



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 001151032	(For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH			3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976			SEX <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, CITY SANTO DOMINGO			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) CALLE PORFIRIO HERRERA #12, PI			
ZIP CODE	TELEPHONE (Include Area Code) (809) 540-1177		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO	STATE	ZIP CODE	TELEPHONE (Include Area Code) (809) 540-1177

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)		
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC		
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>		

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 04 06 2022

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 FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO		17a. <input type="checkbox"/>	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 03 28 2022 TO 03 28 2022		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)		22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. Z0000 B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>		23. PRIOR AUTHORIZATION NUMBER 10D0269502			

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS MODIFIER POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER ID. #
1 RBC SED RATE, AUTO 03 28 22	81	85652	A	46.00	1			ZZ 207ZP0105X NPI 1750301172
2 HEPATITIS B SCREEN HIGH RISK INDIV 03 28 22	81	86706	A	95.00	1			ZZ 207ZP0105X NPI 1750301172
3 HEPATITIS B SCREEN HIGH RISK INDIV 03 28 22	81	87340	A	85.00	1			ZZ 207ZP0105X NPI 1750301172
4 GLYCOSYLATED HEMOGLOBIN TEST 03 28 22	81	83036	A	111.00	1			ZZ 207ZP0105X NPI 1750301172
5 ASSAY OF FERRITIN 03 28 22	81	82728	A	154.00	1			ZZ 207ZP0105X NPI 1750301172
6 ASSAY OF VIT D, CALCIFEDIOL W FRACTIONS, IF PERFORMED 03 28 22	81	82306	A	327.00	1			ZZ 207ZP0105X NPI 1750301172

25. FEDERAL TAX I.D. NUMBER 593337028	SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. MP1595578710	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 818.00	29. AMOUNT PAID \$ 0.00	30. Rsvd for NUCC Use
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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.)

MAYO CLINIC JACKSONVILLE, FL 32224-1865
JACKSONVILLE, MN 55480-1508

SIGNED 04 06 2022

a. b. a. 1285621631 b. ZZ291U00000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

06042218312951-000062-002-0253



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WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

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1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) BLK LUNG (ID#) X (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1177862							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ METZ, JULIO, C					3. PATIENT'S BIRTH DATE MM DD YY SEX 10 22 1971 M F					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME							
5. PATIENT'S ADDRESS (No., Street) PORFIRIO HERRERA NO. 12 PIAN					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) PORFIRIO HERRERA NO. 12 PIANTI							
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE		CITY SANTO DOMINGO		STATE									
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177				ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER							
					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>							
					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC							
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.										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
SIGNED SIGNATURE ON FILE										DATE 04 06 2022							
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 FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJUAN C CARDENAS ROSALES					17a. 17b. NPI 1417211558					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 30 2022 TO 03 30 2022							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. Z0000 B. L. C. L. D. L. E. L. F. L. G. L. H. L. I. L. J. L. K. L. L. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 1 03 30 22 2 11					B. PLACE OF SERVICE EMG 2 VIEWS 71046					C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES <input type="checkbox"/> NO				E. DIAGNOSIS POINTER A F. \$ CHARGES 217.00 G. DAYS OR UNITS 1 H. EPSDT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. # ZZ 2085R0202X NPI 1578524716			
25. FEDERAL TAX I.D. NUMBER 593337028					SSN EIN <input type="checkbox"/> X					26. PATIENT'S ACCOUNT NO. MP1595578750				28. TOTAL CHARGE \$ 217.00 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.) RICHARD D WHITE M.D. SIGNED 04 06 2022										32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865				33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508 a. 1790772317 b. ZZ261QM1300X			



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5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,						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) CALLE PORFIRIO HERRERA #12, PI										
CITY SANTO DOMINGO			STATE			CITY SANTO DOMINGO			STATE										
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												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							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						11. INSURED'S POLICY GROUP OR FECA NUMBER							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>							
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.												b. OTHER CLAIM ID (Designated by NUCC)							
SIGNED SIGNATURE ON FILE												c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC							
DATE 04 06 2022												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.												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. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO												17a. 17b. NPI 1053394452				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 28 2022 TO 03 28 2022			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.							
A. Z0000 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER ID. #						
1 36415 INSERTION OF NEEDLE INTO VEIN FOR COLLECTION OF BLOOD S 03 28 22		11		36415		A		\$ 39.00		1	ZZ	207ZP0105X	NPI 1750301172						
2													NPI						
3													NPI						
4													NPI						
5													NPI						
6													NPI						
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. MP1595578760		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 39.00		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.) GRETCHEN JOHNS M.D.												32. SERVICE FACILITY LOCATION INFORMATION FLA MC CANNADAY BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865 MINNEAPOLIS, MN 55480-1508				33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508			
SIGNED 04 06 2022												a. 1790772317 b. ZZ261QM1300X							

MAYO CLINIC FLORIDA		MAYO CLINIC FLORIDA		3a PAT. CNTL #	MH110067329601	4 TYPE OF BILL					
4500 SAN PABLO RD S		PO BOX 1403		b. MED. REC. #	13-445-565	0131					
JACKSONVILLE FL 322241865		MINNEAPOLIS MN 554801403		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH					
8442179591				590714831	032822	032822					
8 PATIENT NAME		9 PATIENT ADDRESS		a PORFIRIO HERRERA NO. 12 PIANTINI							
b MARTINEZ METZ JULIO C		b SANTO DOMINGO		c d e DO							
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18 19 20 21	CONDITION CODES 22 23 24 25 26 27 28	29 ACCT STATE	30		
10221971	M		3 1		01						
31 OCCURRENCE CODE	32 OCCURRENCE CODE	33 OCCURRENCE CODE	34 OCCURRENCE CODE	35 OCCURRENCE CODE	36 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH	37			
a									a		
b									b		
38 WORLDWIDE CONCIERGE HEALTHCARE SVCS LTD 2813 EXECUTIVE PARK DR SUITE 120 WESTON, FL 33331					39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT				
a									a		
b									b		
c									c		
d									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		
1 0920	OTHER DIAGNOSTIC SERVICE		95910		032822	1	122400	000	1		
2 0922	OTHER DIAGNOSTIC SERVICE		95885LT		032822	2	123600	000	2		
3 0922	OTHER DIAGNOSTIC SERVICE		95887LT		032822	1	40500	000	3		
4									4		
5									5		
6									6		
7									7		
8									8		
9									9		
10									10		
11									11		
12									12		
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14									14		
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16									16		
17									17		
18									18		
19									19		
20									20		
21									21		
22									22		
23	0001 PAGE 1 OF 1	CREATION DATE		040522	TOTALS ➔	286500	000		23		
A	50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1891782470	A
B	A WORLDWIDE CONCIERGE HEAPAPER				Y	Y	000	286500	57 OTHER PRV ID		B
C											C
A	58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.			A
B	MARTINEZ METZ, JULIO		181177862			WORLDWIDE CONC					B
C											C
A	63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME					A	
B					INTERNATIONAL EMPLOYER					B	
C										C	
66 DX	G1220	R531								68	
0											
69 ADMIT DX	70 PATIENT REASON DX	G1220 R531		71 PPS CODE	72 ECI					73	
74 PRINCIPAL PROCEDURE CODE	70 PATIENT REASON DX	G1220 R531	a. OTHER PROCEDURE CODE	b. OTHER PROCEDURE CODE	75	76 ATTENDING NPI	1881683241	QUAL			
						LASTUITTI		FIRSTRYAN J			
c OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	d. OTHER PROCEDURE CODE	e. OTHER PROCEDURE CODE	f. OTHER PROCEDURE DATE		77 OPERATING NPI		QUAL			
						LAST		FIRST			
80 REMARKS	81CC a	B3282N0000X	b			78 OTHER NPI		QUAL			
			c			LAST		FIRST			
			d			79 OTHER NPI		QUAL			
						LAST		FIRST			



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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#)	1a. INSURED'S I.D. NUMBER 1177862 (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ METZ, JULIO, C			3. PATIENT'S BIRTH DATE MM DD YY 10 22 1971			SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME					
5. PATIENT'S ADDRESS (No., Street) PORFIRIO HERRERA NO. 12 PIAN			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) PORFIRIO HERRERA NO. 12 PIAN						
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE			
ZIP CODE (809) 540-1177		TELEPHONE (Include Area Code)					ZIP CODE (809) 540-1177		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						
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
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SIGNED SIGNATURE ON FILE						DATE 04 05 2022						
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 MM DD YY FROM MM DD YY TO						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNRYAN JUITTI			17a. <input type="checkbox"/> 17b. NPI 1881683241			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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												
A. M47812	B. G1220	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. CPT/HCPSCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER	F. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER ID. #
1 72141 MRI SCAN OF 03 28 22		UPPER	11	SPINAL CANAL WITHOUT CONTRAST 72141 26		AB	1059.00	1		ZZ	2085N0700X	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. MP1594914440		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1059.00	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.) AMIT K AGARWAL M.B.B.		32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865		33. BILLING PROVIDER INFO & PH # (844) 217-9591		MINNEAPOLIS, MN 55480-1508						
SIGNED 04 05 2022		a. <input type="checkbox"/> b. <input type="checkbox"/>		a. 1790772317 b. ZZ261QM1300X		PLEASE PRINT OR TYPE			APPROVED OMB-0938-1197 FORM 1500 (02-12)			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

05042218321911-000249-002-1002-1001



HEALTH INSURANCE CLAIM FORM

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

CARRIER
WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR 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 type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH			3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		4. INSURED'S I.D. NUMBER 001151032		(For Program in Item 1)				
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,			6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, PI								
CITY SANTO DOMINGO			STATE		8. RESERVED FOR NUCC USE		CITY SANTO DOMINGO		STATE				
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177						ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER								
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> M <input type="checkbox"/> F								
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)								
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC								
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>								
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 04 04 2022							
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. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO			17a. <input type="checkbox"/>			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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 0 0 0													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0													
A. <input type="checkbox"/> M25551	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPGS	D. MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
1 99202 NEW PATIENT 03 30 22		OFFICE OR OTHER OUTPATIENT VISIT, LEVEL 11	99202	A	304.00	2		ZZ	207X00000X				
2									NPI				
3									NPI				
4									NPI				
5									NPI				
6									NPI				
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. MP1594694760		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 304.00	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.)													
32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865													
33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508													
LUKE S SPENCER GARDNER SIGNED 04 04 2022													
a. <input type="checkbox"/> b. <input type="checkbox"/> a. 1790772317 b. ZZ261QM1300X													



WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

HEALTH INSURANCE CLAIM FORM

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

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 type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 1177862 (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ METZ, JULIO, C			3. PATIENT'S BIRTH DATE MM DD YY 10 22 1971 <input checked="" type="checkbox"/> X F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME						
5. PATIENT'S ADDRESS (No., Street) PORFIRIO HERRERA NO. 12 PIAN			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) PORFIRIO HERRERA NO. 12 PIANI						
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE			
ZIP CODE (809) 540-1177	TELEPHONE (Include Area Code)					ZIP CODE (809) 540-1177	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						
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 04 04 2022							
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 FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJUAN C CARDENAS ROSALES			17a. <input type="checkbox"/>	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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												
A. Z0000	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. CPT/HCPSCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER	DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 93000 ROUTINE ELECTROCARDIOGRAM (ECG) USING 03 30 22 11 93000							AT LEAST 12 LEADS A	127.00	1	ZZ NPI	207RC0000X 1063409225	
2										NPI		
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. MP1594694740		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 127.00		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.) JORGE F TREJO GUTIERR		32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865		33. BILLING PROVIDER INFO & PH # (844) 217-9591		MINNEAPOLIS, MN 55480-1508		MAYO CLINIC JACKSONVILLE PO BOX 1508				
SIGNED 04 04 2022		a. <input type="checkbox"/> b. <input type="checkbox"/>		a. 1790772317 b. ZZ261QM1300X								



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

PHYSICIAN OR SUPPLIER INFORMATION



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

CARRIER

1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input checked="" type="checkbox"/> OTHER (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 001151032						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH										3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976 <input type="checkbox"/> F <input checked="" type="checkbox"/> X						
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, CITY SANTO DOMINGO STATE										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME						
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177								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) CALLE PORFIRIO HERRERA #12, PI										8. RESERVED FOR NUCC USE						
CITY SANTO DOMINGO		STATE								CITY SANTO DOMINGO STATE						
ZIP CODE		TELEPHONE (Include Area Code)								TELEPHONE (Include Area Code) (809) 540-1177						
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)						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										11. INSURED'S POLICY GROUP OR FECA NUMBER						
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.										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX						
SIGNED SIGNATURE ON FILE										b. OTHER CLAIM ID (Designated by NUCC)						
										c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON - WORLDWIDE CONC						
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.						
										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 FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO					17a. <input type="checkbox"/> 17b. NPI 1053394452					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 03 28 2022 TO 03 28 2022						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. Z0000		B. <input type="checkbox"/>		C. <input type="checkbox"/>		D. <input type="checkbox"/>		23. PRIOR AUTHORIZATION NUMBER								
E. <input type="checkbox"/>		F. <input type="checkbox"/>		G. <input type="checkbox"/>		H. <input type="checkbox"/>										
I. <input type="checkbox"/>		J. <input type="checkbox"/>		K. <input type="checkbox"/>		L. <input type="checkbox"/>										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
1 71046 X-RAY OF CHEST, 03 28 22		2 11		VIEWS 71046		A		217.00		1				ZZ NPI	2085R0202X 1427296904	
2														NPI		
3														NPI		
4														NPI		
5														NPI		
6														NPI		
25. FEDERAL TAX I.D. NUMBER 593337028 SSN EIN <input type="checkbox"/> X					26. PATIENT'S ACCOUNT NO. MP1593440630			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 217.00		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.) ISABEL O CORTOPASSI M					32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865			33. BILLING PROVIDER INFO & PH # (844) 217-9591		MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508						
SIGNED 04 01 2022					a. <input type="checkbox"/> b. <input type="checkbox"/>			a. 1790772317		b. ZZ261QM1300X						



