HEALTH INSURANCE CLAIM FORM

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

PICA

Page 1 of 1 855-203-3520

(P)

Worldwide
2813 Executive Park Dr. Center for
Suite 120
Fort Lauderdale 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): 1101042
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Canela, Yokasta	3. PATIENT'S BIRTH DATE: 09 17 1973 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Canela, Yokasta	
5. PATIENT'S ADDRESS (No., Street): 3650 NW 82 ave	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 3650 NW 82 ave	
CITY: Doral STATE: FL	8. RESERVED FOR NUCC USE
CITY: Doral STATE: FL	
ZIP CODE: 33166 TELEPHONE (Include Area Code): (809) 8803280	
ZIP CODE: 33166 TELEPHONE (Include Area Code): (809) 8803280	
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	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 09 17 1973 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: Worldwide	
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 10 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): 10 11 2021 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 Alejandro Badia	17a. 17b. NPI 1346291515
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. G56.01 B. M65.311 C. M25.511 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 10 11 21	10 11 21	11		99214	57	ABC	345 00	1		NPI	1346291515
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 261642118 SSN EIN [X]	26. PATIENT'S ACCOUNT NO.: BHS-C15985	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 345 00	29. AMOUNT PAID: $ 0 00	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Alejandro Badia MD 02 10 2022 SIGNED: SIGNATURE ON FILE DATE	32. SERVICE FACILITY LOCATION INFORMATION Badia Hand to Shoulder 3650 NW 82nd Avenue Suite 103 Doral FL 33166-6662 a. b.		33. BILLING PROVIDER INFO & PH #: (305) 2274263 Badia Hand to Shoulder 3650 NW 82nd Ave Ste 103 Doral FL 33166-6662 a. 1851560031 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Claim Status

(P)

HEALTH INSURANCE CLAIM FORM

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

Page 1 of 1 855-203-3520

Worldwide
2813 Executive Park Dr. Center for
Suite 120
Fort Lauderdale 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#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): WG709807623

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX M	SEX F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Bisono, Rafael	10 11 1959	X		Bisono, Rafael

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
3650 NW 82 Ave	Self X Spouse Child Other	3650 NW 82 Ave

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Doral	FL		Doral	FL

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
33166-6662	(941) 5653635	33166-6662	(941) 5653635

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
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: 10 11 1959 SEX M X / 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: Worldwide
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: 01 17 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
11 22 2021	431		

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
DN Alejandro Badia		1346291515	

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. M70.21 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE	ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 2111220003

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 11 22 21	11 22 21	11		99203	25	A	360 00	1		NPI	1104195585
2 11 22 21	11 22 21	11		73070	RT	A	148 00	1		NPI	1104195585
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
261642118	X	BHS-C16332	X YES / NO	$ 508 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 # (305) 2274263
Kate I Macia PA 01 17 2022 SIGNATURE ON FILE SIGNED DATE	Badia Hand to Shoulder 3650 NW 82nd Avenue Suite 103 Doral FL 33166-6662 a. b.	Badia Hand to Shoulder 3650 NW 82nd Avenue Suite 103 Ste Doral FL 33166-6662 a. 1851560031 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION