

Hospital for Special Surgery Fax Cover Sheet

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

From: Liz Cobena, HSS NPI 1598703019

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

Date/Time: Friday, February 25, 2022

Pages: 07

Comments:

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

Dear Team,

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

With best regards, Liz

Confidentiality Notice

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

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Patient: Alvarez Valdez, Francisco Jose Ju

Medical Record #: 981235

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

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Page 1 of 1



HEALTH INSURANCE CLAIM FORM

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

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HEALTH INSURANCE CLAIM FORM

APPROVED BY HATIONAL ULIFORM OLAM COMMITTEE (MUCC) 68/03

UHC GLOBAL PO BOX 30526

SALT LAKE CITY, UT 84130

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HEALTH INSURANCE CLAIM FORM

APPROVED BY HATIONAL ULIFORM OLAM COMMITTEE (MUCC) 68/03

UHC GLOBAL PO BOX 30526

SALT LAKE CITY, UT 84130

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HEALTH INSURANCE CLAIM FORM

UHC GLOBAL PO BOX 30526

APPROVED BY HATIONAL UHEORM CLAM/COMMITTEE MUCCI 02/12 SALT LAKE CITY, UT 84130 18 EUSUPED/S LO MUMBER MEDICAPE CHAMPMA (Por Program in Item 1) Transmin 1 (Administration) (Modinaldil) Adaption (Od) 685000798562 omm. 2. PATIENT'S NAME (Last Name, Pira, Name, Middle Initian) 4. INSURED/3 (Jawe Cast Hame, First Name, Middle Initial) ALVAREZ VALDEZ, FRANCISCO, SAME S. PATIETO'S ADDRESS (No.: Street) 7. INSURED'S ADDRESS (No., Street) Self X Epouse Child 505 WEST 47TH STREET APT 4GS 505 WEST 47TH STREET APT 4GS 37478 NEW YORK NEW YORK NY NY 2/P 000F YELEPHONE (include Area Code) ZIP CODE TELEPHONE (Includa Area Code) (809)683-3986 10036 (809)683-3986 10036 3. GTHER 1919/PREDS NAME (Last Name, First Dame, Middle Inhai) 11. INSURED'S POLICY GPOUP OR FECA NUMBER 49. IS PATIEDM'S CONDITION RELATED TO NONE MSURED a OTHER INSURED'S POUCY OF GROUP NUMBER A. INSURED'S DATE OF BIRTH WM | DD | YY EMPLOYMENT? (Current or Previous) ````}Y#3 & RESERVED FOR NUOD USE b. OTHER CLAIM ID (Designated by MUCC PATIENT AND PLACE (37%) X NO YES a RESERVED FOR NUCC USE L. INSURANCE PLAN NAME OR PROGRAM NAME c other addiction COMMERCIAL OT-COMMERCIAL OTH IS THERE AROTHER HEALTH BENEFIT PLAN? RISURALICE PLANTIAME OF PROGRAM NAME 785 X NO 89 year nomplete harms 9, 5e, and 9d READ BACK OF FORM BEFORE COMPLETING & SIGNING YEES FORM. 12. PATIELTI'S OF AUTHORIZED PEFFOOTE, SIGNATURE Laurenza me release et any medical or ether information necess bayment of medical benefits to the undersigned physician or supplier for to process this dislim. Laiso request payment of government benefits either to miself or to the party who sociepts assignment services described below SERED SIGNATURE ON FILE SIGNATURE ON FILE DATE 0.2 25 2022 45, OTHER DAT COA. 18 HOSPITALIZATION DATES RELATED TO CUPPER IT SERVICES 17. NAME OF REPERRING PROVIDER OR OTHER SOURCE TO 08 04 2021 ™0×08 04 2021 DNSTEPHEN FEALY PU OUTSIDE LABV \$ OBJAPOBE 19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC) YES X KO 000 BESTRAISSICE BESTRAISSICE 21. CIACROSIS OR MATUPE OF ILLNESS OF INJURY. Relate AL iop inst. 0 _ M19012 _B M7582 WER WFORMATION RENDERING PROVIDER ID 21 08 26 LT 379.00 1 1629085188 ABC 30408 SCHWOS $\mathbb{N}^{(2)}$ (489) 25 FEDERAL TAX LO NUMBER 28. TOTAL CHARGE SS. AMOUNT PAID 25 PATHENT'S ACCOUNT NO 33N F N AA1040579731 251917907 379.00 0.00 SIGUATURE OF PHISICIAN OR SUPPLIER 32 SEPVICE PACILITY LOCATION INFORMATION INCLUDING DEGREES OF OPEDERMALS (I harfly that the statements on the reverse HOSPITAL FOR SPECIAL SURGE HSS RADIOLOGISTS apply to this till and are made a part thereof.) PO BOX 5058 535 E 70TH STREET HOLLIS G POTTER MD NEW YORK, NY 10021 <u>NEW YORK, NY 10087-5058</u> 02 25 2022 * 1598703019 *1255777488