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

CARRIER

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 type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000470671 (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ZRIHEN COHEN, MEIR, E			3. PATIENT'S BIRTH DATE MM DD YY 09 25 1996			SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME				
5. PATIENT'S ADDRESS (No., Street) CALLE PUNTA CHIRIQUI PUNTA P			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) CALLE PUNTA CHIRIQUI PUNTA PAC					
CITY PANAMA CITY		STATE	8. RESERVED FOR NUCC USE			CITY PANAMA CITY		STATE	ZIP CODE 00507		
ZIP CODE 00507		TELEPHONE (Include Area Code) ()				ZIP CODE 00507		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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 04 01 2022					
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 MM DD YY FROM MM DD YY TO					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJUAN C CARDENAS ROSALES			17a. 17b. NPI 1417211558			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 01 19 2022 TO 01 19 2022					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0											
A. Z0000	B. M5450	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 EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. MODIFIER	F. DIAGNOSIS POINTER	G. DAYS OR UNITS	H. EPSTD Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
1 IAAD IA HEPATITIS 01 19 22		81	87340			AB	110.00	1		ZZ 207ZP0105X NPI 1750301172	
2 COMPLETE CBC & AUTO DIFF WBC 01 19 22		81	85025			AB	77.00	1		ZZ 207ZP0105X NPI 1750301172	
3 HEPATITIS C AB TEST 01 19 22		81	86803			AB	266.00	1		ZZ 207ZP0105X NPI 1750301172	
4 ASSAY THYROID STIM HORMONE 01 19 22		81	84443			AB	266.00	1		ZZ 207ZP0105X NPI 1750301172	
5 METABOLIC PANEL, COMPREHENSIVE 01 19 22		81	80053	QW		AB	535.00	1		ZZ 207ZP0105X NPI 1750301172	
6 LIPID PANEL 01 19 22		81	80061	QW		AB	151.00	1		ZZ 207ZP0105X NPI 1750301172	
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. MP1562811352		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1405.00	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.) MAYO CLINIC JACKSONVI											
32. SERVICE FACILITY LOCATION INFORMATION FLA MC VINCENT A. STABILE 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508											
33. BILLING PROVIDER INFO & PH # (844) 217-9591 a. 1285621631 b. ZZ291U00000X											



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER												1a. INSURED'S I.D. NUMBER 000470671 (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ZRIHEN COHEN, MEIR, E				3. PATIENT'S BIRTH DATE MM DD YY 09 25 1996				SEX M		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME				
5. PATIENT'S ADDRESS (No., Street) CALLE PUNTA CHIRIQUI PUNTA P				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) CALLE PUNTA CHIRIQUI PUNTA PAC						
CITY PANAMA CITY		STATE		CITY PANAMA CITY		STATE								
ZIP CODE 00507		TELEPHONE (Include Area Code) ()		ZIP CODE 00507		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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>						
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 04 01 2022										
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 FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJUAN C CARDENAS ROSALES				17a. _____ 17b. NPI 1417211558				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0														
A. Z0000	B. M5450	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 EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. MODIFIER		F. DIAGNOSIS POINTER		G. \$ CHARGES		H. DAYS OR UNITS EPSDT Family Plan	I. I. D. QUAL.	J. RENDERING PROVIDER ID. #		
1 ASSAY OF VIT D, CALCIFEDIOL W FRACTIONS, IF PERFORMED 01 19 22	81	82306				AB	327.00	1		ZZ	207ZP0105X NPI 1750301172			
2 RBC SED RATE, AUTO 01 19 22	81	85652				AB	46.00	1		ZZ	207ZP0105X NPI 1750301172			
3 ASSAY OF FERRITIN 01 19 22	81	82728				AB	154.00	1		ZZ	207ZP0105X NPI 1750301172			
4 HEPATITIS B SURFACE AB TEST 01 19 22	81	86706				AB	144.00	1		ZZ	207ZP0105X NPI 1750301172			
5											NPI			
6											NPI			
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. MP1562811352		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 671.00		29. AMOUNT PAID \$ 0.00		30. Resvd 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.)														
32. SERVICE FACILITY LOCATION INFORMATION FLA MC VINCENT A. STABILE 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865														
33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508														
MAYO CLINIC JACKSONVI SIGNED		DATE 04 01 2022	a. 1285621631		b. ZZ291U00000X									



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#) X (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000992442																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PAGES, MARISOL					3. PATIENT'S BIRTH DATE MM DD YY 05 06 1971 M X F X					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																																																															
5. PATIENT'S ADDRESS (No., Street) PABLO CASALS NO. 6 TORRE OXO					6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other					7. INSURED'S ADDRESS (No., Street) PABLO CASALS NO. 6 TORRE OXO,																																																															
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE					CITY SANTO DOMINGO		STATE																																																														
ZIP CODE 00000		TELEPHONE (Include Area Code) (809) 732-4694							ZIP CODE 00000		TELEPHONE (Include Area Code) (809) 732-4694																																																														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER 755630																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES X NO					a. INSURED'S DATE OF BIRTH MM DD YY M X F X																																																															
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? YES X NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)																																																															
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? YES X NO					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.																																																															
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20. OUTSIDE LAB? \$ CHARGES YES X NO 000																																																																									
22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																									
23. PRIOR AUTHORIZATION NUMBER																																																																									
<table border="1"> <thead> <tr> <th>F.</th> <th>G.</th> <th>H.</th> <th>I.</th> <th>J.</th> </tr> <tr> <th>\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>EPSDT Family Plan</th> <th>ID. QUAL.</th> <th>RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td>ZZ 152W00000X</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>NPI 1437121001</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>ZZ 152W00000X</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>NPI 1437121001</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>ZZ 152W00000X</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>NPI 1437121001</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> </tbody> </table>														F.	G.	H.	I.	J.	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #					ZZ 152W00000X					NPI 1437121001					ZZ 152W00000X					NPI 1437121001					ZZ 152W00000X					NPI 1437121001					NPI															
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1	92015 TEST TO DETERMINE IF PRESCRIPTION EYE WEAR IS NEEDED	11	92015	A	132.00	1	ZZ	152W00000X																																																																	
2	92004 NEW PATIENT COMPLETE EXAM OF VISUAL SYSTEM	11	92004	ABCD	582.00	1	ZZ	152W00000X																																																																	
3	92134 IMAGING OF RETINA	11	92134	A	223.00	1	ZZ	152W00000X																																																																	
4							NPI																																																																		
5							NPI																																																																		
6							NPI																																																																		
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 X					26. PATIENT'S ACCOUNT NO. MP1593965170		27. ACCEPT ASSIGNMENT? (for gov. claims, see back) YES X NO		28. TOTAL CHARGE \$ 937.00		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.) MANISH H PATEL O.D.					32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865				33. BILLING PROVIDER INFO & PH # (844) 217-9591																																																																
SIGNED 04 04 2022					a. b.		a. 1790772317 b. ZZ261QM1300X		PO BOX 1508 MAYO CLINIC JACKSONVILLE MINNEAPOLIS, MN 55480-1508																																																																

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

040422183108441-000050-002-0206



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 001151032					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH					3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976 M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME					
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,					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) CALLE PORFIRIO HERRERA #12, PI					
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE					CITY SANTO DOMINGO		STATE				
ZIP CODE (809) 540-1177		TELEPHONE (Include Area Code)							ZIP CODE (809) 540-1177		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					
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC					
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 04 04 2022										
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. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO					17a. NPI 1053394452					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 31 2022 TO 03 31 2022					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0															
A. Z20828		B. D509		C. L		D. L		E. L		F. L		G. L		H. L	
I. L		J. L		K. L		L. L		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.	
22. RESUBMISSION CODE ORIGINAL REF. NO.															
23. PRIOR AUTHORIZATION NUMBER 10D0269502															
24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER From MM DD YY To MM DD YY PLACE OF SERVICE EMG CPT/HCPCS MODIFIER															
1	HEP B CORE AB TEST, IGM 03 31 22 81 86705 A 183.00 1 ZZ 207ZP0105X ASSAY OF FERRITIN 03 31 22 81 82728 B 154.00 1 ZZ 207ZP0105X														
2	HEPATITIS BE AB TEST 03 31 22 81 86707 A 196.00 1 ZZ 207ZP0105X														
3	IAAD IA HEPATITIS BE ANTIGEN 03 31 22 81 87350 A 108.00 1 ZZ 207ZP0105X														
4															
5															
6															
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If gov. claims, see back) 593337028 <input checked="" type="checkbox"/> X MP1593965250 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO															
28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use \$ 641.00 \$ 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 FLA MC VINCENT A. STABILE 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865 MINNEAPOLIS, MN 55480-1508															
33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508															
MAYO CLINIC JACKSONVI SIGNED 04 04 2022 a. 1285621631 b. ZZ291U00000X															



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) X (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 001151032					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH						3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976			SEX F X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME						
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,						6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other			7. INSURED'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, PI								
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE								
ZIP CODE (809) 540-1177		TELEPHONE (Include Area Code)					ZIP CODE (809) 540-1177		TELEPHONE (Include Area Code)								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES X NO											
b. AUTO ACCIDENT? YES X NO						a. INSURED'S DATE OF BIRTH MM DD YY SEX M F											
c. OTHER ACCIDENT? YES X NO						b. OTHER CLAIM ID (Designated by NUCC)											
d. INSURANCE PLAN NAME OR PROGRAM NAME						c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC											
10d. CLAIM CODES (Designated by NUCC)												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X 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.												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 04 04 2022												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 FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO				17a. NPI 1053394452				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 31 2022 TO 03 31 2022									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES YES X NO 000					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. Z20828		B. I		C. I		D. I		23. PRIOR AUTHORIZATION NUMBER									
E. I		F. I		G. I		H. I											
I. I		J. I		K. I		L. I											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE EMG				B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				E. MODIFIER		F. DIAGNOSIS POINTER		G. \$ CHARGES		H. DAYS OR UNITS	I. EPSDT Family Plan	J. ID. QUAL.	K. RENDERING PROVIDER ID. #
1 36415 INSERTION OF NEEDLE INTO VEIN FOR COLLECTION OF BLOOD S 03 31 22 11 36415								A		ZZ 39.00 1		NPI		207ZP0105X 1750301172			
2																	
3																	
4																	
5																	
6																	
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 X				26. PATIENT'S ACCOUNT NO. MP1593965230				27. ACCEPT ASSIGNMENT? (for gov't. claims, see back) X YES NO		28. TOTAL CHARGE \$ 39.00		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.) GRETCHEN JOHNS M.D.				32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865						33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508							
SIGNED 04 04 2022				a. b.				a. 1790772317		b. ZZ261QM1300X							



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER 001151032 (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH										3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, CITY SANTO DOMINGO ZIP CODE										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
8. RESERVED FOR NUCC USE										7. INSURED'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, PI CITY SANTO DOMINGO ZIP CODE			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										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			
d. INSURANCE PLAN NAME OR PROGRAM NAME										11. INSURED'S POLICY GROUP OR FECA NUMBER WORLDWIDE CON-WORLDWIDE CONC			
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										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. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO ^{17b.} NPI 1053394452										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 31 2022 TO 03 31 2022			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. Z20828 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 1 HEPATITIS B , DNA, QUANT 03 31 22					B. PLACE OF SERVICE C. EMG 2 RST MC SUPERIOR DRIVE SUPP 3050 SUPERIOR DR NW 4 ROCHESTER, MN 55905-1770					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 27. ACCEPT ASSIGNMENT? For govt. claims, see back 28. TOTAL CHARGE \$ 730.00 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use NPI 1750301172			
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input type="checkbox"/> X					26. PATIENT'S ACCOUNT NO. MP1593965210 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					27. ACCEPT ASSIGNMENT? For govt. claims, see back 28. TOTAL CHARGE \$ 730.00 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC Use NPI 1750301172			
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.) MAYO CLINIC JACKSONVI SIGNED 04 04 2022										32. SERVICE FACILITY LOCATION INFORMATION RST MC SUPERIOR DRIVE SUPP 3050 SUPERIOR DR NW ROCHESTER, MN 55905-1770 a. 1093792350 b.			
33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508 a. 1285621631 b. ZZ291U00000X													



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

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 type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 001151032	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH		3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME			
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, PI		
CITY SANTO DOMINGO	STATE					CITY SANTO DOMINGO	STATE	
ZIP CODE	TELEPHONE (Include Area Code) (809) 540-1177					ZIP CODE	TELEPHONE (Include Area Code) (809) 540-1177	

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)

YES NO

b. AUTO ACCIDENT?

