Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

Olivia Ivory
Financial Manager
Montefiore Medical Center
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FAX

To: WWS **From: Olivia Ivory**

Fax: 954-206-0014 **Pages: 20 (including cover sheet)**

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

MEMO

Please see claims for patient Victoria E. Acosta Saladin Member ID #000965132.

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

1 PAY CNTL # HB1106421144406 | 4 TYPE OF BILL 111
6 MED. REC. # 09022210
5 FED TAX NO. 131740114 | 6 STATEMENT COVERS PERIOD FROM 051121 THROUGH 051321 | 7

2 PATIENT NAME: ACOSTA SALADIN VICTORIA E
3a PATIENT ADDRESS: 3411 WAYNE AVE, APT 11A
b BRONX c NY d 10467

8 BIRTHDATE 08131963 | 9 SEX F | 10 DATE 05112101 | 11 ADMISSION HR 1 | 12 TYPE 4 | 13 SRC 1401 | 14 DHR C5 | 15 STAT | 16 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

50 WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER FOR INT
SUITE 120
WESTON, FL 33331
718-920-2582

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	7246	80	2		
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
0111	MED-SUR-GY/PVT	11200.00		1	1120000	000	
0121	MED-SUR-GY/2BED	10400.00		1	1040000	000	
0250	PHARMACY			156	18581	000	
0300	LAB			4	113400	000	
0301	LAB/CHEMISTRY			9	197700	000	
0302	LAB/IMMUNOLOGY			4	138400	000	
0305	LAB/HEMATOLOGY			6	96600	000	
0306	LAB/BACT-MICRO			3	66500	000	
0324	DX X-RAY/CHEST			1	35500	000	
0424	PHYS THERP/EVAL			1	53800	000	
0434	OCCUP THERP/EVAL			1	51300	000	
0444	SPEECH THERP/EVAL			1	91200	000	
0480	CARDIOLOGY			1	467000	000	
0610	MRT			2	809100	000	
0611	MRI/BRAIN			1	678400	000	
0730	EKG/ECG			1	59700	000	
0731	HOLTER MONT			2	212600	000	
0001	PAGE 1 OF 1		CREATION DATE 082421		TOTALS 5249781	000	

50 PAYER NAME: WORLDWIDE SEGUROS | 51 HEALTH PLAN ID: 98999 | 52 REL INFO: Y | 53 ASG BEN: Y | 54 PRIOR PAYMENTS: 000 | 55 EST. AMOUNT DUE: 4028735 | 56 NPI: 1952476988 | 57 OTHER PRV ID: 131740114

58 INSURED'S NAME: ACOSTA SALADIN, VICTORIA | 59 P REL: 18 | 60 INSURED'S UNIQUE ID: 000965132 | 61 GROUP NAME: WWMA | 62 INSURANCE GROUP NO.: 755630

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

66 ICD-10 I63411 YZ87891 E785 YM069 YZ20822 Y
0

67 ADMIT DX: I63411 | 70 PATIENT REASON DX | 71 PPS CODE: 066 | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE: B246ZZ4 051221
a. OTHER PROCEDURE CODE DATE: B24BZZZ 051221
b. OTHER PROCEDURE CODE DATE | c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 75

80 REMARKS: NYHCRA INDIGENT %: 9.63

81CC		
a		
b		
c		
d		

76 ATTENDING NPI 1295046092 QUAL 0B0028334 LAST CHENG FIRST NATALIE T
77 OPERATING NPI 1295046092 QUAL 0B00283347 LAST CHENG FIRST NATALIE T
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

UB-04 CMS 1450 APPROVED OMB NO. 0938-0997 QL TFP24394587 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Montefiore
THE UNIVERSITY HOSPITAL FOR ALBERT EINSTEIN COLLEGE OF MEDICINE

P.O. Box 412510
Boston, MA 02241-2510

Account #	Total Charges	Current Balance
1106421144	**$52,497.81**	**$40,287.35**

Victoria Eugenia Acosta Saladin
3411 Wayne ave, apt 11A
BRONX, NY 10467

Guarantor ID: 3893926

Visit Coverages:
International Insurance - International Patient Elector List

This is an itemization of your hospital services for:

