1 NICKLAUS CHILDRENS HOSPIT
3100 SW 62 AVENUE
MIAMI FL 331553009
3056666511

2 NICKLAUS CHILDRENS HOSPIT
PO BOX 862192
ORLANDO FL 32886-2192

3a PAT. CNTL # 15096523
b. MED. REC. # 1122116083 12222605
4 TYPE OF BILL 0131
5 FED. TAX NO. 590638499
6 STATEMENT COVERS PERIOD FROM 032322 THROUGH 032322
7

8 PATIENT NAME
b PESSO NAHUM JACOBO LEV

9 PATIENT ADDRESS
a PH BELLAGIO CALLE PUNTA CHIRIQUI PUNTA PACIFICA A
b PANAMA CITY
c
d
e PA

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
06012021	M	032322	12	3	2	20	01			

31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a 11	032322													
b														

38
PESSO LEVY GUILAAD
PH BELLAGIO CALLE PUNTA CHIRIQUI PUNTA

PANAMA CITY

39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
a					
b					
c					
d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0252	DRUGS/NONGENERIC		032322	1	38700		
0372	UNLISTED ANESTH PROCEDUR	01999	032322	9	804600		
0471	EVOKED AUDITORY TEST LIM	92587	032322	1	92100		
0471	AEP THRSHLD EST MLT FREQ	92652	032322	1	84300		
0471	TYMPANOMETRY	92567	032322	1	6700		
0710	RECOVERY ROOM		032322	1	115000		
0001	PAGE 1 OF 1		CREATION DATE 032822		TOTALS	1141400	000

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
WORLDWIDE CONCIERGE HEALT	00010	Y	Y	000	000	1871540237	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
PESSO LEVY GUILAAD	19	WPG671303354		76570101

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
2203210017		

66 DX
H918X1
0

67 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX | 70 PATIENT REASON DX Z0110 | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	74 PRINCIPAL PROCEDURE DATE	a. OTHER PROCEDURE CODE	a. OTHER PROCEDURE DATE	b. OTHER PROCEDURE CODE	b. OTHER PROCEDURE DATE	75

c. OTHER PROCEDURE CODE	c. OTHER PROCEDURE DATE	d. OTHER PROCEDURE CODE	d. OTHER PROCEDURE DATE	e. OTHER PROCEDURE CODE	e. OTHER PROCEDURE DATE

80 REMARKS WORLDWIDE CONCIERGE
5201 BLUE LAGOON
SUITE 976
MIAMI FL 33126

81CC		
a	B3	282NC2000X
b		
c		
d		

76 ATTENDING NPI 1407072499 QUAL
LAST DAVE FIRST SANDEEP P
77 OPERATING NPI 1407072499 QUAL
LAST DAVE FIRST SANDEEP P
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 UB04! NUBC TFP24394485 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

WORLWIDE MEDICAL SEGUROS
2813 EXECUTIVE PARK DRIVE CENTER
SUITE 120
FORT LAUDERDALE, FL 33331

HEALTH INSURANCE CLAIM FORM

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

PICA W2WV QC2203311643126

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 001239782
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MESSINA RAMIREZ, ENZO	3. PATIENT'S BIRTH DATE MM DD YY: 05/04/2021 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): RAMIREZ TERC, MARIA	
5. PATIENT'S ADDRESS (No., Street): 2813 EXECUTIVE PARK DRIVE CENTER SUITE 120	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): 2813 EXECUTIVE PARK DRIVE CENTER SUIT	
CITY: FORT LAUDERDALE STATE: FL	8. RESERVED FOR NUCC USE
CITY: FORT LAUDERDALE STATE: FL	
ZIP CODE: 33331 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 33331 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 755630	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX: 08/23/1990 M [ ] F [X]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 04/01/22

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN RAFAEL E LLANSO MD	17a. 17b. NPI 1659305589
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ZZ208200000X	
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. Q750 B. Z87898 C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 10D2047053

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03/18/22	03/18/22	11		99243		AB	399.47	1		NPI	1417110974
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 463756071 [ ] [X]	26. PATIENT'S ACCOUNT NO.: 15109844	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 399.47	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.) JORDAN P STEINBERG SIGNED 04/01/22 DATE	32. SERVICE FACILITY LOCATION INFORMATION PLASTIC SURGERY 3100 SW 62 AVENUE MIAMI FL 33155-3009 a. 1427073436 b.		33. BILLING PROVIDER INFO & PH # ( ) NICKLAUS CHILDRENS PEDIATRIC SPECIA PO BOX 947095 ATLANTA GA 30394-7095 a. 1942754890 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PAGE 2 OF 2

000196

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(QESP) 40:T008:000196:002:0000: CMS-1500 2/2 10A