Hospital for Special Surgery Fax Cover Sheet

To: Seguros Worldwide To Fax: 954-206-0014

From: Liz Cobena, HSS NPI 1598703019

Phone: 917-260-3033 Fax: 917-260-4933

Date/Time: Friday, February 25, 2022

Pages: 07

Comments:

Re: Jose Francisco Alvarez Valdez, ID: 685000798562, dob: 11/23/1957

Dear Team,
Please find a summary of charges along with the open claims and advise if you need anything on our side to provide payment.

With best regards,
Liz

Confidentiality Notice

This message is intended only for the use of the individuals or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure. If the reader of this message is not the intended recipient or any 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 communication in error, please call the number listed above immediately and mail the original faxed message, to the attention of the sender, at the following address: Hospital for Special Surgery, 535 East 70th Street, New York, NY, 10021.

HOSPITAL FOR SPECIAL SURGERY

Patient: Alvarez Valdez, Francisco Jose Ju
Medical Record #: 981235

Insurance Information:
(1) UnitedHealth Care Global, Pol# 685000798562, Grp# 798562

Explanation of Benefits

Services Provided				*Insurance Responsibility*			*Patient Responsibility*						
Provider	**Description**	**Visit Date**	**Charges**	**Insurance Allowance**	**Insurance Payments**	**Insurance Balance**	**Deductible**	**Co-Ins**	**NYS Surcharge**	**Other**	**Patient Payment**	**Patient Balance**	**TOTAL BALANCE**
Hospital													
HSS	X-rays	03-Aug-21	$880.40	($284.40)	($332.00)	$0.00	$264.00	$0.00	$0.00	$0.00	$0.00	$264.00	$264.00
HSS	MRI	04-Aug-21	$3,733.00	($1,997.00)	$0.00	$0.00	$1,736.00	$0.00	$0.00	($1.00)	$0.00	$1,735.00	$1,735.00
HSS	COVID screening	27-Sep-21	$242.00	$0.00	($242.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HSS	Labs	30-Sep-21	$455.00	($56.00)	($399.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HSS	Ambulatory Surgery Fee (e.g., OR, supplies, implants, etc.)	30-Sep-21	$19,295.00	$0.00	$0.00	$19,295.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$19,295.00
Subtotal for Hospital:			$24,605.40	($2,337.40)	($973.00)	$19,295.00	$2,000.00	$0.00	$0.00	($1.00)	$0.00	$1,999.00	$21,294.00
Professional													
East River Medical Assoc PC		30-Sep-21	$3,410.00	$0.00	$0.00	$3,410.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,410.00
Fealy, Stephen MD	To be sent separately		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HSS Pathologists		30-Sep-21	$194.00	$0.00	$0.00	$194.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$194.00
HSS Radiologists		04-Aug-21	$379.00	$0.00	$0.00	$379.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$379.00
HSS Radiologists		03-Sep-21	$100.00	$0.00	$0.00	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100.00
Subtotal for Professional:			$4,083.00	$0.00	$0.00	$4,083.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,083.00
Surgeon													
Gonzalez DellaValle, Alejandro MD	To be sent separately		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Subtotal for Surgeon:			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Grand Total:			**$28,688.40**	**($2,337.40)**	**($973.00)**	**$23,378.00**	**$2,000.00**	**$0.00**	**$0.00**	**($1.00)**	**$0.00**	**$1,999.00**	**$25,377.00**

HSS ASC OF MANHATTAN LLC 1233 2ND AVENUE NEW YORK NY 100656705 2126061784	HSS ASC OF MANHATTAN LLC PO BOX 3700 NEW YORK NY100083700	5 PAT CNTL #: 50021264024404 6 MED REC #: 981235 0831 7 FED. TAX NO. 471353602 8 STATEMENT COVERS PERIOD FROM 093021 THROUGH 093021

9 PATIENT NAME	10 PATIENT ADDRESS			
ALVAREZ VALDEZ FRANCISCO J	505 WEST 47TH STREET APT 4GS	NEW YORK	NY	10036

11 BIRTHDATE	12 SEX	13 DATE	14 TYPE	15 SRC	16 DHR	17 STAT	18 CONDITION CODES	19
11231957	M		3	2		01		

20	21 OCCURRENCE CODE	21 OCCURRENCE DATE	22 OCCURRENCE CODE	22 OCCURRENCE DATE	23	24 OCCURRENCE SPAN CODE	24 OCCURRENCE SPAN FROM	24 OCCURRENCE SPAN THROUGH	25
11	092321								

UHC GLOBAL
PO BOX 30526

SALT LAKE CITY, UT 84130

26	27 VALUE CODES CODE	27 VALUE CODES AMOUNT	28 VALUE CODES CODE	28 VALUE CODES AMOUNT	29 VALUE CODES CODE	29 VALUE CODES AMOUNT
A						
B						
C						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0278	MEDICAL/SURGICAL SUPPLIE	C1713	093021	1	260600	000	
0490	AMBULATORY SURGICAL CARE	23430LT	093021	1	820100	000	
0490	AMBULATORY SURGICAL CARE	29822LT	093021	1	820100	000	
0636	N443825010201ML100	J0131	093021	100	14300	000	
0636	N454288010301ML2	J0171	093021	20	8800	000	
0636	N400409080501UN1	J0690	093021	2	600	000	
0636	N463323016516ML1	J1100	093021	4	400	000	
0636	N463323016116ML1	J1885	093021	1	400	000	
0636	N400409230517ML2	J2250	093021	2	400	000	
0636	N423155054831ML2	J2405	093021	4	200	000	
0636	N463323026959ML29.05	J2704	093021	50	2900	000	
0636	N400338011703ML500	J7120	093021	1	700	000	
0001	PAGE 1 OF 1	CREATION DATE	022522	TOTALS	1929500	000	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL IND	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 INT	1346792165
UHC GLOBAL		Y	Y	000	1929500	OTHER PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
ALVAREZ VALDEZ, FRANCISCO	18	685000798562	COMMERCIAL OTH	

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

67 M7502 M7522 I

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
	M7502		

73 EXTERNAL CAUSE OF INJURY CODE	74 PRINCIPAL PROCEDURE CODE	DATE	75	76 ATTENDING NPI 1215951900 QUAL	
				LAST FEALY	FIRST STEPHEN
77 OTHER PROCEDURE CODE	DATE	78 OTHER PROCEDURE CODE	DATE	79 OTHER PROCEDURE CODE	DATE
				79 OPERATING NPI 1215951900 QUAL	
				LAST FEALY	FIRST STEPHEN

NYHCRA SURCHARGES NOT INCLUDED

80 REMARKS			81 CC
	a	B3261QA1903X	
	b		
	c		
	d		

82 OTHER	NPI	QUAL
LAST		FIRST
82 OTHER	NPI	QUAL
LAST		FIRST

HEALTH INSURANCE CLAIM FORM

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

UNITED HEALTHCARE GLOBAL
PO BOX 30526
SALT LAKE CITY, UT , 84130

PICA | 1 CB 7607 | 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)	685000031122
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)
ALVAREZ VALDEZ, FRANCISCO, JOSE	11 23 1957 M [X] F [ ]	ALVAREZ VALDEZ, FRANCISCO, JOSE
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
505 W 47TH ST APT 4GS		505 W 47TH ST APT 4GS
CITY: NEW YORK / STATE: NY	8. RESERVED FOR NUCC USE	CITY: NEW YORK / STATE: NY
ZIP CODE: 100362451 / TELEPHONE (Include Area Code): (809) 6833986		ZIP CODE: 100362451 / TELEPHONE (Include Area Code): (809) 6833986
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 / SEX: 11 23 1957 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: UNITED HEALTHCARE GLOBAL
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:

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: DN STEPHEN FEALY MD	17a. [ ] 17b. NPI 1215951900	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		22. RESUBMISSION CODE: ORIGINAL REF. NO.
A. M75.02 B. C. D. E. F. G. H. I. J. K. L.		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. #
7 Begin 1037 End 1200											
09 30 2021	09 30 2021	24		01630	AA	A	3410 00	11	N	NPI	1144438896
										NPI	
										NPI	
										NPI	
										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
134003705	[X]	0251033	[X] YES [ ] NO	$ 3410 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 # (844) 2684820
SIGNED: SIGNATURE ON FILE DATE: 10/02/2021	HSS ASC OF MANHATTAN, LLC 1233 2nd Ave NEW YORK NY 10065 6705	EAST RIVER MEDICAL ASSOCIATES PC 535 EAST 70TH STREET NEW YORK NY 10021 4823
	a. 1346792165 b.	a. 1932162567 b.

