



# HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331



PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) BLK LUNG (ID#) (ID#)												1a. INSURED'S I.D. NUMBER <input type="text"/> (For Program in Item 1) 685000037882							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LAMA, ENRIQUE						3. PATIENT'S BIRTH DATE MM DD YY 08 06 1941 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) LAMA, ENRIQUE							
5. PATIENT'S ADDRESS (No., Street) PASEO DOLMEN 13						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) PASEO DOLMEN 13							
CITY ENSANCHEZ PARAESO			STATE			CITY ENSANCHEZ PARAESO			STATE										
ZIP CODE 00009		TELEPHONE (Include Area Code) ( )				ZIP CODE 00009		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 76570101							
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 08 06 1941 M <input checked="" 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							
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												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 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							
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. C9000				B. <input type="text"/> C. <input type="text"/> D. <input type="text"/>				23. PRIOR AUTHORIZATION NUMBER											
E. <input type="text"/> F. <input type="text"/> G. <input type="text"/> H. <input type="text"/>				I. <input type="text"/> J. <input type="text"/> K. <input type="text"/> L. <input type="text"/>				F. \$ CHARGES G. DAYS OR UNITS H. EPSCOT Family Pan I. ID. QUAL. J. RENDERING PROVIDER ID. #											
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							
1 03 30 22 03 30 22 22				2 03 30 22 03 30 22 22				3 03 30 22 03 30 22 22				4 03 30 22 03 30 22 22							
5 03 30 22 03 30 22 22				6 03 30 22 03 30 22 22				7 03 30 22 03 30 22 22				8 03 30 22 03 30 22 22							
9 03 30 22 03 30 22 22				10 03 30 22 03 30 22 22				11 03 30 22 03 30 22 22				12 03 30 22 03 30 22 22							
13 03 30 22 03 30 22 22				14 03 30 22 03 30 22 22				15 03 30 22 03 30 22 22				16 03 30 22 03 30 22 22							
17 03 30 22 03 30 22 22				18 03 30 22 03 30 22 22				19 03 30 22 03 30 22 22				20 03 30 22 03 30 22 22							
21 03 30 22 03 30 22 22				22 03 30 22 03 30 22 22				23 03 30 22 03 30 22 22				24 03 30 22 03 30 22 22							
25. FEDERAL TAX I.D. NUMBER SSN EIN 592579938 <input type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. U383191600				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 660.00							
29. AMOUNT PAID \$ <input type="text"/>				30. Rsvd for NUCC Use <input type="checkbox"/>				33. BILLING PROVIDER INFO & PH # ( )											
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.) JAMES EDWARD HOFFMAN												32. SERVICE FACILITY LOCATION INFORMATION UMHC SCCC 1475 NW 12TH AVE MIAMI, FL 331361002				UMIAMI MEDICINE-HEMATOLOGY PO BOX 281046 ATLANTA, GA 303841046			
SIGNED <input type="checkbox"/>				DATE <input type="text"/>				a. 1679660617 b. <input type="text"/>				a. 1194776062 b. <input type="text"/>							

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

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



CARHIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



April 07, 2022

8100 Oak Lane  
Suite 404  
Miami Lakes, FL 33016  
United States of America

Phone 305-447-4094  
Toll Free 800-573-5952  
Fax 305-447-5898

[info@ipfs-corporation.com](mailto:info@ipfs-corporation.com)  
[www.ipfs-corporation.com](http://www.ipfs-corporation.com)

**VIA MAIL**

Worldwide Concierge Healthcare Services  
2813 Executive Park Drive, Suite 120  
Weston, FL. 33331

**RE:** Alvarez Mendez, Hortensia del Carmen  
**Date of Services:** 12/09/2021  
**D.O.B.:** 11/23/1966

Dear Sirs,

Please provide payment status. Attached you will find **UB** for this account.

Hospital name:	Account #	Insured ID #	Patient name:	Total Charges:
University of Miami Hospital	57407706	50891	Alvarez Mendez, Hortensia del Carmen	\$ 3,475.00
<b>Balance pending of payment:</b>				<b>\$ 3,475.00</b>

Thank you for your assistance and cooperation. If you have any question or require additional information contact me at your convenience.

Sincerely,

A blue ink signature of the name "C. Louis Yepez".

C. Louis Yepez  
Account Manager  
**IPFS Corporation**  
**Tel: 305-447-86222**  
**Fax: 305-569-7704**  
**E-mail: cyepez@ipfs-corporation.com**

UMHC 1475 NW 12 AVE MIAMI 3052432900		UMHC P.O. BOX 402005 ATLANTA GA 303842005		3a PAT. CNTL # b MED. REC. # 5. TAX NO.	5740770600 23074517	4 TYPE OF BILL 0131			
8 PATIENT NAME <b>b ALVAREZ MENDEZ HORTENSIA D</b>		9 PATIENT ADDRESS <b>b MIAMI</b>		6 STATEMENT COVERS PERIOD FROM TO 592616017 120921 120921		7			
10 BIRTHDATE <b>11231966</b>		11 SEX <b>F</b>	ADMISSION DATE <b>3 2</b>	12 HR 13 TYPE 15 SRC	16 DHR 17 STAT <b>01</b>	18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30			
31 OCCURENCE DATE CODE		32 OCCURENCE DATE CODE	33 OCCURENCE DATE CODE	34 OCCURENCE DATE CODE	35 OCCURENCE SPAN FROM CODE	36 OCCURENCE SPAN THROUGH CODE	37		
<b>a b</b> 38 WORLDWIDE CONCIERGE 2813 EXECUTIVE PARK DRIVE CENTER FOR INT SUITE 120 WESTON, FL 33331 855-203-3520									
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 2 3 4	0274 MEDICAL/SURGICAL SUPPLIES 0510 CLINIC - GENERAL CLASSIF 0920 OTHER DIAGNOSTIC SERVICE 0920 OTHER DIAGNOSTIC SERVICE	V2531 G0463 92132 92313		120921 120921 120921 120921	2 1 1 1	249600 31000 27900 39000	000 000 000 000	1 2 3 4	
5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22									
23	0001 PAGE 1 OF 1	CREATION DATE		121321	TOTALS ➡	347500	000	23	
50 PAYER NAME <b>A WORLDWIDE CONCIERGE</b>		51 HEALTH PLAN ID <b>01999</b>		52 REL. INFO <b>Y</b>	53 AMG. BEN. <b>Y</b>	54 PRIOR PAYMENTS <b>000</b>	55 EST. AMOUNT DUE <b>347500</b>	56 NPI <b>1679660617</b>	
<b>B</b>							57 OTHER		
<b>C</b>							PRV ID		
58 INSURED'S NAME <b>A ALVAREZ MENDEZ, HORTENSIA</b>		59 P. REL. <b>18000050891</b>	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO. <b>755630</b>		
<b>B</b>									
<b>C</b>									
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME			
<b>A</b>									
<b>B</b>									
<b>C</b>									
66 DX <b>H18603</b>								68	
0									
69 ADMIT DX <b>H18603</b>	70 PATIENT REASON DX <b>H18603</b>	71 PPS CODE <b>72 ECI</b>						73	
74 PRINCIPAL PROCEDURE CODE <b>a</b>	OTHER PROCEDURE DATE <b>CODE</b>	OTHER PROCEDURE DATE <b>CODE</b>	75	76 ATTENDING NPI <b>1184058174</b>	QUAL				
				LAST FRANKEL		FIRST STEPHANIE TH			
c OTHER PROCEDURE CODE <b>d</b>	OTHER PROCEDURE DATE <b>CODE</b>	OTHER PROCEDURE DATE <b>CODE</b>	e OTHER PROCEDURE DATE <b>CODE</b>	77 OPERATING NPI	QUAL				
				LAST		FIRST			
80 REMARKS		81CC <b>3</b>	B3284300000X			78 OTHER NPI	QUAL		
		b				LAST		FIRST	
		c				79 OTHER NPI	QUAL		
		d				LAST		FIRST	



## HEALTH INSURANCE CLAIM FORM

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

PICA COMMERCIAL ASSIGNED 48

INTL WORLDWIDE SEGUROS INTL HM  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
FORT LAUDERDALE, FL 33331

CARRIER

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) <b>NINFRIAS, MARILIN E</b>												3. PATIENT'S BIRTH DATE MM   DD   YY <b>04   24   1968</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> X	
5. PATIENT'S ADDRESS (No., Street) <b>18063 NW 60TH CT</b>												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY <b>HIALEAH</b>		STATE <b>FL</b>		8. RESERVED FOR NUCC USE		CITY <b>HIALEAH</b>		STATE <b>FL</b>					
ZIP CODE <b>33015</b>		TELEPHONE (Include Area Code) <b>(849)803 6484</b>				ZIP CODE <b>33015</b>		TELEPHONE (Include Area Code) <b>(849) -803-6484</b>					
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) <input type="checkbox"/>	
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. 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.												11. INSURED'S POLICY GROUP OR FECA NUMBER <b>9445976</b>	
SIGNATURE ON FILE												12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
SIGNED _____ DATE <b>04/06/22</b>												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM   DD   YY <b>02   19   22</b> QUAL <b>431</b>												15. OTHER DATE MM   DD   YY QUAL. <input type="checkbox"/> MM <input type="checkbox"/> DD <input type="checkbox"/> YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE   												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY	
17a. _____ 17b. NPI _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <b>02   19   22</b> TO <b>02   19   22</b>	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. <b>M25.511</b>		B. <b>M75.81</b>		C. _____ D. _____		E. ICD Ind. <b>0</b>		F. _____ G. _____ H. _____		I. ID. <b>0</b> J. RENDERING PROVIDER ID. # <b>1033143698</b>			
E. _____		F. _____		G. _____		H. _____		F. \$ CHARGES		G. DAYS OR UNITS			
I. _____		J. _____		K. _____		L. _____		H. EPSDT Family Plan		I. ID. QUAL.			
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	
25. FEDERAL TAX I.D. NUMBER <b>65-0622859</b>		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. <b>306903178/30</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 1369 00</b>		29. AMOUNT PAID <b>\$ 0 00</b>		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.) <b>GARRETT MD, VICTORIA</b>												32. SERVICE FACILITY LOCATION INFORMATION <b>UNIVERSITY OF MIAMI HOSPI 1400 NW. 12th Ave. MIAMI, FL 33136-1003</b>	
SIGNATURE ON FILE <b>04/06/22</b>												33. BILLING PROVIDER INFO & PH. # <b>(800)-562-2945</b> <b>PARAGON CONTRACTING SERVICES, PO BOX 634710 CINCINNATI, OH 45263-4710</b>	
SIGNED <b>04/06/22</b>												34. OUTSOURCED BILLING (02-12) <b>b. ZZ193200000X</b>	



**IPFS**  
International  
Patient Financial  
Services Corporation

April 07, 2022

8100 Oak Lane  
Suite 404  
Miami Lakes, FL 33016  
United States of America

Phone 305-447-4094  
Toll Free 800-573-5952  
Fax 305-447-5898

[info@ipfs-corporation.com](mailto:info@ipfs-corporation.com)  
[www.ipfs-corporation.com](http://www.ipfs-corporation.com)

**VIA MAIL**

Worldwide Concierge Healthcare Svcs.  
2813 Executive Park Drive, Suite 120  
Weston, FL 33331

**RE:** Martinez Gonzalez, Jose Ramon  
**Date of Services:** 11/30/2021  
**D.O.B.:** 10/25/1954

Dear Sirs,

Please provide payment status. Attached you will find **UB** for this account.

Hospital name:	Account #	Insured ID #	Patient name:	Total Charges:
University of Miami Hospital	56082146	999045064	Martinez Gonzalez, Jose Ramon	\$ 26,502.00

**Balance pending of payment:**

**\$ 26,502.00**

Thank you for your assistance and cooperation. If you have any question or require additional information contact me at your convenience.

Sincerely,

C. Louis Yepez  
Account Manager  
**IPFS Corporation**  
**Tel:** 305-447-86222  
**Fax:** 305-569-7704  
**E-mail:** [cyepez@ipfs-corporation.com](mailto:cyepez@ipfs-corporation.com)

UMHC 1475 NW 12 AVE MIAMI			UMHC P.O. BOX 402005 ATLANTA			3a PAT. CNTL # b MED. REC. #	5608214601 20050697	4 TYPE OF BILL 0131			
3052432900			GA 303842005 D.TAX NO.			6 STATEMENT COVERS PERIOD FROM TO	7				
8 PATIENT NAME <b>b MARTINEZ GONZALEZ JOSE R</b>			9 PATIENT ADDRESS <b>b SANTO DOMINGO</b>			592616017 113021 113021					
10 BIRTHDATE <b>10251954</b>		11 SEX <b>M</b>	ADMISSION DATE <b>3 2</b>	13 H.R. <b>01</b>	14 TYPE <b>5 SRC</b>	16 DHR	17 STAT <b>01</b>	18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE	30		
31 OCCURENCE CODE DATE	32 OCCURENCE CODE DATE	33 OCCURENCE CODE DATE	34 OCCURENCE CODE DATE	35 OCCURENCE CODE DATE	CONDITION CODES			36 OCCURENCE SPAN FROM	THROUGH	37	
a	b	c	d	e	DO	a	b	c	d	e	
<b>38 WORLDWIDE CONCIERGE 2813 EXECUTIVE PARK DRIVE CENTER FOR INT SUITE 120 WESTON, FL 33331 855-203-3520</b>											
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	0250 PHARMACY - GENERAL CLASS						113021	1	34600	000	1
2	0250 N400065079550ML500						113021	1	28700	000	2
3	0250 N408065183150ML1.05						113021	1	209400	000	3
4	0250 N468682092064ML15						113021	1	10800	000	4
5	0250 N499999-9991-02ML0.05						113021	1	1400	000	5
6	0270 MEDICAL/SURGICAL SUPPLIE						113021	1	24400	000	6
7	0272 MEDICAL/SURGICAL SUPPLIE						113021	2	31700	000	7
8	0276 MEDICAL/SURGICAL SUPPLIE			V2788GY			113021	1	447200	000	8
9	0360 OPERATING ROOM SERVICES			66984LT			113021	1	905800	000	9
10	0370 ANESTHESIA - GENERAL CLA						113021	1	352700	000	10
11	0636 N400409475518ML2			J2405			113021	4	1500	000	11
12	0710 RECOVERY ROOM - GENERAL						113021	3	602000	000	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23	0001 PAGE 1 OF 1			CREATION DATE			011322	TOTALS ➔	2650200	000	23
A	50 PAYER NAME <b>WORLDWIDE CONCIERGE</b>			51 HEALTH PLAN ID <b>01999</b>			52 REL. INFO <b>Y</b>	53 ASG. BEN. <b>Y</b>	54 PRIOR PAYMENTS <b>000</b>	55 EST. AMOUNT DUE <b>2650200</b>	56 NPI <b>1679660617</b>
B										57 OTHER	
C										PRVID	
A	58 INSURED'S NAME <b>MARTINEZ GONZALEZ, JOSE R</b>			59 P. REL <b>18999045064</b>	60 INSURED'S UNIQUE ID			61 GROUP NAME <b>INTL WORLDWIDE</b>			62 INSURANCE GROUP NO.
B											
C											
A	63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME				
B											
C											
66 DX	H2512	I422	N400	F419	R361	E785	I119	E669	Z6832	68	
0Z8249	Z87891	Z79899	Z7982								
69 ADMIT DX	70 PATIENT REASON DX			H2512	Z20822	71 PPS CODE	72 ECI			73	
74	PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	DATE	b	CODE	OTHER PROCEDURE DATE	75	76 ATTENDING	NPI 1891710752	QUAL	
								LAST YOO		FIRST SONIA H	
c	OTHER PROCEDURE CODE	OTHER PROCEDURE CODE	DATE	e	CODE	OTHER PROCEDURE DATE		77 OPERATING	NPI 1891710752	QUAL	
								LAST YOO		FIRST SONIA H	
80	REMARKS	81CC a	B3284300000X			78 OTHER	NPI		QUAL		
		b				LAST			FIRST		
		c				79 OTHER	NPI		QUAL		
		d				LAST			FIRST		



WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331

## HEALTH INSURANCE CLAIM FORM

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



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"/> (BLK LUNG ID#) <input checked="" type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 685000821152								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO						3. PATIENT'S BIRTH DATE MM DD YY SEX 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO								
5. PATIENT'S ADDRESS (No., Street) 6354 NW 104 CT						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) 6354 NW 104 CT								
CITY MEDLEY			STATE FL			8. RESERVED FOR NUCC USE			CITY MEDLEY			STATE FL								
ZIP CODE 33178		TELEPHONE (Include Area Code) ( )							ZIP CODE 33178		TELEPHONE (Include Area Code) ( )									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:								
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)								
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						11. INSURED'S POLICY GROUP OR FECA NUMBER 755630								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												a. INSURED'S DATE OF BIRTH MM DD YY SEX 12 11 1972 M <input checked="" 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 DATE												c. INSURANCE PLAN NAME OR PROGRAM NAME								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.						15. OTHER DATE MM DD YY QUAL.						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN NAMRATA CHANDHOK						17a. _____ 17b. NPI 1811336696						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												SIGNED Signature on File								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
A. C9200				B. _____				C. _____				D. _____								
E. _____				F. _____				G. _____				H. _____								
I. _____				J. _____				K. _____				L. _____								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY						B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				E. MODIFIER		F. DIAGNOSIS POINTER		G. DAYS OR UNITS		H. EPSCD Family Plan	I. I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	15	21	04	15	21	22		88360	26		A	199	00	1	ZZ	207Z0000X			
2	04	15	21	04	15	21	22		85097			A	184	00	1	NPI	1306057419			
3	04	15	21	04	15	21	22		88305	26		A	140	00	1	ZZ	207Z0000X			
4	04	15	21	04	15	21	22		88342	26	59	A	131	00	1	NPI	1306057419			
5	04	15	21	04	15	21	22		85060			A	93	00	1	ZZ	207Z0000X			
6	04	15	21	04	15	21	22		88341	26	59	A	79	00	1	NPI	1306057419			
25. FEDERAL TAX I.D. NUMBER SSN EIN 592579938 <input checked="" type="checkbox"/> X						26. PATIENT'S ACCOUNT NO. U382220421				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 920 00		29. AMOUNT PAID \$		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.) JENNIFER ROSE CHAPMAN-FREDRICK												32. SERVICE FACILITY LOCATION INFORMATION UNIVERSITY OF MIAMI HOSPITALS A 1400 NW 12TH AVE MIAMI, FL 331361003				33. BILLING PROVIDER INFO & PH # ( ) UMIAMI MEDICINE-PATHOLOGY PO BOX 281046 ATLANTA, GA 303841046				
SIGNED DATE a. 1679660617						b. a. 1518917350 b.														





WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331

## HEALTH INSURANCE CLAIM FORM

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



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) 685000821152						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO						3. PATIENT'S BIRTH DATE MM DD YY 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO						
5. PATIENT'S ADDRESS (No., Street) 6354 NW 104 CT						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) 6354 NW 104 CT						
CITY MEDLEY			STATE FL			CITY MEDLEY			STATE FL									
ZIP CODE 33178		TELEPHONE (Include Area Code) ( )				ZIP CODE 33178		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						
a. OTHER INSURED'S POLICY OR GROUP NUMBER						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)						b. INSURED'S DATE OF BIRTH MM DD YY 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE						10d. CLAIM CODES (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME						
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.						
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												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 DN: NAMRATA CHANDHOK						17a. NPI 1811336696						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						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. C9200      B. _____      C. _____      D. _____ E. _____      F. _____      G. _____      H. _____ I. _____      J. _____      K. _____      L. _____												23. PRIOR AUTHORIZATION NUMBER 10D0280714						
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. ID. QUAL	J. RENDERING PROVIDER ID. #
1	04 15 21	04 15 21	22		88311	26			A	48 00	1		ZZ	207ZH0000X	NPI	1306057419		
2	04 15 21	04 15 21	22		88313	26			A	46 00	1		ZZ	207ZH0000X	NPI	1306057419		
3																		
4																		
5																		
6																		
25. FEDERAL TAX I.D. NUMBER SSN EIN 592579938 <input type="checkbox"/> X						26. PATIENT'S ACCOUNT NO. U382220421			27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (For govt. claims, see back)			28. TOTAL CHARGE \$ 920 00		29. AMOUNT PAID \$		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.) JENNIFER ROSE CHAPMAN-FREDRICK						32. SERVICE FACILITY LOCATION INFORMATION UNIVERSITY OF MIAMI HOSPITALS A 1400 NW 12TH AVE MIAMI, FL 331361003			33. BILLING PROVIDER INFO & PH # ( ) UMIAMI MEDICINE-PATHOLOGY PO BOX 281046 ATLANTA, GA 303841046									
SIGNED DATE 1679660617						b.			a. 1518917350 b.									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

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



WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331

## HEALTH INSURANCE CLAIM FORM

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



PICA

<input type="checkbox"/> PICA <b>1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER</b> <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#)												<b>1a. INSURED'S I.D. NUMBER</b> 685000821152 <small>(For Program in Item 1)</small>											
<b>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</b> GUZMAN, RODOLFO												<b>3. PATIENT'S BIRTH DATE</b> MM DD YY SEX 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/>											
<b>5. PATIENT'S ADDRESS (No., Street)</b> 6354 NW 104 CT												<b>6. PATIENT RELATIONSHIP TO INSURED</b> Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
<b>CITY</b> MEDLEY												<b>7. INSURED'S ADDRESS (No., Street)</b> 6354 NW 104 CT											
<b>ZIP CODE</b> 33178		<b>STATE</b> FL										<b>CITY</b> MEDLEY											
<b>ZIP CODE</b> 33178		<b>STATE</b> FL										<b>ZIP CODE</b> 33178											
<b>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</b>												<b>10. IS PATIENT'S CONDITION RELATED TO:</b>											
<b>a. OTHER INSURED'S POLICY OR GROUP NUMBER</b>												<b>a. EMPLOYMENT? (Current or Previous)</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
<b>b. RESERVED FOR NUCC USE</b>												<b>b. AUTO ACCIDENT?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)											
<b>c. RESERVED FOR NUCC USE</b>												<b>c. OTHER ACCIDENT?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
<b>d. INSURANCE PLAN NAME OR PROGRAM NAME</b>												<b>10d. CLAIM CODES (Designated by NUCC)</b>											
<b>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</b> 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>11. INSURED'S POLICY GROUP OR FECA NUMBER</b> 755630											
<b>SIGNED</b> Signature on File												<b>12. IS THERE ANOTHER HEALTH BENEFIT PLAN?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>											
<b>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)</b> MM DD YY QUAL.												<b>15. OTHER DATE</b> MM DD YY QUAL.											
<b>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</b> DN ANTONIO JIMENEZ JIMENEZ												<b>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</b> FROM MM DD YY TO MM DD YY											
<b>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</b>												<b>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</b> FROM MM DD YY TO MM DD YY 07 13 21 08 05 21											
<b>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</b> Relate A-L to service line below (24E)												<b>20. OUTSIDE LAB?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES											
A. C9200 B. D849 C. Z9481 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												<b>22. RESUBMISSION CODE</b> ORIGINAL REF. NO.											
<b>24. A. DATE(S) OF SERVICE</b> From MM DD YY To MM DD YY 08 05 21 08 05 21												<b>D. PROCEDURES, SERVICES, OR SUPPLIES</b> (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 99238						<b>E. DIAGNOSIS POINTER</b> ABC					
<b>25. FEDERAL TAX I.D. NUMBER</b> SSN EIN 592579938 <input type="checkbox"/> X												<b>26. PATIENT'S ACCOUNT NO.</b> U382220451						<b>27. ACCEPT ASSIGNMENT?</b> (For gov't. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
<b>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</b> <i>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</i> TRENT PENG WANG												<b>28. TOTAL CHARGE</b> \$ 279 00						<b>29. AMOUNT PAID</b> \$ _____					
<b>32. SERVICE FACILITY LOCATION INFORMATION</b> UMHC SCCC 1475 NW 12TH AVE MIAMI, FL 331361002												<b>33. BILLING PROVIDER INFO &amp; PH #</b> ( )											
<b>SIGNED</b> DATE 1679660617 b.												a. 1194776062 b.											
<b>NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a></b>																							
<b>PLEASE PRINT OR TYPE</b>																							
11/11/21 10:57 AM 1 0002330 20220330 2C0GV102 156182-2 2 oz DOM 2C0GV10000 156182 MC																							
3936844192																							
<b>APPROVED OMB-0938-1197 FORM 1500 (02-12)</b>																							

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331

## HEALTH INSURANCE CLAIM FORM

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



PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA 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"/> (BLK LUNG ID#) <input checked="" type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 685000821152											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO						3. PATIENT'S BIRTH DATE MM DD YY SEX 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO											
5. PATIENT'S ADDRESS (No., Street) 6354 NW 104 CT						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) 6354 NW 104 CT											
CITY MEDLEY			STATE FL			8. RESERVED FOR NUCC USE			CITY MEDLEY			STATE FL											
ZIP CODE 33178			TELEPHONE (Include Area Code) ( )						ZIP CODE 33178			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 SEX 12 11 1972 M <input checked="" 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											
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												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 DN ANTONIO JIMENEZ JIMENEZ						17a. 17b. NPI 1558519603						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											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. C9200				B. K521				C. R112				D. D849											
E. D61810				F. Z9481				G. K649				H. K1230											
I. T451X5A				J. L.				K. L.				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 ICD Ind. 0		F. \$ CHARGES		G. DAYS OR UNITS	H. EP/SOT Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER ID. #		
1	08	02	21	08	02	21	21	99233		ABCD		399	00	1		ZZ	207RH0003X						
2	08	01	21	08	01	21	21	99233		ABCD		399	00	1	NPI	ZZ	207RH0003X						
3	07	31	21	07	31	21	21	99233		ABCD		399	00	1	NPI	ZZ	207RH0003X						
4	07	30	21	07	30	21	21	99233		ABCD		399	00	1	NPI	ZZ	207RH0003X						
5	07	29	21	07	29	21	21	99233		ABCD		399	00	1	NPI	ZZ	207RH0003X						
6																	NPI						
25. FEDERAL TAX I.D. NUMBER SSN EIN 592579938 <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. U382220441						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1995.00		29. AMOUNT PAID \$		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.) TRENT PENG WANG												32. SERVICE FACILITY LOCATION INFORMATION UMHC SCCC 1475 NW 12TH AVE MIAMI, FL 331361002						33. BILLING PROVIDER INFO & PH # ( ) UMIAMI MEDICINE-HEMATOLOGY PO BOX 281046 ATLANTA, GA 303841046					
SIGNED DATE						a. 1679660617 b.						a. 1194776062 b.											



PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER



## **HEALTH INSURANCE CLAIM FORM**

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

WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331



CARRIER

PICA

MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/>	1a. INSURED'S I.D. NUMBER 685000821152	(For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO			3. PATIENT'S BIRTH DATE MM DD YY 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO									
5. PATIENT'S ADDRESS (No., Street) 6354 NW 104 CT			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) 6354 NW 104 CT									
CITY MEDLEY		STATE FL	8. RESERVED FOR NUCC USE			CITY MEDLEY		STATE FL							
ZIP CODE 33178	TELEPHONE (Include Area Code) ( )					ZIP CODE 33178	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 12 11 1972 M <input checked="" 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									
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.									
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															
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 DN NAMRATA CHANDHOK			17a. 17b. NPI 1811336696			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. C9200	B.	C.	D.	E.	F.	G.	H.	I.							
J.	K.	L.													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER	F. \$ CHARGES									
04 15 21 04 15 21 22			88189			A	421 00	1							
ZZ 207Z0000X NPI 1306057419															
NPI															
NPI															
NPI															
NPI															
NPI															
25. FEDERAL TAX I.D. NUMBER SSN EIN 592579938 <input checked="" type="checkbox"/>									26. PATIENT'S ACCOUNT NO. U382220411		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 421 00	29. AMOUNT PAID \$	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.) JENNIFER ROSE CHAPMAN-FREDRICK									32. SERVICE FACILITY LOCATION INFORMATION UMHC SCCC 1475 NW 12TH AVE MIAMI, FL 331361002			33. BILLING PROVIDER INFO & PH # ( ) UMIAMI MEDICINE-PATHOLOGY PO BOX 281046 ATLANTA, GA 303841046			
SIGNED									a. 1C700000017 b.			a. 1519017250 b.			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION





WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331

## HEALTH INSURANCE CLAIM FORM

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



PICA																																																														
1. MEDICARE (Medicare#)		MEDICAID (Medicaid#)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	OTHER (ID#)																																																			
<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="6" style="width: 50%;">3. PATIENT'S BIRTH DATE MM DD YY</td> <td colspan="6" style="width: 50%;">SEX 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/></td> </tr> <tr> <td colspan="12" style="font-size: small; padding-top: 5px;">4. INSURED'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO</td> </tr> </table>												3. PATIENT'S BIRTH DATE MM DD YY						SEX 12 11 1972 M <input checked="" type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO																																						
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) GUZMAN, RODOLFO						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																								
5. PATIENT'S ADDRESS (No., Street) 6354 NW 104 CT						7. INSURED'S ADDRESS (No., Street) 6354 NW 104 CT																																																								
CITY MEDLEY			STATE FL			CITY MEDLEY			STATE FL																																																					
ZIP CODE 33178		TELEPHONE (Include Area Code) ( )				ZIP CODE 33178		TELEPHONE (Include Area Code) ( )																																																						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:																																																								
<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="width: 33%;">a. OTHER INSURED'S POLICY OR GROUP NUMBER</td> <td colspan="3" style="width: 33%;">a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td colspan="3" style="width: 34%;">a. INSURED'S DATE OF BIRTH MM DD YY</td> </tr> <tr> <td colspan="3">b. RESERVED FOR NUCC USE</td> <td colspan="3">b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td colspan="3">b. OTHER CLAIM ID (Designated by NUCC)</td> </tr> <tr> <td colspan="3">c. RESERVED FOR NUCC USE</td> <td colspan="3">c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td colspan="3">c. INSURANCE PLAN NAME OR PROGRAM NAME</td> </tr> <tr> <td colspan="6">d. INSURANCE PLAN NAME OR PROGRAM NAME</td> <td colspan="6">10d. CLAIM CODES (Designated by NUCC)</td> </tr> </table>						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			d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="6">11. INSURED'S POLICY GROUP OR FECA NUMBER 755630</td> </tr> <tr> <td colspan="6">d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    If yes, complete items 9, 9a, and 9d.</td> </tr> </table>						11. INSURED'S POLICY GROUP OR FECA NUMBER 755630						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    If yes, complete items 9, 9a, and 9d.					
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<p><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> <p>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.</p>																																																														
SIGNED Signature on File						DATE																																																								
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 DN ANTONIO JIMENEZ JIMENEZ						17a. MM DD YY 17b. NPI 1558519603																																																								
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 07 13 21 TO 08 05 21																																																														
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																																														
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    \$ CHARGES																																																														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0																																																														
A. Z5111		B. C9201		C. D849		D. Z9484		22. RESUBMISSION CODE 7				ORIGINAL REF. NO. 21202186808																																																		
E. I10		F. T451X5A		G. L		H. L		23. PRIOR AUTHORIZATION NUMBER																																																						
I. L		J. L		K. L		L. L																																																								
24. A. DATE(S) OF SERVICE From MM DD YY		B. PLACE OF SERVICE To MM DD YY		C. EMG		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 07 15 21		2 07 15 21		3 21		4 99233		5 ABCD	6 399 00	7 1	8 ZZ	9 NPI	10 207RH0003X	11 1326067596																																																
11		12		13		14		15	16	17	18	19	20																																																	
12		13		14		15		16	17	18	19	20	21																																																	
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16		17		18		19		20	21	22	23	24	25																																																	
25. FEDERAL TAX I.D. NUMBER 592579938		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. U382419911		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 399 00		29. AMOUNT PAID \$		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.) LAZAROS JOHN LEKAKIS																																																														
32. SERVICE FACILITY LOCATION INFORMATION UMHC SCCC 1475 NW 12TH AVE MIAMI, FL 331361002																																																														
33. BILLING PROVIDER INFO & PH # ( ) UMIAMI MEDICINE-HEMATOLOGY PO BOX 281046 ATLANTA, GA 303841046																																																														
34. SIGNED		35. DATE		36. a. 1679660617		37. b.		38. a. 1194776062		39. b.																																																				





# HEALTH INSURANCE CLAIM FORM

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

PICA

WORLDWIDE CONCIERGE  
2813 EXECUTIVE PARK DRIVE CENT  
SUITE 120  
WESTON FL 33331



CARRIER

PICA											
1. MEDICARE (Medicare#)		MEDICAID (Medicaid#)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	OTHER (ID#)
1a. INSURED'S I.D. NUMBER <b>685000821152</b> (For Program in Item 1)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>GUZMAN, RODOLFO</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>12 11 1972</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street) <b>6354 NW 104 CT</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY <b>MEDLEY</b>			STATE <b>FL</b>			8. RESERVED FOR NUCC USE					
ZIP CODE <b>33178</b>		TELEPHONE (Include Area Code) <b>( )</b>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)					
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)					
11. INSURED'S POLICY GROUP OR FECA NUMBER <b>755630</b>											
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					
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. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17b. NPI			20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES								
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. C9200	B. I10	C. D61810	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. H. I. J. \$ CHARGES DAYS OR UNITS EPSPOT Family Plan ID. RENDERING PROVIDER ID. # NPI	
1 05 06 21	05 06 21	21	21	99233		ABC	399 00	1	ZZ	363L0000X	
2 05 05 21	05 05 21	21	21	99233		A	399 00	1	ZZ	363L0000X	
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER <b>592579938</b>		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. <b>U368825952</b>		27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 798 00</b>		29. AMOUNT PAID <b>\$</b>	
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.) <b>WILSON G GARCIA</b>						32. SERVICE FACILITY LOCATION INFORMATION UMHC SCCC 1475 NW 12TH AVE MIAMI, FL 331361002					
33. BILLING PROVIDER INFO & PH # ( ) UMIAMI MEDICINE-HEMATOLOGY PO BOX 281046 ATLANTA, GA 303841046											
SIGNED		DATE		a. 1679660617		b.		a. 1194776062		b.	

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

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



PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION