LIEN
2450 STANWELL DRIVE

CONCORD, CA, 94520

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 X (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): test 123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TEST, CHERIE

3. PATIENT'S BIRTH DATE: 01 01 1958 SEX: M F X

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

5. PATIENT'S ADDRESS (No., Street): 111 ONE LANE

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

7. INSURED'S ADDRESS (No., Street):

CITY: BOCA RATON STATE: FL

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 33431 TELEPHONE (Include Area Code): ( )

ZIP CODE: 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: 04/05/06

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) X YES NO

a. INSURED'S DATE OF BIRTH: 01 01 1958 SEX: M 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? X YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: LIEN

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.

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:

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): 01 20 2010 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES

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

A. S43.004S B. S42.251S 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. #
Chronic Care Management											
01 31 21	01 31 21	11		00000		AB	63.41	1		NPI	1588699532
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 680477806 SSN EIN X

26. PATIENT'S ACCOUNT NO.: PT00071058

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

28. TOTAL CHARGE: $ 63.41

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.)

BARRY MESKIN (DPM)
1588699532 10 03 2024
SIGNED SOF DATE

32. SERVICE FACILITY LOCATION INFORMATION

Oakland - Webster St. Office
2923 Webster St. Suite 202
Oakland CA 946092428

a. 1790893196 b.

33. BILLING PROVIDER INFO & PH # P: 9456919806

BOOMERANG HEALTHCARE
PO BOX 888584
Los Angeles,CA 900888584

a. 1922198779 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

LIEN
2450 STANWELL DRIVE

CONCORD, CA, 94520

HEALTH INSURANCE CLAIM FORM

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a. INSURED'S DATE OF BIRTH: 01 01 1958 SEX: M 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? X YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: LIEN

d. INSURANCE PLAN NAME OR PROGRAM NAME

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A. S43.004S B. S42.251S C. D.

E. F. G. H.

I. J. K. L.

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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. #
Chronic Care Management											
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										NPI	
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27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

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XXX PICA

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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	ROSAS, ALEJANDRO	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	ROSAS, ALEJANDRO
3. PATIENT'S BIRTH DATE MM DD YY / SEX	06 22 2000 M (X) F ( )		
5. PATIENT'S ADDRESS (No., Street)	4716 WONG ST	6. PATIENT RELATIONSHIP TO INSURED	Self (X) Spouse ( ) Child ( ) Other ( )
7. INSURED'S ADDRESS (No., Street)	4716 WONG ST		
CITY	GUADALUPE	STATE	CA
8. RESERVED FOR NUCC USE			
CITY	GUADALUPE	STATE	CA
ZIP CODE	934341723	TELEPHONE (Include Area Code)	( )
ZIP CODE	934341723	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	DOI 07/19/2021		
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	06 22 2000 M (X) F ( )		
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)	YES (X) NO ( )
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.		

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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		17a.	
		17b. NPI	
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
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	A. F0781 B. M792 C. M7918 D. G44309 E. F. G. H. I. J. K. L.	ICD Ind. 0	
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 02 27 23	02 27 23	11		99214	25	ABCD	1000 00	1		NPI	1407297005
2 02 27 23	02 27 23	11		64405		B	2000 00	1		NPI	1407297005
3 02 27 23	02 27 23	11		64450		B	2000 00	1		NPI	1407297005
4 02 27 23	02 27 23	11		20552		BC	700 00	1		NPI	1407297005
5 02 27 23	02 27 23	11		96365		D	1000 00	1		NPI	1407297005
6										NPI	

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
204889115 ( ) (X)	447147	(X) YES ( ) NO	$ 6700 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.) AMAR ANAND, MD SIGNED 08 10 24 DATE	32. SERVICE FACILITY LOCATION INFORMATION CSSCTR - OAKLAND 7677 OAKPORT ST STE 600 OAKLAND CA 946211944 a. NPI b.		33. BILLING PROVIDER INFO & PH # (408) 3565292 COMPREHENSIVE SPINE & SPORTS PO BOX 321449 LOS GATOS CA 950320124 a. 1437339686 b.	