAB/CHEMISTRY	84153	072121	1	19100	000	
0301	LAB/CHEMISTRY	84154	072121	1	19100	000	
0301	LAB/CHEMISTRY	84402	072121	1	58700	000	
0301	LAB/CHEMISTRY	84403	072121	1	57000	000	
0301	LAB/CHEMISTRY	84443	072121	1	34000	000	
0305	LAB/HEMATOLOGY	85025	072121	1	10100	000	
0001	PAGE 1 OF 1	CREATION DATE	022222	TOTALS	253900	000	

50 PAYER NAME WWS | 51 HEALTH PLAN ID 98999 | 52 REL INFO Y | 53 ASG BEN Y | 54 PRIOR PAYMENTS 000 | 55 EST. AMOUNT DUE 165035 | 56 NPI 1952476988 | 57 OTHER PRV ID 131740114

58 INSURED'S NAME FERRUA, JUAN | 59 P REL 18 | 60 INSURED'S UNIQUE ID 000966282 | 61 GROUP NAME INTERNATIONAL | 62 INSURANCE GROUP NO. 755630

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

66 DX R9720 | R9431 | E7801 | I10 | I2510 | 0 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

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

80 REMARKS NYHCRA INDIGENT %: 0 | 81CC B3282N00000X
a
b
c
d

76 ATTENDING NPI 1740394618 QUAL | LAST MARIA | FIRST PEDRO P
77 OPERATING NPI QUAL | LAST FIRST
78 OTHER NPI QUAL | LAST FIRST
79 OTHER NPI QUAL | LAST FIRST

UB-04 CMS-1450 APPROVED OMB-0938-0997 NUBC OT LIC3810506 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA | 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): 03628902
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FERRUA, JUAN	3. PATIENT'S BIRTH DATE: MM 11 DD 30 YY 1964 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): BRISTOL PLAZA 210 E. 65TH ST	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): BRISTOL PLAZA, 210 E. 65TH ST	
CITY: NEW YORK STATE: NY	8. RESERVED FOR NUCC USE
CITY: NEW YORK STATE: NY	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (646) 531-6542	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (646) 531-6542	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: MM 11 DD 30 YY 1964 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: INTERNATIONAL-INTERNATIONAL	
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: 07 21 2021	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
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	
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. R9720 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 07 21 21 07 21 21	11		99203		A	750.37	1		ZZ	2088000000X
									NPI	1740394618
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
131740114	[ ]	[X]	P1260322120	YES [X] NO [ ]	$ 750.37	$ 0.00	

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 # ( )
PEDRO P MARIA DO 07 22 2021 SIGNED DATE	MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

CARRIER

PICA | PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
OTHER X (ID#)	03628902
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FERRUA,JUAN	3. PATIENT'S BIRTH DATE: 11 30 1964 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): BRISTOL PLAZA 210 E. 65TH ST	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): BRISTOL PLAZA, 210 E. 65TH ST	
CITY: NEW YORK STATE: NY	8. RESERVED FOR NUCC USE
CITY: NEW YORK STATE: NY	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
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 11 DD 30 YY 1964 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: INTERNATIONAL-INTERNATIONAL	
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: 07 21 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
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
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 7 ORIGINAL REF. NO.
A. R9431 B. E7801 C. I10 D. I2510 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

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 07 21 21 07 21 21	11		99214		ABCD	636.77	1		ZZ NPI	207RC0000X 1669567210
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
131740114 X	P1264186180	YES X NO	$ 636.77	$ 0.00	

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 # ( )
MARIO J GARCIA MD	MMC HUTCH TOWER II	MONTEFIORE MEDICAL CENTER
	1250 WATERS PLACE	PO BOX 412514
	BRONX, NY 10461-2720	BOSTON, MA 02241-2514
08 20 2021	a. 1962704650 b.	a. 1063525152 b. ZZ282N000000X
SIGNED DATE		

HEALTH INSURANCE CLAIM FORM

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

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

CARRIER

PICA | PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) / (Medicaid#) / (ID#/DoD#) / (Member ID#) / (ID#) / (ID#) / X (ID#)	03628902
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA,JUAN	3. PATIENT'S BIRTH DATE SEX 11 30 1964 M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST	
CITY: NEW YORK — STATE: NY	8. RESERVED FOR NUCC USE
CITY: NEW YORK — STATE: NY	
ZIP CODE: 10065 — TELEPHONE (Include Area Code): (646) 531-6542	
ZIP CODE: 10065 — TELEPHONE (Include Area Code): (646) 531-6542	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER NONE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES / X NO
a. INSURED'S DATE OF BIRTH SEX MM 11 DD 30 YY 1964 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 INTERNATIONAL-INTERNATIONAL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
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 07 21 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNMARIO J GARCIA	17a. 17b. NPI 1669567210	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY 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. 0 A. R9431 B. E7801 C. I10 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE — ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

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 07 21 21 07 21 21	11		99214		ABC	636.77	1		ZZ NPI	207RC0000X 1669567210
2 07 21 21 07 21 21	11		93000		A	273.46	1		ZZ NPI	207RC0000X 1669567210
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
131740114 X	P1260734120	X YES NO	$ 910.23	$ 0.00	

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 # ( )
MARIO J GARCIA MD 07 26 2021 SIGNED DATE	MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

1a PAY CNTL # HB1605022271501 | b. MED REC. # 03628902 | TYPE OF BILL 131

5 FED. TAX NO. 131740114 | 6 STATEMENT COVERS PERIOD FROM 072621 THROUGH 072621 | 7

PATIENT NAME a FERRUA JUAN | 9 PATIENT ADDRESS a BRISTOL PLAZA 210 E. 65TH ST b NEW YORK c NY d 10065 e

10 BIRTHDATE 11301964 | 11 SEX M | 12 DATE ADMISSION 07262111 | 13 HR | 14 TYPE 3 | 15 SRC 2 | 16 DHR | 17 STAT 01 | 18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES | 29 ACDT 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

8 WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331
718-920-2582

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a
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
0614	MRI/OTHER	72195	072621	1	394800	000	

0001 PAGE 1 OF 1 CREATION DATE 022222 TOTALS 394800 000

50 PAYER NAME WWS | 51 HEALTH PLAN ID 98999 | 52 REL INFO Y | 53 ASG BEN Y | 54 PRIOR PAYMENTS 000 | 55 EST. AMOUNT DUE 256620 | 56 NPI 1952476988 | 57 OTHER PRV ID 131740114

58 INSURED'S NAME FERRUA, JUAN | 59 P REL 18 | 60 INSURED'S UNIQUE ID 000966282 | 61 GROUP NAME INTERNATIONAL | 62 INSURANCE GROUP NO. 755630

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

66 DX R9720 N400 0 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | 74 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 1720245582 QUAL 0B0025561
LAST KANMANIRAJA FIRST DEVARAJU
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS NYHCRA INDIGENT %: 9.63

81CC a B3282N00000X
b
c
d

JB-04 CMS-1450 APPROVED OMB-0938-0997 NUBC Uniform Billing Committee LIC3/810506 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

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

CARRIER

PICA ☐ PICA ☐

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 03628902

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
FERRUA, JUAN	MM 11 DD 30 YY 1964	M ☒ F ☐	SAME

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
BRISTOL PLAZA 210 E. 65TH ST	Self ☒ Spouse ☐ Child ☐ Other ☐	BRISTOL PLAZA, 210 E. 65TH ST

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
NEW YORK	NY		NEW YORK	NY

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
10065	(809) 383-9293	10065	(809) 383-9293

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	a. INSURED'S DATE OF BIRTH MM 11 DD 30 YY 1964 SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: INTERNATIONAL-INTERNATIONAL
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ 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 07 27 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNPEDRO P MARIA	17a. 17b. NPI 1740394618	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 $ CHARGES

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

A. N400 B. R9720 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 07 27 21 07 27 21	22		72195	26	AB	500.00	1		ZZ NPI	2085R0202X 1720245582
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
131740114	☐	☒	P1261302300	☒ YES ☐ NO	$ 500.00	$ 0.00	

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 # ( )
DEVARAJU KANMANIRAJA	MONTEFIORE MEDICAL CENTER	MONTEFIORE MEDICAL CENTER
	1250 WATERS PLACE	PO BOX 412514
	BRONX, NY 10461-2720	BOSTON, MA 02241-2514
SIGNED 07 29 2021 DATE	a. 1962704650 b.	a. 1063525152 b. ZZ282N00000X

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

36 PAT. CNTL #: HB1605022482O3
b. MED. REC. #: 03628902
TYPE OF BILL: 131

5 FED. TAX NO.: 131740114
6 STATEMENT COVERS PERIOD: FROM 072821 THROUGH 072821

1 PATIENT NAME: FERRUA JUAN
9 PATIENT ADDRESS: BRISTOL PLAZA 210 E. 65TH ST
b NEW YORK c NY d 10065

10 BIRTHDATE: 11301964
11 SEX: M
12 ADMISSION DATE: 07282111
13 HR
14 TYPE: 3
15 SRC: 2
16 DHR
17 STAT: 01
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE
30

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

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331
718-920-2582

39 CODE VALUE CODES AMOUNT
40 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT
a
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
0310	PATH LAB	88305	072821	6	723600	000	
0636	N463323001002ML2	J1580	072821	1	268	000	
0001	PAGE 1 OF 1	CREATION DATE	022222	TOTALS	723868	000	