PLACE (State)
 YES NO

c. OTHER ACCIDENT?

YES NO

10d. CLAIM CODES (Designated by NUCC)

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 04 04 2022

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

DNJOAN M IRIZARRY ALVARADO 17b. NPI 1053394452

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

ICD Ind. 0

A. D509

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

K. _____

L. _____

24. A. DATE(S) OF SERVICE

B. PLACE OF SERVICE

From MM DD YY

To MM DD YY

C. EMG

D. CPT/HCPCS

D. PROCEDURES, SERVICES, OR SUPPLIES
(Explain Unusual Circumstances)

E. MODIFIER

E. DIAGNOSIS
POINTER

1 HEMOGLOBIN ELECTROPHORESIS

03 31 22

81

83020

90

A

A

113.00

1

ZZ

207ZP0105X

NPI

1750301172

2 ASSAY OF G6PD ENZYME

03 31 22

81

82955

90

A

A

139.00

1

ZZ

207ZP0105X

NPI

1750301172

3 HEMOGLOBIN CHROMOTOGRAPHY

03 31 22

81

83021

90

A

A

162.00

1

ZZ

207ZP0105X

NPI

1750301172

4

5

6

25. FEDERAL TAX I.D. NUMBER

SSN EIN

593337028

X

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.)

MAYO CLINIC JACKSONVI

04 04 2022

DATE

a. 1093792350 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

↑ CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

040422/18310841-000106-002-002 - 0429



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER												1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
<input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#)			<input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#)			<input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)			001151032					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH				3. PATIENT'S BIRTH DATE MM DD YY			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME					
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, CITY SANTO DOMINGO				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) CALLE PORFIRIO HERRERA #12, PI CITY SANTO DOMINGO							
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE		ZIP CODE	TELEPHONE (Include Area Code) (809) 540-1177		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>							
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC							
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>							
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 03 31 2022								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 FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO				17a. <input type="checkbox"/> 17b. NPI 1053394452			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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.		
A. E041		B. <input type="checkbox"/>		C. <input type="checkbox"/>		D. <input type="checkbox"/>		F. <input type="checkbox"/> \$ CHARGES		G. <input type="checkbox"/> DAYS OR UNITS	H. <input type="checkbox"/> EPSDT Family Plan	I. <input type="checkbox"/> ID. QUAL.	J. <input type="checkbox"/> RENDERING PROVIDER ID. #	
E. <input type="checkbox"/>		F. <input type="checkbox"/>		G. <input type="checkbox"/>		H. <input type="checkbox"/>								
I. <input type="checkbox"/>		J. <input type="checkbox"/>		K. <input type="checkbox"/>		L. <input type="checkbox"/>								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS POINTER		F. <input type="checkbox"/> \$ CHARGES		G. <input type="checkbox"/> DAYS OR UNITS	H. <input type="checkbox"/> EPSDT Family Plan	I. <input type="checkbox"/> ID. QUAL.	J. <input type="checkbox"/> RENDERING PROVIDER ID. #	
1 99243 PATIENT OFFICE 03 30 22		11		CONSULTATION, LEVEL 3 99243		A		\$ 577.00		1	ZZ NPI	207RE0101X 1205147303		
2												NPI		
3												NPI		
4												NPI		
5												NPI		
6												NPI		
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. MP1592890150		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 577.00		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.) SARIKA N RAO D.O.		32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865		33. BILLING PROVIDER INFO & PH # (844) 217-9591										
SIGNED 03 31 2022		a. <input type="checkbox"/>		b. <input type="checkbox"/>		a. 1790772317		b. ZZ261QM1300X						



HEALTH INSURANCE CLAIM FORM

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

PICA

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER												1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
<input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#)			<input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#)			<input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/>			000470671					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ZRIHEN COHEN, MEIR, E				3. PATIENT'S BIRTH DATE MM DD YY				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) CALLE PUNTA CHIRIQUI PUNTA P				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) CALLE PUNTA CHIRIQUI PUNTA PAC		
CITY PANAMA CITY		STATE		8. RESERVED FOR NUCC USE				CITY PANAMA CITY		STATE				
ZIP CODE 00507		TELEPHONE (Include Area Code) ()						ZIP CODE 00507		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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY						
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>						
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 03 31 2022												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 FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJUAN C CARDENAS ROSALES				17a. <input type="checkbox"/> 17b. NPI 1417211558				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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.		
A. M5450	B. M25512	C. M25511	D. M549	I. 	J. 	K. 	L. 	F. 	G. 	H. 	I. 	J. 		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. MODIFIER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
1 99204 NEW PATIENT 01 19 22	OFFICE 11	11	OR OTHER OUTPATIENT 99204	VISIT, LEVEL ABCD	4 707.00	1	ZZ NPI	208100000X 1477877991						
2									NPI					
3									NPI					
4									NPI					
5									NPI					
6									NPI					
25. FEDERAL TAX I.D. NUMBER 593337028	SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. MP1561539942		27. ACCEPT ASSIGNMENT? <i>(For govt. claims, see back)</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 707.00	29. AMOUNT PAID \$ 0.00	30. Rsrd 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.) PAUL M SCHOLTEN M.D.				32. SERVICE FACILITY LOCATION INFORMATION FLA MCH FLORIDA HOSPITAL 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865				33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508						
SIGNED 03 31 2022				a. b. 				a. 1790772317 b. ZZ261QM1300X						



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR 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 type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000470671 (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ZRIHEN COHEN, MEIR, E							3. PATIENT'S BIRTH DATE MM DD YY 09 25 1996	SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME							
5. PATIENT'S ADDRESS (No., Street) CALLE PUNTA CHIRQUI PUNTA P							6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY PANAMA CITY		STATE		8. RESERVED FOR NUCC USE					CITY PANAMA CITY		STATE					
ZIP CODE 00507		TELEPHONE (Include Area Code) ()							ZIP CODE 00507		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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE							b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC				
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
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.												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 03 31 2022												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 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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.				
A. G894	B. M5450	C. M25511	D. M25512	23. PRIOR AUTHORIZATION NUMBER												
E. R197	F. Z720	G. R519	H. _____													
I. _____	J. _____	K. _____	L. _____													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. MODIFIER F. DIAGNOSIS POINTER G. \$ CHARGES H. DAYS OR UNITS I. ID. QUAL. J. RENDERING PROVIDER ID. #																
1 99204 NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, LEVEL 4 01 19 22 11 99204 33 ABCD 707.00 1 ZZ 207R00000X NPI 1417211558																
2 _____ NPI																
3 _____ NPI																
4 _____ NPI																
5 _____ NPI																
6 _____ NPI																
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. MP1562201872				27. ACCEPT ASSIGNMENT? <i>(For govt. claims, see back)</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 707.00		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.) JUAN C CARDENAS ROSAL SIGNED 03 31 2022				32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865				33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508								
a. _____ b. _____				a. 1790772317 b. ZZ261QM1300X												