Patient: Acosta Saladin,Victoria Eugenia Admission Date: 05/11/21
Hospital Account: 1106421144 Discharge Date: 05/13/21

Current Hospital Account Balance: 40,287.35

ACCOUNT DETAILS

Hospital Charges

Rev Code	Description	Quantity	CPT/Charge Code	Amount	Service Date
0111	HC PRIVATE	1		11,200.00	05/11/2021
0121	HC SEMI-PRIVATE	1		10,400.00	05/12/2021
0250	ACETAMINOPHEN 325 MG TAB	2		0.11	05/11/2021
0250	ASPIRIN 325 MG TAB	2		0.48	05/11/2021
0250	ASPIRIN 81 MG TBEC	1		0.03	05/12/2021
0250	ASPIRIN 81 MG TBEC	1		0.03	05/13/2021
0250	ATORVASTATIN 20 MG TAB	1		0.68	05/11/2021
0250	ATORVASTATIN 80 MG TAB	1		1.07	05/12/2021
0250	DEXAMETHASONE PER 1 MG	4		2.64	05/11/2021
0250	DEXAMETHASONE PER 1 MG	4		2.64	05/11/2021
0250	ENOXAPARIN PER 10 MG	4		12.40	05/11/2021
0250	ENOXAPARIN PER 10 MG	4		12.40	05/12/2021
0250	ENOXAPARIN PER 10 MG	4		12.40	05/13/2021
0250	GADOBUTROL PER .1 ML	1		1.07	05/11/2021
0250	GADOBUTROL PER .1 ML	75		79.53	05/11/2021
0250	LACTATED RINGERS PER 1000 ML	1		20.00	05/11/2021
0250	LEVETIRACETAM PER 10 MG	50		39.60	05/11/2021
0250	PANTOPRAZOLE 40 MG TBEC	1		0.73	05/11/2021
0300	HC BLOOD TYPING ABO	1	86900	291.00	05/11/2021
0300	HC BLOOD TYPING RH (D)	1	86901	310.00	05/11/2021
0300	HC RBC ANTIBODY SCREEN	1	86850	425.00	05/11/2021
0300	HC URINALYSIS AUTO W/O SCOPE	1	81003	108.00	05/11/2021
0301	HC ASSAY OF BETA-2 PROTEIN	1	82232	228.00	05/13/2021
0301	HC ASSAY OF MAGNESIUM	1	83735	164.00	05/11/2021
0301	HC ASSAY OF PHOSPHORUS	1	84100	104.00	05/11/2021
0301	HC ASSAY THYROID STIM HORMONE	1	84443	340.00	05/12/2021
0301	HC COMPREHEN METABOLIC PANEL	1	80053	317.00	05/11/2021