50 PAYER NAME: WWS
51 HEALTH PLAN ID: 98999
52 REL. INFO: Y
53 ASG. BEN.: Y
54 PRIOR PAYMENTS: 000
55 EST. AMOUNT DUE: 470514
56 NPI: 1952476988
57 OTHER PRV ID: 131740114

58 INSURED'S NAME: FERRUA, JUAN
59 P REL: 18
60 INSURED'S UNIQUE ID: 000966282
61 GROUP NAME: INTERNATIONAL
62 INSURANCE GROUP NO.: 755630

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: R9720
67 0
68

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

74 PRINCIPAL PROCEDURE CODE / DATE
74 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

80 REMARKS: NYHCRA INDIGENT %: 9.63
81 CC a: B3282N00000X
b
c
d

76 ATTENDING NPI 1740394618 QUAL
LAST MARIA FIRST PEDRO P
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450 APPROVED OMB-0938-0997 NUBC 01 LIC3810508 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

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

CARRIER

PICA | 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): 03628902
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FERRUA,JUAN	3. PATIENT'S BIRTH DATE: MM 11 DD 30 YY 1964 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): BRISTOL PLAZA 210 E. 65TH ST	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): BRISTOL PLAZA, 210 E. 65TH ST	
CITY: NEW YORK STATE: NY	8. RESERVED FOR NUCC USE
CITY: NEW YORK STATE: NY	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
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 11 DD 30 YY 1964 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: INTERNATIONAL-INTERNATIONAL	
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: 07 28 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNPEDRO P MARIA	17a. 17b. NPI 1740394618
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. R9720 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 07 28 21 07 28 21	11		55700		A	3127.18	1		ZZ NPI	208800000X 1740394618
2 07 28 21 07 28 21	11		76872		A	1030.00	1		ZZ NPI	208800000X 1740394618
3 07 28 21 07 28 21	11		96372	59	A	243.05	1		ZZ NPI	208800000X 1740394618
N463323001002 ML2										
4 07 28 21 07 28 21	11		J1580		A	2.68	1		NPI	1740394618
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 131740114 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: P1261467800	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 4402.91	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.) PEDRO P MARIA DO 07 30 2021 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	33. BILLING PROVIDER INFO & PH # ( ) MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N000000X			

HEALTH INSURANCE CLAIM FORM

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

PICA

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

CARRIER

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): 03628902
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FERRUA, JUAN	3. PATIENT'S BIRTH DATE: MM 11 DD 30 YY 1964 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): BRISTOL PLAZA 210 E. 65TH ST	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): BRISTOL PLAZA, 210 E. 65TH ST	
CITY: NEW YORK STATE: NY	8. RESERVED FOR NUCC USE
CITY: NEW YORK STATE: NY	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
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 11 DD 30 YY 1964 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: INTERNATIONAL-INTERNATIONAL	
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: 07 28 2021	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNPEDRO P MARIA	17a. 17b. NPI 1740394618
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. R9720 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

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 07 28 21 07 28 21	22		88305	26	A	1050.00	6		ZZ NPI	207ZP0102X 1598104721
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
131740114	[ ]	[X]	P1263081790	[X] YES [ ] NO	$ 1050.00	$ 0.00	

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 # ( )
GARRISON F PEASE MD	MONTEFIORE MEDICAL CENTER	MONTEFIORE MEDICAL CENTER
	111 EAST 210TH STREET	PO BOX 412514
	BRONX, NY 10467-2401	BOSTON, MA 02241-2514
SIGNED 08 12 2021 DATE	a. 1588859870 b.	a. 1063525152 b. ZZ282N000000X

HEALTH INSURANCE CLAIM FORM

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

WWS
2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

CARRIER

PICA | PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	000966282
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FERRUA, JUAN	3. PATIENT'S BIRTH DATE: 11 30 1964 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): BRISTOL PLAZA 210 E. 65TH ST	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): BRISTOL PLAZA, 210 E. 65TH ST	
CITY: NEW YORK STATE: NY	8. RESERVED FOR NUCC USE
CITY: NEW YORK STATE: NY	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
ZIP CODE: 10065 TELEPHONE (Include Area Code): (809) 383-9293	
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 [X] NO
a. INSURED'S DATE OF BIRTH: MM 11 DD 30 YY 1964 SEX: 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: INTERNATIONAL-INTERNATIONAL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
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 16 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 MM DD YY FROM TO MM DD YY
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
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. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. R9720 B. N400 C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

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 02 16 22 02 16 22	11		99213		AB	477.54	1		ZZ NPI	208800000X 1740394618
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
131740114 [ ] [X]	P1288521890	[X] YES [ ] NO	$ 477.54	$ 0.00	

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 # ( )
PEDRO P MARIA DO 02 17 2022 SIGNED DATE	MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N000000X