HEALTH INSURANCE CLAIM FORM

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

PICA

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) BLK LUNG (ID#) X (ID#)												1a. INSURED'S I.D. NUMBER 000470671 (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ZRIHEN COHEN, MEIR, E						3. PATIENT'S BIRTH DATE MM DD YY 09 25 1996 M X F			4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME						
5. PATIENT'S ADDRESS (No., Street) CALLE PUNTA CHIRIQUI PUNTA P						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) CALLE PUNTA CHIRIQUI PUNTA PAC						
CITY PANAMA CITY			STATE			8. RESERVED FOR NUCC USE			CITY PANAMA CITY			STATE			
ZIP CODE 00507			TELEPHONE (Include Area Code) ()						ZIP CODE 00507			TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER 755630						
						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)						
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC						
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.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
SIGNED SIGNATURE ON FILE												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 FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJUAN C CARDENAS ROSALES						17a. 17b. NPI 1417211558			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 01 18 2022 TO 01 18 2022						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. M549 B. M5450 C. M542 D. ICD Ind. 0 E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. MODIFIER F. DIAGNOSIS POINTER				F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. #											
1 72070 X-RAY OF MIDDLE SPINE, 2 VIEWS 01 18 22 11 72070 A 212.00 1 ZZ 2085R0202X NPI 1235171745															
2 72100 X-RAY OF LOWER AND SACRAL SPINE, 2-3 VIEWS 01 18 22 11 72100 B 257.00 1 ZZ 2085R0202X NPI 1235171745															
3 72040 X-RAY OF UPPER SPINE, 2-3 VIEWS 01 18 22 11 72040 C 238.00 1 ZZ 2085R0202X NPI 1235171745															
4															
5															
6															
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. MP1562442902			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 707.00		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.) DANIEL E WESSELL M.D.				32. SERVICE FACILITY LOCATION INFORMATION FLA MCH FLORIDA HOSPITAL 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865			33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508								
SIGNED 03 31 2022				a. b.			a. 1790772317 b. ZZ261QM1300X								



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER 000992442 (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PAGES, MARISOL					3. PATIENT'S BIRTH DATE MM DD YY SEX 05 06 1971 M F X					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME					
5. PATIENT'S ADDRESS (No., Street) PABLO CASALS NO. 6 TORRE OXO					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					7. INSURED'S ADDRESS (No., Street) PABLO CASALS NO. 6 TORRE OXO,					
CITY SANTO DOMINGO		STATE			8. RESERVED FOR NUCC USE					CITY SANTO DOMINGO		STATE			
ZIP CODE 00000		TELEPHONE (Include Area Code) (809) 732-4694								ZIP CODE 00000		TELEPHONE (Include Area Code) (809) 732-4694			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER 755630					
					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)					
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC					
										d. 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.										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										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 FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNBEVERLY J ROSEBERRY					17a. _____ 17b. NPI 1780857698					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 28 2022 TO 03 28 2022					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. R922		B. _____		C. _____		D. _____		E. _____		F. _____		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
E. _____		F. _____		G. _____		H. _____		I. _____		J. _____					
I. _____		J. _____		K. _____		L. _____									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS		E. MODIFIER		F. DIAGNOSIS POINTER		G. \$ CHARGES		H. DAYS OR UNITS	I. EPSDT Family Plan	J. ID. QUAL.	K. RENDERING PROVIDER ID. #
1 N408888002141 UN.055 03 28 22		11 A9500						A		145.00 1				ZZ	2085R0202X
2 NON-HEU TC-99M ADD-ON/DOSE 03 28 22		11 Q9969						A		1.00 1				ZZ	2085R0202X
3														NPI	
4														NPI	
5														NPI	
6														NPI	
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. MP1593114040		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 146.00		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.) ANDREY P MOROZOV M.D.				32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865				33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508							
SIGNED 03 31 2022				a. _____ b. _____				a. 1790772317 b. ZZ261QM1300X							



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000992442							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PAGES, MARISOL						3. PATIENT'S BIRTH DATE MM DD YY 05 06 1971 M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME							
5. PATIENT'S ADDRESS (No., Street) PABLO CASALS NO. 6 TORRE OXO						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) PABLO CASALS NO. 6 TORRE OXO,							
CITY SANTO DOMINGO			STATE			CITY SANTO DOMINGO			STATE										
ZIP CODE 00000		TELEPHONE (Include Area Code) (809) 732-4694				ZIP CODE 00000		TELEPHONE (Include Area Code) (809) 732-4694											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER 755630							
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>							
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC							
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.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
SIGNED SIGNATURE ON FILE DATE 03 31 2022												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 FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNBEVERLY J ROSEBERRY				17a. _____ 17b. NPI 1780857698				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 28 2022 TO 03 28 2022											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.							
A. N6002	B. R928	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____	23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. MODIFIER F. DIAGNOSIS MODIFIER				E. DIAGNOSIS POINTER				\$ CHARGES				F. G. H. I. J. \$ CHARGES DAYS OR UNITS EPDS/ Family Plan ID. QUAL. RENDERING PROVIDER ID. #							
1 19000 ASPIRATION OF CYST OF BREAST, FIRST CYST 03 28 22 11 19000 LT A 437.00 1												ZZ 2085R0202X NPI 1154685246							
2 76942 ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT 03 28 22 11 76942 A 1088.00 1												ZZ 2085R0202X NPI 1154685246							
3 76642 LIMITED ULTRASOUND SCAN OF 1 BREAST 03 28 22 11 76642 LT B 466.00 1												ZZ 2085R0202X NPI 1154685246							
4 _____												NPI							
5 _____												NPI							
6 _____												NPI							
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input checked="" type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. MP1593113950				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 1991.00		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.) KRISTIN A ROBINSON M.												32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865				33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508			
SIGNED 03 31 2022												a. 1790772317 b. ZZ261QM1300X							



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR 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 <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 1177862 (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ METZ, JULIO, C			3. PATIENT'S BIRTH DATE 10 22 1971 <input checked="" type="checkbox"/> F <input type="checkbox"/>			SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME					
5. PATIENT'S ADDRESS (No., Street) PORFIRIO HERRERA NO. 12 PIAN			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) PORFIRIO HERRERA NO. 12 PIAN						
CITY SANTO DOMINGO		STATE	8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE	ZIP CODE (809) 540-1177			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 04 01 2022						
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 FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNARVEEN K BHASIN			17a. <input type="checkbox"/> 17b. NPI 1376641183			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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.
A. T781XXA	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS EPSDT Family Plan	H. I. J. ID. QUAL. RENDERING PROVIDER ID. #		
1 99212 ESTABLISHED 03 31 22	11	99212	PATIENT OFFICE OR OTHER OUTPATIENT VISIT, L 25			A	182.00 1	ZZ NPI	207K00000X 1376641183			
2 95076 TEST FOR ALLERGY USING INGESTED ITEMS, 03 31 22	11	95076	INITIAL 2 HOURS			A	638.00 1	ZZ NPI	207K00000X 1376641183			
3 95079 TEST FOR ALLERGY USING INGESTED ITEMS, 03 31 22	11	95079	EACH ADDITIONAL			A	681.00 1	ZZ NPI	207K00000X 1376641183			
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER 593337028	SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. MP1593661500	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 1501.00	29. AMOUNT PAID \$ 0.00	30. Rsvd for NUCC Use NPI						
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.) ARVEEN K BHASIN M.D.			32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865			33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508						
SIGNED 04 01 2022			a. b.			a. 1790772317 b. ZZ261QM1300X						



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER 001151032 (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH					3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976 M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME			
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,					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) CALLE PORFIRIO HERRERA #12, PI			
CITY SANTO DOMINGO		STATE			8. RESERVED FOR NUCC USE		CITY SANTO DOMINGO			STATE			
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177					ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC			
d. 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.			
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 04 01 2022										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 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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. D509 B. E041 C. M25551 D. M5450 E. Z20828 F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTER PR VISIT EST PATIENT LEVEL 3 03 31 22 11 99213 ABCD										23. PRIOR AUTHORIZATION NUMBER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. # ZZ 207R00000X NPI 1053394452			
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. MP1593661560 27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
28. TOTAL CHARGE \$ 296.00										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.) JOAN M IRIZARRY ALVAR SIGNED 04 01 2022			
32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865										33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508 a. 1790772317 b. ZZ261QM1300X			



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

CARRIER

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 type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 001151032 (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH							3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976	SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME							
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,							6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE					CITY SANTO DOMINGO		STATE					
ZIP CODE (809) 540-1177		TELEPHONE (Include Area Code)							ZIP CODE (809) 540-1177		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				
a. OTHER INSURED'S POLICY OR GROUP NUMBER							a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> M <input type="checkbox"/> F				
b. RESERVED FOR NUCC USE							b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC				
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				
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.												SIGNED SIGNATURE ON FILE				
SIGNED SIGNATURE ON FILE							DATE 04 01 2022					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 FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJOAN M IRIZARRY ALVARADO				17a. NPI 1053394452				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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.				
A. Z136	B. _____	C. _____	D. _____	ICD Ind. 0	23. PRIOR AUTHORIZATION NUMBER											
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				E. MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #		
1 93000 ROUTINE ELECTROCARDIOGRAM (ECG) USING 03 29 22 11 93000								A	AT LEAST 12 LEADS 127.00 1				ZZ 207RC0001X NPI 1710974977			
2													NPI			
3													NPI			
4													NPI			
5													NPI			
6													NPI			
25. FEDERAL TAX I.D. NUMBER 593337028				SSN EIN <input type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. MP1593661530		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 127.00	29. AMOUNT PAID \$ 0.00	30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) THOMAS R FLIPSE M.D.												32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865				
SIGNED 04 01 2022												33. BILLING PROVIDER INFO & PH # (844) 217-9591 MINNEAPOLIS, MN 55480-1508				
a. b. a. 1790772317 b. ZZ261QM1300X												MAYO CLINIC JACKSONVILLE PO BOX 1508				



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#) X (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1177862			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ METZ, JULIO, C					3. PATIENT'S BIRTH DATE MM DD YY 10 22 1971			SEX X F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME			
5. PATIENT'S ADDRESS (No., Street) PORFIRIO HERRERA NO. 12 PIAN					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) PORFIRIO HERRERA NO. 12 PIANI					
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE				
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177					ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER			
					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					a. INSURED'S DATE OF BIRTH MM DD YY M F			
					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC			
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.										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
SIGNED SIGNATURE ON FILE DATE 04 01 2022										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 FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNSARIKA N RAO					17a. _____ 17b. NPI 1205147303			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 03 29 2022 TO 03 29 2022					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. E039		B. _____		C. _____		D. _____		E. _____		23. PRIOR AUTHORIZATION NUMBER			
E. _____		F. _____		G. _____		H. _____		I. _____		F. _____ G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
I. _____		J. _____		K. _____		L. _____							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER		F. E. DIAGNOSIS POINTERS		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			
1 36415 03 29 22		2 11		3 36415		4 A		5 39.00 1		6 ZZ 207ZP0105X NPI 1750301172 NPI NPI NPI NPI			
7 2		8 3		9 4		10 5		11 6					
25. FEDERAL TAX I.D. NUMBER 593337028		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. MP1593440500		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 39.00		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.) GRETCHEN JOHNS M.D. SIGNED 04 01 2022										32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865			
										33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508			
										a. 1790772317 b. ZZ261QM1300X			



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

CARRIER

<input type="checkbox"/> PICA <input type="checkbox"/> PICA														
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER 000992442 (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PAGES, MARISOL			3. PATIENT'S BIRTH DATE MM DD YY 05 06 1971			SEX <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME							
5. PATIENT'S ADDRESS (No., Street) PABLO CASALS NO. 6 TORRE OXO			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) PABLO CASALS NO. 6 TORRE OXO,								
CITY SANTO DOMINGO	STATE	8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO			STATE	ZIP CODE 00000					
ZIP CODE 00000	TELEPHONE (Include Area Code) (809) 732-4694								TELEPHONE (Include Area Code) (809) 732-4694					
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>								
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)								
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON - WORLDWIDE CONC								
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									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.									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									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 FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNTARYN L SMITH			17a. <input type="checkbox"/> 17b. NPI 1417344771			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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. N924 B. N938 C. Z30430 D. N858 E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>									22. RESUBMISSION CODE ORIGINAL REF. NO.					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPSC D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. MODIFIER F. MODIFIER 58300 INSERTION OF IUD FOR PREGNANCY PREVENTION 03 30 22 11 58300 ABC 577.00 1 ZZ 207R00000X 58100 BIOPSY OF LINING OF UTERUS 03 30 22 11 58100 AB 520.00 1 ZZ 207R00000X N450419042301 UN1 03 30 22 11 J7298 AB 1626.40 1 ZZ 207R00000X PR VISIT EST PATIENT LEVEL 3 03 30 22 11 99213 25 ABD 296.00 1 ZZ 207R00000X 5 6									23. PRIOR AUTHORIZATION NUMBER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. # NPI 1417344771 NPI 1417344771 NPI 1417344771 NPI 1417344771 NPI 1417344771 NPI 1417344771					
25. FEDERAL TAX I.D. NUMBER 593337028			SSN EIN <input type="checkbox"/> X			26. PATIENT'S ACCOUNT NO. MP1593661470			27. ACCEPT ASSIGNMENT? (or govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 3019.40	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.) TARYN L SMITH M.D. SIGNED 04 01 2022									32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865			33. BILLING PROVIDER INFO & PH # (844) 217-9591 MINNEAPOLIS, MN 55480-1508 MAYO CLINIC JACKSONVILLE PO BOX 1508		
									a. 1790772317 b. ZZ261QM1300X					



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1177862									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ METZ, JULIO, C						3. PATIENT'S BIRTH DATE MM DD YY 10 22 1971			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) PORFIRIO HERRERA NO. 12 PIAN						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) PORFIRIO HERRERA NO. 12 PIANTI												
CITY SANTO DOMINGO		STATE		8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO		STATE												
ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177					ZIP CODE		TELEPHONE (Include Area Code) (809) 540-1177												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						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						11. INSURED'S POLICY GROUP OR FECA NUMBER									
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC)									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC									
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.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
SIGNED SIGNATURE ON FILE DATE 04 01 2022												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 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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. G1220		B. E063		C. K649		D. K5900		23. PRIOR AUTHORIZATION NUMBER													
E. T781XXA		F. R748		G. E663		H. _____		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #													
I. _____		J. _____		K. _____		L. _____															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS POINTER MODIFIER		25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. MP1593440550		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 707.00		29. AMOUNT PAID \$ 0.00		30. Rsvd for NUCC Use	
1 99204 NEW PATIENT 03 30 22		11		99204		33		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.) JUAN C CARDENAS ROSAL				32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865		33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508							
2								34. PAYMENT INFORMATION													
3								35. PAYMENT INFORMATION													
4								36. PAYMENT INFORMATION													
5								37. PAYMENT INFORMATION													
6								38. PAYMENT INFORMATION													
38. PAYMENT INFORMATION								39. PAYMENT INFORMATION													
40. PAYMENT INFORMATION								41. PAYMENT INFORMATION													
42. PAYMENT INFORMATION								43. PAYMENT INFORMATION													
44. PAYMENT INFORMATION								45. PAYMENT INFORMATION													
46. PAYMENT INFORMATION								47. PAYMENT INFORMATION													
48. PAYMENT INFORMATION								49. PAYMENT INFORMATION													
50. PAYMENT INFORMATION								51. PAYMENT INFORMATION													
52. PAYMENT INFORMATION								53. PAYMENT INFORMATION													
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HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) X (ID#)												1a. INSURED'S I.D. NUMBER 001151032 (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHAHIN KOSTA, ELIZABETH						3. PATIENT'S BIRTH DATE MM DD YY 09 07 1976			SEX M F X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME								
5. PATIENT'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12,						6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other			7. INSURED'S ADDRESS (No., Street) CALLE PORFIRIO HERRERA #12, PI										
CITY SANTO DOMINGO			STATE			8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO			STATE							
ZIP CODE			TELEPHONE (Include Area Code) (809) 540-1177						ZIP CODE			TELEPHONE (Include Area Code) (809) 540-1177							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES X NO						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>							
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES X NO PLACE (State)						c. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES X NO						d. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES X NO If yes, complete items 9, 9a, and 9d.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												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 04 01 2022												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 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? \$ CHARGES <input type="checkbox"/> YES X NO 000							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. M5450 B. M25551 C. E041 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												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. CPT/HCPCS E. MODIFIER F. PROCECDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)												E. DIAGNOSIS ICD Ind. 0 POINTER		23. PRIOR AUTHORIZATION NUMBER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. I.D. QUAL. J. RENDERING PROVIDER ID. #					
1	99204 NEW PATIENT		OFFICE		OR OTHER OUTPATIENT VISIT, LEVEL		4		ZZ		207R00000X								
	03 28 22		11	99204			ABC	707.00	1	NPI	1053394452								
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. MP1593440600				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 707.00		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.) JOAN M IRIZARRY ALVAR												32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865							
												33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508 MINNEAPOLIS, MN 55480-1508							
SIGNED 04 01 2022												a. 1790772317 b. ZZ261QM1300X							



HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTHCARE SVC
2813 EXECUTIVE PARK DR SUITE 120

WESTON, FL 33331

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1177862					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MARTINEZ METZ, JULIO, C						3. PATIENT'S BIRTH DATE MM DD YY 10 22 1971			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) PORFIRIO HERRERA NO. 12 PIAN						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) PORFIRIO HERRERA NO. 12 PIANTI								
CITY SANTO DOMINGO			STATE			8. RESERVED FOR NUCC USE			CITY SANTO DOMINGO			STATE					
ZIP CODE (809) 540-1177			TELEPHONE (Include Area Code)						ZIP CODE (809) 540-1177			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					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX								
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)								
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME WORLDWIDE CON-WORLDWIDE CONC								
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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.												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 04 01 2022												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 FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNJUAN C CARDENAS ROSALES				17a. 17b. NPI 1417211558				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? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 000					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. T781XXA	B. _____	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____	23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE EMG				B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. F. G. H. I. J. K. L. Diagnosis Pointer \$ CHARGES DAYS OR UNITS EPST Family Plan I.D. QUAL. RENDERING PROVIDER ID. #									
1 95004 TEST FOR ALLERGY USING ALLERGENIC EXTRACT 03 30 22 11 95004 A 308.00 11 ZZ 207K00000X NPI 1376641183	2 99243 PATIENT OFFICE CONSULTATION, LEVEL 3 03 30 22 11 99243 25 A 577.00 1 ZZ 207K00000X NPI 1376641183	3	4	5	6												
25. FEDERAL TAX I.D. NUMBER SSN EIN 593337028 <input checked="" type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. MP1593661520				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 885.00		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.) ARVEEN K BHASIN M.D.												32. SERVICE FACILITY LOCATION INFORMATION FLA MC DAVIS BUILDING 4500 SAN PABLO RD S JACKSONVILLE, FL 32224-1865 MINNEAPOLIS, MN 55480-1508					
SIGNED 04 01 2022												33. BILLING PROVIDER INFO & PH # (844) 217-9591 MAYO CLINIC JACKSONVILLE PO BOX 1508					
												a. 1790772317 b. ZZ261QM1300X					