



Olivia Ivory

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FAX

To: WWS

From: Olivia Ivory

Fax: 954-206-0014

Pages: 11 (including cover sheet)

Phone: 786-485-7447

Date: 02/22/2022

MEMO

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

Feb/22/2022 12:47:06 PM
MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

International Dept Montefiore 7187981671

2/11

3a PAT. CNTL # 03628902
b. MED. REC. # 131

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

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

0 BIRTHDATE 11 SEX 12 DATE OF BIRTH 13 ADMISSION 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21
11301964 M 072121 111 3 2 01 GO

7 OCCURRENCE DATE 32 OCCURRENCE DATE 33 OCCURRENCE DATE 34 OCCURRENCE DATE 35 CODE
36 CODE 37 CODE 38 CODE 39 CODE 40 CODE 41 CODE 42 CODE 43 CODE 44 CODE 45 CODE 46 CODE 47 CODE 48 CODE 49 CODE

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

43 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0300	LAB	36415	072121	1	9800	000	
0301	LAB/CHEMISTRY	80048	072121	1	17100	000	
0301	LAB/CHEMISTRY	80061	072121	1	29000	000	
0301	LAB/CHEMISTRY	84153	072121	1	19100	000	
0301	LAB/CHEMISTRY	84154	072121	1	19100	000	
0301	LAB/CHEMISTRY	84402	072121	1	58700	000	
0301	LAB/CHEMISTRY	84403	072121	1	57000	000	
0301	LAB/CHEMISTRY	84443	072121	1	34000	000	
0305	LAB/HEMATOLOGY	85025	072121	1	10100	000	

0001 PAGE 1 OF 1 CREATION DATE 022222 TOTALS 253900 000

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

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

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

36 20 R9720 R9431 E7801 I10 I2510

69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE
75
76 ATTENDING NPI 1740394618
77 OPERATING NPI
78 OTHER NPI
79 OTHER NPI

NYHCRA INDIGENT #: 0
B3282N00000X
80 REMARKS
81 CO a
b
c
d



HEALTH INSURANCE CLAIM FORM

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

WWS

 2813 EXECUTIVE PARK DRIVE
 SUITE 120
 WESTON, FL 33331

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID NUMBER (For Program in Item 1) 03628902	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA, JUAN		3. PATIENT'S BIRTH DATE MM DD YY 01 30 1964	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST	
8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER NONE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 07 21 2021		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R9720	
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. ID. J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER SSN EIN 131740114 26. PATIENT'S ACCOUNT NO. P1260322120 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 750.37 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) PEDRO P MARIA DO SIGNED 07 22 2021 DATE		32. SERVICE FACILITY LOCATION INFORMATION MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X			



HEALTH INSURANCE CLAIM FORM

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

WWS

 2813 EXECUTIVE PARK DRIVE
 SUITE 120
 WESTON, FL 33331

<input type="checkbox"/> PICA		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medical#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (IC#) OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 03628902	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA, JUAN		3. PATIENT'S BIRTH DATE MM DD YY 11 30 1964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST	
CITY NEW YORK STATE NY		CITY NEW YORK STATE NY	
ZIP CODE 10065 TELEPHONE (Include Area Code) (809) 383-9293		ZIP CODE 10065 TELEPHONE (Include Area Code) (809) 383-9293	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER NONE		a. INSURED'S DATE OF BIRTH MM DD YY 11 30 1964 SEX <input type="checkbox"/> M <input type="checkbox"/> F	
b. OTHER CLAIM ID (Designated by NUCC)		b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL-INTERNATIONAL		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
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. SIGNATURE ON FILE DATE 07 21 2021		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R9431 E7801 I10 ICD Ind. 0 I2510		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		22. RESUBMISSION 7 CODE ORIGINAL REF. NO.	
1 07 21 21 07 21 21 11 99214 ABCD 636.77 1		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER 131740114 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. P1264186180	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 636.77	
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.) MARIO J GARCIA MD		32. SERVICE FACILITY LOCATION INFORMATION MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720	
SIGNED 08 20 2021 DATE		33. BILLING PROVIDER INFO & PH # () MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514	
a. 1962704650 b.		a. 1063525152 b. ZZ282N00000X	

**HEALTH INSURANCE CLAIM FORM**

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

WWS

2813 EXECUTIVE PARK DRIVE
SUITE 120
WESTON, FL 33331

<input type="checkbox"/> PICA										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 03628902									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA, JUAN										3. PATIENT'S BIRTH DATE MM DD YY 11 30 1964 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME									
CITY NEW YORK										CITY NEW YORK									
STATE NY										STATE NY									
ZIP CODE 10065										ZIP CODE 10065									
TELEPHONE (Include Area Code) (646) 531-6542										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:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										11. INSURED'S POLICY GROUP OR FECA NUMBER NONE									
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. SIGNATURE ON FILE SIGNED DATE 07 21 2021										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE QUAL. MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNMARIO J GARCIA										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R9431 E7801 I10 ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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/HCPUS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
1 07 21 21 07 21 21 11 99214 ABC 636.77 1										ZZ 207RC0000X 1669567210									
2 07 21 21 07 21 21 11 93000 A 273.46 1										ZZ 207RC0000X 1669567210									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER 131740114										26. PATIENT'S ACCOUNT NO. P1260734120									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 910.23									
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.) MARIO J GARCIA MD 07 26 2021 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.									
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X																			

MONTEFIORE MEDICAL CENTER
111 EAST 210 STREET
BRONX NY 104672401

3a PAT. CNTRL. #	HB160502271501	4b OF BILL	131
b. MED. REC. #	03628902		
5 FED. TAX NO.	131740114	6 STATEMENT COVERS PERIOD FROM	072621
		THROUGH	072621
9 PATIENT ADDRESS	BRISTOL PLAZA 210 E. 65TH ST		
	NY	10065	

PATIENT NAME: FERRUA JUAN
PATIENT ADDRESS: NEW YORK

0 BIRTH DATE: 11301964
1 SEX: M
12 DATE: 072621
13 HR: 11
14 TYPE: 3
15 SRC: 2
16 DHR: 01

1 OCCURRENCE DATE: 01
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HEALTH INSURANCE CLAIM FORM

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

WWS

 2813 EXECUTIVE PARK DRIVE
 SUITE 120
 WESTON, FL 33331

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 03628902	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA, JUAN		3. PATIENT'S BIRTH DATE MM DD YY 11 30 1964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST	
CITY NEW YORK		CITY NEW YORK	
STATE NY		STATE NY	
ZIP CODE 10065		ZIP CODE 10065	
TELEPHONE (Include Area Code) (809) 383-9293		TELEPHONE (Include Area Code) (809) 383-9293	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER NONE		a. INSURED'S DATE OF BIRTH MM DD YY 11 30 1964 SEX <input type="checkbox"/> M <input type="checkbox"/> F	
b. OTHER CLAIM ID (Designated by NUCC)		b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL-INTERNATIONAL		c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL-INTERNATIONAL	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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.		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 DATE 07 27 2021		SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNPEDRO P MARIA		17a. 1740394618	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) N400 R9720 ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
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. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 07 27 21 07 27 21 22 72195 26 AB 500.00 1		ZZ 2085R0202X 1720245582	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER 131740114 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. P1261302300	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 500.00	
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.) DEVARAJU KANMANIRAJA		32. SERVICE FACILITY LOCATION INFORMATION MONTEFIORE MEDICAL CENTER 1250 WATERS PLACE BRONX, NY 10461-2720	
SIGNED 07 29 2021 DATE		a. 1962704650 b.	
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514		a. 1063525152 b. ZZ282N00000X	

8/11

SR PAT. CONT. #	FD180502240205	4 TYPE OF BILL	131
6. MED. REC. #	03628902		
5 FED. TAX NO.	131740114	6 STATEMENT COVERS PERIOD FROM	7 THROUGH
	131740114	072821	072821
L PLAZA 210 E. 65TH ST			
	c NY	d 10065	e

0	BIRTHDATE	1	SEX	12	DATE	ADMISSION	13	HR	14	TYPE	15	SPC	16	DHR	17	STAT	CONDITION CODES											29	ADDT	30
1	11301964	M		0	72821111				3		2				01		18	19	20	21	22	23	24	25	26	27	28		STATE	

[illegible]

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[illegible]

REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0310	PATH LAB	88305	072821	6	723600	000	
0636	N463323001002ML2	J1580	072821	1	268	000	

00001	PAGE	1	OF	1	CREATION DATE	022222	TOTALS	723868	000
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50 PAYER NAME	51 HEALTH PLAN ID	52 TEL INFO	53 FAX INFO	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	131740114
WWS	98999	Y	Y	000	470514	57	131740114
						OTHER	
						PRV ID	

58 INSURED'S NAME FERRUA, JUAN	59 P.REL 18	60 INSURED'S UNIQUE ID 000966282	61 GROUP NAME INTERNATIONAL	62 INSURANCE GROUP NO. 755630
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63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

[illegible]

69 ADMIT DX		70 PATIENT REASON DX				71 PPS CODE		72 ECI				73	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE				75		76 ATTENDING NPI		1740394618	
										QUAL			
										LAST MARIA		FIRST PEDRO P	
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE CODE		e. OTHER PROCEDURE CODE						77 OPERATING NPI		QUAL	
										LAST		FIRST	

NYHCRA INDIGENT %: 9.63		81CC	B3282N00000X	LAST	FIRST
50 REMARKS		a		78 OTHER	QUAL
		b		LAST	FIRST
		c		79 OTHER	QUAL
		d		LAST	FIRST



HEALTH INSURANCE CLAIM FORM

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

WWS

 2813 EXECUTIVE PARK DRIVE
 SUITE 120
 WESTON, FL 33331

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID NUMBER (For Program in Item 1) 03628902	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA, JUAN		3. PATIENT'S BIRTH DATE MM DD YY 01 30 1964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST CITY NEW YORK STATE NY ZIP CODE 10065 TELEPHONE (Include Area Code) (809) 383-9293		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME 7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST CITY NEW YORK STATE NY ZIP CODE 10065 TELEPHONE (Include Area Code) (809) 383-9293	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 07 28 2021		11. INSURED'S POLICY GROUP OR FECA NUMBER NONE a. INSURED'S DATE OF BIRTH MM DD YY 01 30 1964 SEX <input type="checkbox"/> M <input type="checkbox"/> F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL-INTERNATIONAL d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNPEDRO P MARIA 17a. 1740394618 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R9720 A. B. C. D. E. F. G. H. I. J. K. L.		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. EPSONI Family Plan I. ID. QUAL J. RENDERING PROVIDER ID #	
1 07 28 21 07 28 21 11 55700 A 3127.18 1		2 07 28 21 07 28 21 11 76872 A 1030.00 1	
3 07 28 21 07 28 21 11 96372 59 A 243.05 1		4 07 28 21 07 28 21 11 J1580 A 2.68 1	
5		6	
25. FEDERAL TAX I.D. NUMBER 131740114 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. P1261467800	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) PEDRO P MARIA DO SIGNED 07 30 2021 DATE		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 4402.91 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use	
32. SERVICE FACILITY LOCATION INFORMATION MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.		33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X	



HEALTH INSURANCE CLAIM FORM

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

WWS

 2813 EXECUTIVE PARK DRIVE
 SUITE 120
 WESTON, FL 33331

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)	
TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)	
GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)	
OTHER <input checked="" type="checkbox"/> (ID#)		18. INSURED'S I.D. NUMBER (For Program in Item 1) 03628902	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA, JUAN		3. PATIENT'S BIRTH DATE MM DD YY 01 30 1964	
SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST		8. RESERVED FOR NUCC USE	
CITY NEW YORK		CITY NEW YORK	
STATE NY		STATE NY	
ZIP CODE 10065		ZIP CODE 10065	
TELEPHONE (Include Area Code) (809) 383-9293		TELEPHONE (Include Area Code) (809) 383-9293	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER NONE		a. INSURED'S DATE OF BIRTH MM DD YY 01 30 1964	
b. OTHER CLAIM ID (Designated by NUCC)		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL-INTERNATIONAL		b. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
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. SIGNATURE ON FILE SIGNED DATE 07 28 2021		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNPEDRO P MARIA		17a. NPI 1740394618	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R9720		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. _____ B. _____ C. _____ D. _____		23. PRIOR AUTHORIZATION NUMBER	
E. _____ F. _____ G. _____ H. _____		F. \$ CHARGES	
I. _____ J. _____ K. _____ L. _____		G. DAYS OR UNITS	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		H. EPSOT Family Plan	
B. PLACE OF SERVICE		I. ID. QUAL	
C. EMG		J. RENDERING PROVIDER ID #	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HPCPS MODIFIER		E. DIAGNOSIS POINTER	
1 07 28 21 07 28 21 22		2 88305 26	
3 A		4 1050.00 6	
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HEALTH INSURANCE CLAIM FORM

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

WWS

 2813 EXECUTIVE PARK DRIVE
 SUITE 120
 WESTON, FL 33331

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000966282	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FERRUA, JUAN		3. PATIENT'S BIRTH DATE MM DD YY 11 30 1964 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) BRISTOL PLAZA 210 E. 65TH ST		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) BRISTOL PLAZA, 210 E. 65TH ST	
8. RESERVED FOR NUCC USE		CITY NEW YORK STATE NY	
ZIP CODE 10065 TELEPHONE (Include Area Code) (809) 383-9293		ZIP CODE 10065 TELEPHONE (Include Area Code) (809) 383-9293	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER 755630	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 02 16 2022		a. INSURED'S DATE OF BIRTH MM DD YY 11 30 1964 SEX <input type="checkbox"/> M <input type="checkbox"/> F	
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		b. OTHER CLAIM ID (Designated by NUCC)	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		c. INSURANCE PLAN NAME OR PROGRAM NAME INTERNATIONAL- INTERNATIONAL	
15. OTHER DATE MM DD YY QUAL.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R9720 N400 ICD Ind. 0		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 02 16 22 02 16 22 11 99213 AB 477.54 1		ZZ 208800000X 1740394618	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER 131740114 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. P1288521890	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 477.54	
29. AMOUNT PAID \$ 0.00		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) PEDRO P MARIA DO 02 17 2022 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION MMC HUTCH TOWER II 1250 WATERS PLACE BRONX, NY 10461-2720 a. 1962704650 b.	
33. BILLING PROVIDER INFO & PH # MONTEFIORE MEDICAL CENTER PO BOX 412514 BOSTON, MA 02241-2514 a. 1063525152 b. ZZ282N00000X			