Rev Code	Description	Quantity	CPT/Charge Code	Amount	Service Date
0301	HC DRUG SCRN QUAN LEVETIRACETAM	1	80177	137.00	05/11/2021
0301	HC GLYCOSYLATED HEMOGLOBIN TEST	1	83036	226.00	05/12/2021
0301	HC LIPID PANEL	1	80061	290.00	05/12/2021
0301	HC METABOLIC PANEL TOTAL CA	1	80048	171.00	05/12/2021
0302	HC BETA-2 GLYCOPROTEIN ANTIBODY	1	86146	264.00	05/13/2021
0302	HC BETA-2 GLYCOPROTEIN ANTIBODY	1	86146	264.00	05/13/2021
0302	HC CARDIOLIPIN ANTIBODY EA IG	2	86147	856.00	05/13/2021
0305	HC COMPLETE CBC W/AUTO DIFF WBC	1	85025	101.00	05/11/2021
0305	HC COMPLETE CBC W/AUTO DIFF WBC	1	85025	101.00	05/12/2021
0305	HC PROTHROMBIN TIME FOR LAB	1	85610	110.00	05/11/2021
0305	HC RUSSELL VIPER VENOM DILUTED	1	85613	396.00	05/13/2021
0305	HC THROMBOPLASTIN TIME PART (PTT);PLASMA/WHLE BLD	1	85730	129.00	05/11/2021
0305	HC THROMBOPLASTIN TIME PART (PTT);PLASMA/WHLE BLD	1	85730	129.00	05/13/2021
0306	HC BLOOD CULTURE FOR BACTERIA	1	87040	157.00	05/11/2021
0306	HC COVID-19 LAB TEST NON-CDC HIGH THROUGHPUT TECH	1	U0004	250.00	05/11/2021
0306	HC URINE CULTURE/COLONY COUNT	1	87086	258.00	05/11/2021
0324	HC X-RAY EXAM CHEST 1 VIEW	1	71045	355.00	05/11/2021
0424	HC PT EVAL LOW COMPLEX 20 MIN	1	97161	538.00	05/12/2021
0434	HC OT EVAL LOW COMPLEX 30 MIN	1	97165	513.00	05/13/2021
0444	HC EVALUATE SWALLOWING FUNCTION	1	92610	912.00	05/13/2021
0480	HC TTE W/DOPPLER COMPLETE	1	93306	4,670.00	05/12/2021
0610	HC MR ANGIOGRAPHY HEAD W/O DYE	1	70544	4,960.00	05/11/2021
0610	HC MR ANGIOGRAPHY NECK W/O DYE	1	70547	3,131.00	05/11/2021
0611	HC MRI BRAIN STEM W/O & W/DYE	1	70553	6,784.00	05/11/2021
0730	HC ELECTROCARDIOGRAM TRACING	1	93005	597.00	05/11/2021
0731	HC ECG MONIT/REPRT UP TO 48 HRS;RECORDING	1	93225	893.00	05/13/2021
0731	HC ECG MONIT/REPRT UP TO 48 HRS;SCANNING ANALYSIS	1	93226	1,233.00	05/13/2021

Total hospital charges: **52,497.81**

Hospital Payments and Adjustments

Date	Description	Amount
08/24/21	International Insurance Adjustments	-12,210.46

Total hospital payments and adjustments: **-12,210.46**

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

a PAT CNTL # HB1106441168O2 | b MED REC # 09022210 | TYPE OF BILL 131

5 FED. TAX NO. 131740114 | 6 STATEMENT COVERS PERIOD FROM 051421 THROUGH 051421 | 7

9 PATIENT NAME a ACOSTA SALADIN VICTORIA E | 9 PATIENT ADDRESS a 3411 WAYNE AVE, APT 11A | b BRONX | c NY | d 10467 | e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
08131963	F	051421		3	1		01													

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

39 WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER FOR INT
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	86850	051421	1	42500	000	
0300	LAB	86900	051421	1	29100	000	
0300	LAB	86901	051421	1	31000	000	
0481	CARDIC CATH LAB	93312	051421	1	225168	000	
0481	CARDIC CATH LAB	93320TC	051421	1	225166	000	
0481	CARDIC CATH LAB	93325TC	051421	1	225166	000	
0636	N400409230517ML2	J2250	051421	2	172	000	
0636	N400409909422ML1	J3010	051421	1	250	000	
0637	DRUGS/SELF ADMIN		051421	1	270	000	
0001	PAGE 1 OF 1	CREATION DATE	082421	TOTALS	778792	000	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1952476988
WORLDWIDE SEGUROS	98999	Y	Y	000	597652	57 OTHER PRV ID	131740114

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
ACOSTA SALADIN, VICTORIA	18	000965132	WWMA	755630

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX										68
	I63511	I081	E785	Z87891						
	0									

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

74 PRINCIPAL PROCEDURE CODE	DATE	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

81CC	
a	B3282N00000X
b	
c	
d	

76 ATTENDING	NPI 1669567210	QUAL 0B0024210
LAST GARCIA	FIRST MARIO J	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

1a PAT. CNTL #: HB1106444683O1
b. MED. REC. #: 09022210
4 TYPE OF BILL: 131
5 FED. TAX NO: 131740114
6 STATEMENT COVERS PERIOD: FROM 051721 THROUGH 051721
7

8 PATIENT NAME: a | b ACOSTA SALADIN VICTORIA E
9 PATIENT ADDRESS: a 3411 WAYNE AVE, APT 11A | b BRONX | c NY | d 10467 | e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08131963	F	051721	14	3	2		01													

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

38 WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER FOR INT
SUITE 120
WESTON, FL 33331
718-920-2582

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 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
0300	LAB	C9803	051721	1	5700	000	
0306	LAB/BACT-MICRO	U0004	051721	1	25000	000	
0001	PAGE 1 OF 1	CREATION DATE	082421	TOTALS	30700	000	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
WORLDWIDE SEGUROS	98999	Y	Y	000	23559	1952476988	131740114

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
ACOSTA SALADIN, VICTORIA	18	000965132	WWMA	755630

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX										68
	Z03818	Z20822								
	0									

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 1669567210 QUAL 0B0024210
LAST GARCIA FIRST MARIO J
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		
b		
c		
d		

B3282N00000X

JB-04 CMS-1450 APPROVED OMB NO. 0938-0997 OJ TFP213945B7 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

3a PAT. CNTL # HB1106445U7204
b. MED. REC. # 09022210
4 TYPE OF BILL 131
5 FED. TAX NO. 131740114
6 STATEMENT COVERS PERIOD FROM 051821 THROUGH 051821

8 PATIENT NAME: ACOSTA SALADIN VICTORIA E
9 PATIENT ADDRESS: 3411 WAYNE AVE, APT 11A, BRONX NY 10467

10 BIRTHDATE: 08131963
11 SEX: F
12 ADMISSION DATE: 051821
13 HR:
14 TYPE: 3
15 SRC: 2
17 STAT: 01

38 WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER FOR INT
SUITE 120
WESTON, FL 33331
718-920-2582

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0250	PHARMACY		051821	1	776	000
0278	SUPPLY/IMPLANTS	C1764	051821	1	1938000	000
0481	CARDIC CATH LAB	33285	051821	1	2112500	000
0001	PAGE 1 OF 1	CREATION DATE	082421	TOTALS	4051276	000

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
WORLDWIDE SEGUROS	98999	Y	Y	000	3108989	1952476988

57 OTHER PRV ID: 131740114

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
ACOSTA SALADIN, VICTORIA	18	000965132	WWMA	755630

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 0: I639 Z87891

69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1073003497 QUAL 0B0030380
LAST ZHANG FIRST XIAODONG
77 OPERATING NPI 1073003497 QUAL 0B00303805
LAST ZHANG FIRST XIAODONG
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS: NYHCRA INDIGENT %: 9.63
81CC a: B3282N00000X

Montefiore
THE UNIVERSITY HOSPITAL FOR ALBERT EINSTEIN COLLEGE OF MEDICINE

P.O. Box 412510
Boston, MA 02241-2510

Account #	Total Charges	Current Balance
1106445072	**$40,512.76**	**$31,089.89**

Victoria Eugenia Acosta Saladin
3411 Wayne ave, apt 11A
BRONX, NY 10467

Guarantor ID: 3893926

Visit Coverages:
International Insurance - International Patient Elector List

This is an itemization of your hospital services for:

Patient: Acosta Saladin,Victoria Eugenia
Hospital Account: 1106445072
Admission Date: 05/18/21
Discharge Date: 05/18/21

Current Hospital Account Balance: 31,089.89

ACCOUNT DETAILS

Hospital Charges

Rev Code	Description	Quantity	CPT/Charge Code	Amount	Service Date
0250	LIDOCAINE-EPINEPHRINE 1 %-1:100,000 SOLN	1		7.76	05/18/2021
0278	MONITOR ICM REVEAL LINQ SYSTEM	1	C1764	19,380.00	05/18/2021
0481	HC CARDIOLOGY: CARDIAC CATH LAB PER 30 MIN	1		21,125.00	05/18/2021
Total hospital charges:					**40,512.76**

Hospital Payments and Adjustments

Date	Description	Amount
08/24/21	International Insurance Adjustments	-9,422.87
Total hospital payments and adjustments:		**-9,422.87**

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

a. PAT. CNTL # [illegible] | TYPE OF BILL 131
b. MED. REC. # 09022210

5 FED. TAX NO. 131740114 | 6 STATEMENT COVERS PERIOD FROM 081621 THROUGH 081621

3 PATIENT NAME: ACOSTA SALADIN VICTORIA E
9 PATIENT ADDRESS: PONCIO SABATER NO 6, TORRE RENN PISO 6 | NEW YORK | NY | 10150

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
08131963	F	08162110		3	2		01	G0		

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 WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER FOR INT
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	081621	1	9800	000	
0301	LAB/CHEMISTRY	84443	081621	1	34000	000	
0001	PAGE 1 OF 1	CREATION DATE	022222	TOTALS	43800	000	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1952476988
WORLDWIDE SEGUROS	98999	Y	Y	000	28470	57 OTHER PRV ID	131740114

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
ACOSTA SALADIN, VICTORIA	18	000965132	WWMA	755630

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX: E02 0

67 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	68

74 PRINCIPAL PROCEDURE CODE DATE	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 1669567210 QUAL 0B0024210
LAST GARCIA FIRST MARIO J
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	

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

PICA

PATIENT AND INSURED INFORMATION

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): 000965132

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE

3. PATIENT'S BIRTH DATE MM DD YY: 08 13 1963 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

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

7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

CITY: BRONX STATE: NY

8. RESERVED FOR NUCC USE

CITY: BRONX STATE: NY

ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542

ZIP CODE: 10467 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: 755630

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: 08 13 1963 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 05 11 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: DNDELROY COLEMAN

17a.

17b. NPI 1508131780

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 05 11 2021 TO 05 13 2021

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. G9389 B. 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	05	11	21	05	11	21	21		71045	26	A	65.00	1		ZZ	2085R0202X
														NPI	1184717324
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 131740114 [ ] [X]

26. PATIENT'S ACCOUNT NO.: P1251746630

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

28. TOTAL CHARGE $ 65.00

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.)

SEYMOUR SPRAYREGEN MD

SIGNED 05 17 2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MONTEFIORE MEDICAL CENTER
111 EAST 210TH STREET
BRONX, NY 10467-2401

a. 1588859870 b.

33. BILLING PROVIDER INFO & PH # ( )

MONTEFIORE MEDICAL CENTER
PO BOX 412514
BOSTON, MA 02241-2514

a. 1063525152 b. ZZ282N00000X

HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
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): 000965132	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE	3. PATIENT'S BIRTH DATE: 08 13 1963 SEX: M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME
5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A
CITY: BRONX STATE: NY	8. RESERVED FOR NUCC USE	CITY: BRONX STATE: NY
ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542		ZIP CODE: 10467 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: 755630
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY: 08 13 1963 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: 05 18 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: DNMARIO J GARCIA	17a. 17b. NPI 1669567210	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. I63511 B. 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 05 18 21 05 18 21	22		33285		A	25695.00	1		ZZ NPI	390200000X 1073003497
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 131740114 ☐ ☒	26. PATIENT'S ACCOUNT NO.: P1257072110	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE: $25695.00	29. AMOUNT PAID: $ 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.) XIAODONG ZHANG MD SIGNED 06 28 2021 DATE	32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 111 EAST 210TH STREET BRONX, NY 10467-2401 a. 1588859870 b.	33. BILLING PROVIDER INFO & PH # ( ) MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X		30. Rsvd for NUCC Use

HEALTH INSURANCE CLAIM FORM

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

PICA

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
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): 000965132	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE	3. PATIENT'S BIRTH DATE: MM 08 DD 13 YY 1963 SEX: M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME
5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A
CITY: BRONX STATE: NY	8. RESERVED FOR NUCC USE	CITY: BRONX STATE: NY
ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542		ZIP CODE: 10467 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: 755630
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH: MM 08 DD 13 YY 1963 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 05 19 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: DNMARIO J GARCIA	17a. 17b. NPI 1669567210	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. I63511 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. EFSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 05 19 21 05 19 21	11		99213		A	477.54	1		ZZ NPI	207RC0000X 1669567210
2 05 19 21 05 19 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	P1252244950	YES [X] NO [ ]	$ 751.00	$ 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 # ( )
MARIO J GARCIA MD SIGNED 05 20 2021 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

HEALTH INSURANCE CLAIM FORM

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

PICA

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
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): 000965132

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN, VICTORIA EUGE

3. PATIENT'S BIRTH DATE: 08 13 1963 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): PONCIO SABATER NO 6, TORRE R

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

7. INSURED'S ADDRESS (No., Street): PONCIO SABATER NO 6, TORRE REN

CITY: NEW YORK STATE: NY

8. RESERVED FOR NUCC USE

CITY: NEW YORK STATE: NY

ZIP CODE: 10150 TELEPHONE (Include Area Code): ( )

ZIP CODE: 10150 TELEPHONE (Include Area Code): ( )

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 [ ] NO [X]

a. INSURED'S DATE OF BIRTH: MM 08 DD 13 YY 1963 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: 05 29 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: DNENRICO CASTELLUCCI

17a.

17b. NPI: 1821354622

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: 05 18 2021 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. I63511 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 2105100021

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 05 29 21	05 29 21	21		93227		A	235.00	1		ZZ NPI	207RC0000X 1952491821
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 131740114 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: P1280764770

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

28. TOTAL CHARGE: $ 235.00

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.)

KEVIN J FERRICK MD

SIGNED 12 21 2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MONTEFIORE MEDICAL CENTER
111 EAST 210TH STREET
BRONX, NY 10467-2401

a. 1588859870 b.

33. BILLING PROVIDER INFO & PH # ( )

MONTEFIORE MEDICAL CENTER
PO BOX 412514
BOSTON, MA 02241-2514

a. 1063525152 b. ZZ282N00000X

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

CARRIER

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

PATIENT AND INSURED INFORMATION

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): 000965132

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE

3. PATIENT'S BIRTH DATE: 08 13 1963 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

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

7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

CITY: BRONX STATE: NY

8. RESERVED FOR NUCC USE

CITY: BRONX STATE: NY

ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542

ZIP CODE: 10467 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: 755630

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: 08 13 1963 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: 06 16 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: DNKEVIN J FERRICK

17a.

17b. NPI 1952491821

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. R002 B. 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 06 16 21	06 16 21	22		93298		A	245.00	1		ZZ	207RC0000X
										NPI	1952491821
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 131740114 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: P1261720670

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

28. TOTAL CHARGE: $ 245.00

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.)

KEVIN J FERRICK MD

SIGNED 08 02 2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MONTEFIORE MEDICAL CENTER
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. ZZ282N00000X

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

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2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

PICA

PATIENT AND INSURED INFORMATION

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): 000965132

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE

3. PATIENT'S BIRTH DATE: 08 13 1963 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

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

7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

CITY: BRONX STATE: NY

8. RESERVED FOR NUCC USE

CITY: BRONX STATE: NY

ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542

ZIP CODE: 10467 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: 755630

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: 08 13 1963 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 17 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: DNLUIGI DI BIASE

17a.

17b. NPI: 1891045837

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. R002 B. 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 17 21	07 17 21	22		93298		A	245.00	1		ZZ	207RC0000X
										NPI	1891045837
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 131740114 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: P1263496300

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

28. TOTAL CHARGE: $ 245.00

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.)

LUIGI DI BIASE MD

SIGNED 08 16 2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MONTEFIORE MEDICAL CENTER
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. ZZ282N00000X

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

CARRIER

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

PATIENT AND INSURED INFORMATION

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): 000965132
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE	3. PATIENT'S BIRTH DATE: 08 13 1963 SEX: M [ ] F [X]		4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME
5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A
CITY: BRONX STATE: NY	8. RESERVED FOR NUCC USE		CITY: BRONX STATE: NY
ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542			ZIP CODE: 10467 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: 755630
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: 08 13 1963 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 08 16 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. R002 B. I63511 C. M05711 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 08 16 21	08 16 21	11		99214		ABC	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]	P1264186190	[X] YES [ ] 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 SIGNED 08 20 2021 DATE	MMC MEDICAL ARTS PAVILION 3400 BAINBRIDGE AVENUE BRONX, NY 10467-2404 a. 1346435682 b.	MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X

HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
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): 000965132

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE

3. PATIENT'S BIRTH DATE: 08 13 1963 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

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

7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A

CITY: BRONX STATE: NY

8. RESERVED FOR NUCC USE

CITY: BRONX STATE: NY

ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542

ZIP CODE: 10467 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: 755630

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: MM 08 DD 13 YY 1963 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: 09 17 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: DNLUIGI DI BIASE

17a.

17b. NPI 1891045837

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 [ ] NO [X] $ CHARGES

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

R002

A. 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 09 17 21	09 17 21	22		93298		A	245.00	1		ZZ	207RC0000X
										NPI	1891045837
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 131740114 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: P1270538470

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

28. TOTAL CHARGE: $ 245.00

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.)
LUIGI DI BIASE MD
SIGNED 10 11 2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION
MONTEFIORE MEDICAL CENTER
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. ZZ282N00000X

HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
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): 000965132
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN, VICTORIA EUGE	3. PATIENT'S BIRTH DATE: 08 13 1963 SEX M ☐ F ☒		4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME
5. PATIENT'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street): 3411 WAYNE AVE, APT 11A
CITY: BRONX STATE: NY	8. RESERVED FOR NUCC USE		CITY: BRONX STATE: NY
ZIP CODE: 10467 TELEPHONE (Include Area Code): (646) 531-6542			ZIP CODE: 10467 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: 755630
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒		a. INSURED'S DATE OF BIRTH: MM DD YY 08 13 1963 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: 10 18 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: DNLUIGI DI BIASE	17a. 17b. NPI 1891045837	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. R002 B. 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 10 18 21 10 18 21	22		93298		A	245.00	1		ZZ NPI	207RC0000X 1891045837
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	☐	☒	P1275909020	☒ YES ☐ NO	$ 245.00	$ 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 # ( )
LUIGI DI BIASE MD SIGNED 11 16 2021 DATE	MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X

HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
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)		
	000965132		
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)	
ACOSTA SALADIN, VICTORIA EUGE	08 13 1963 M ☐ F ☒	SAME	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
PONCIO SABATER NO 6, TORRE R	Self ☒ Spouse ☐ Child ☐ Other ☐	PONCIO SABATER NO 6, TORRE REN	
CITY: NEW YORK STATE: NY	8. RESERVED FOR NUCC USE	CITY: NEW YORK STATE: NY	
ZIP CODE: 10150 TELEPHONE (Include Area Code): ( )		ZIP CODE: 10150 TELEPHONE (Include Area Code): ( )	
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 ☐ NO ☒	a. INSURED'S DATE OF BIRTH SEX	
		08 13 1963 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.	

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 11 18 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

PATIENT AND INSURED INFORMATION

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: DNKEVIN J FERRICK	17a. 17b. NPI 1952491821	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. R002 B. 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 11 18 21 11 18 21	22		93298		A	245.00	1		ZZ NPI	207RC0000X 1952491821
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 ☒	P1280764760	☒ YES ☐ NO	$ 245.00	$ 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 # ( )
KEVIN J FERRICK MD SIGNED 12 21 2021 DATE	MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

WORLDWIDE SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER F
SUITE 120
WESTON, FL 33331

CARRIER

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): 000965132

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ACOSTA SALADIN,VICTORIA EUGE

3. PATIENT'S BIRTH DATE: 08 13 1963 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): PONCIO SABATER NO 6, TORRE R

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

7. INSURED'S ADDRESS (No., Street): PONCIO SABATER NO 6, TORRE REN

CITY: NEW YORK STATE: NY

8. RESERVED FOR NUCC USE

CITY: NEW YORK STATE: NY

ZIP CODE: 10150 TELEPHONE (Include Area Code): ( )

ZIP CODE: 10150 TELEPHONE (Include Area Code): ( )

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 [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 08 13 1963 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: 12 19 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: DNKEVIN J FERRICK

17a.

17b. NPI: 1952491821

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. R002 B. 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 12 19 21	12 19 21	22		93298		A	245.00	1		ZZ NPI	3902000000X 1073003497
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 131740114 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: P1286150310

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

28. TOTAL CHARGE: $ 245.00

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.)

XIAODONG ZHANG MDPHD

SIGNED 02 01 2022 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MONTEFIORE MEDICAL CENTER
1250 WATERS PLACE
BRONX, NY 10461-2720

a. 1962704650 b.

33. BILLING PROVIDER INFO & PH # ( )

MONTEFIORE MEDICAL CENTER
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BOSTON, MA 02241-2514

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