HEALTH INSURANCE CLAIM FORM

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

UHC GLOBAL
PO BOX 30526

SALT LAKE CITY, UT 84130

CARRIER

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): 685000798562

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ALVAREZ VALDEZ, FRANCISCO, J

3. PATIENT'S BIRTH DATE: 11 23 1957 SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 505 WEST 47TH STREET APT 4GS

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

7. INSURED'S ADDRESS (No., Street): 505 WEST 47TH STREET APT 4GS

CITY: NEW YORK STATE: NY

8. RESERVED FOR NUCC USE

CITY: NEW YORK STATE: NY

ZIP CODE: 10036 TELEPHONE (Include Area Code): (809)683-3986

ZIP CODE: 10036 TELEPHONE (Include Area Code): (809)683-3986

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 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: COMMERCIAL OT-COMMERCIAL OTH

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 25 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: DNSTEPHEN FEALY

17a.

17b. NPI 1215951900

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: 000

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

A. M66812 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 33D0712044

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 09	30	21	09	30	21	22		88304	26	A	194.00	1		NPI	1306801592
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 134357667 SSN EIN: EIN X

26. PATIENT'S ACCOUNT NO.: AC1040934001

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

28. TOTAL CHARGE: $ 194.00

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.)

THOMAS W BAUER MD

SIGNED: 02 25 2022

32. SERVICE FACILITY LOCATION INFORMATION

HOSPITAL FOR SPECIAL SURGE
535 E 70TH STREET
NEW YORK, NY 10021-4823
a 1598703019 b

33. BILLING PROVIDER INFO & PH # (866)825-8303

HSS PATHOLOGY
PO BOX 29234
NEW YORK, NY 10087-9234
a 1942423363 b

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

UHC GLOBAL
PO BOX 30526

SALT LAKE CITY, UT 84130

HEALTH INSURANCE CLAIM FORM

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

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): 685000798562

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)
ALVAREZ VALDEZ, FRANCISCO, J	11 23 1957	M X F	SAME

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
505 WEST 47TH STREET APT 4GS	Self X Spouse Child Other	505 WEST 47TH STREET APT 4GS

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)
10036	(809)683-3986		10036	(809)683-3986

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)	a. INSURED'S DATE OF BIRTH (MM DD YY) SEX
	YES X NO	M F

b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	

c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	COMMERCIAL OT-COMMERCIAL OTH

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 25 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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO
DNSTEPHEN FEALY		1215951900	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB?	$ CHARGES
	YES X NO	000

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))	ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. M19012 B. M19011 C. M25512 D. M25511 E. F. G. H. I. J. K. L.	0		

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 08 03 21 08 03 21	22		73030	26 LT	AC	50.00	1		NPI	1811903339
2 08 03 21 08 03 21	22		73030	26 RT	BD	50.00	1		NPI	1811903339
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
251917907	X	AA1040426191	X YES NO	$ 100.00	$ 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 # (866) 689-8865
ERIC M BOGNER MD	HOSPITAL FOR SPECIAL SURGE 535 E 70TH STREET NEW YORK, NY 10021-4823	HSS RADIOLOGISTS PO BOX 5058 NEW YORK, NY 10087-5058
SIGNED 02 25 2022	a 1598703019 b	a 1255777488 b

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

UHC GLOBAL
PO BOX 30526

SALT LAKE CITY, UT 84130

CARRIER

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): 685000798562

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ALVAREZ VALDEZ, FRANCISCO, J

3. PATIENT'S BIRTH DATE: 11 23 1957 SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 505 WEST 47TH STREET APT 4GS

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

7. INSURED'S ADDRESS (No., Street): 505 WEST 47TH STREET APT 4GS

CITY: NEW YORK STATE: NY

8. RESERVED FOR NUCC USE

CITY: NEW YORK STATE: NY

ZIP CODE: 10036 TELEPHONE (Include Area Code): (809)683-3986

ZIP CODE: 10036 TELEPHONE (Include Area Code): (809)683-3986

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 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: COMMERCIAL OT-COMMERCIAL OTH

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 25 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 (First) INJURY (Accident) 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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNSTEPHEN FEALY

17a.

17b. NPI 1215951900

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 04 2021 TO 08 04 2021

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO X $ CHARGES: 000

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

A. S43432A B. M7582 C. M19012 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 08 04 21	08 04 21	22		73221	26 LT	ABC	379.00	1		NPI	1629085188
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 251917907 X

26. PATIENT'S ACCOUNT NO.: AA1040579731

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

28. TOTAL CHARGE: $ 379.00

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.)

HOLLIS G POTTER MD

SIGNED 02 25 2022

32. SERVICE FACILITY LOCATION INFORMATION

HOSPITAL FOR SPECIAL SURGE
535 E 70TH STREET
NEW YORK, NY 10021-4823
a 1598703019 b

33. BILLING PROVIDER INFO & PH # (866)689-8865

HSS RADIOLOGISTS
PO BOX 5058
NEW YORK, NY 10087-5058
a 1255777488 b

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION