HEALTH INSURANCE CLAIM FORM

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

WORLDWIDE CONCIERGE HEALTH SVC
2813 EXECUTIVE PARK DR

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 (ID#) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 001147872

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): GOMEZ ALVAREZ, YURI, A

3. PATIENT'S BIRTH DATE MM DD YY: 03 09 1970 | SEX: M X | F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): GOMEZ, YURI

5. PATIENT'S ADDRESS (No., Street): CALLE A NO 20 RESIDENCIAL

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other X

7. INSURED'S ADDRESS (No., Street): CALLE A NO 20 RESIDENCIAL

CITY: SANTO DOMINGO | STATE: XX

8. RESERVED FOR NUCC USE

CITY: SANTO DOMINGO | STATE: XX

ZIP CODE: 00000 | TELEPHONE (Include Area Code): (809 541-2030

ZIP CODE: 00000 | TELEPHONE (Include Area Code): (809 541-2030

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: 03 09 1970 | SEX: M X | F

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: COMMERCIAL/MA-WORLDWIDE CONC

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 02 16 2022

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: DNRONY SHIMONY

17a. 1GD91979

17b. NPI 1689761207

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO X — $ CHARGES: 000

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M7502 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 22 21		11		99244		A	1060 00	1		NPI	1386601979
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 46-4151225 EIN X

26. PATIENT'S ACCOUNT NO.: P231444742

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO X

28. TOTAL CHARGE: $ 1060 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.)

BRADFORD O PARSONS MD

SIGNED 02 16 2022

32. SERVICE FACILITY LOCATION INFORMATION

5 E 98TH ST
5 E 98TH STREET
NEW YORK, NY 10029-6501

a. 1114358348

33. BILLING PROVIDER INFO & PH #: ( )

ORTHOPEDIC DEPARTMENT OF MOUN
PO BOX 29905
NEW YORK, NY 10087-8082

a. 1114358348

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION