



LIEN
2450 STANWELL DRIVE

CONCORD, CA, 94520

HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (DoD/DoD) CHAMPVA <input type="checkbox"/> (Member/Dep) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BOX (LINO) <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Programs in Item 1) test 123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TEST, CHERIE		3. PATIENT'S BIRTH DATE MM DD YY 01 01 1958 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 111 ONE LANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY BOCA RATON		7. INSURED'S ADDRESS (No., Street)	
STATE FL		CITY	
ZIP CODE 33431		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (Include Area Code) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER 04/05/06	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY 01 01 1958 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. OTHER CLAIM ID (Designated by NUCC)	
b. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME LIEN	
c. RESERVED FOR NUCC USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items 9, 10a, and 10b.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 01 20 2010 QUAL. 431		15. OTHER DATE QUAL. MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17a. <input type="checkbox"/> NP1		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. S43.004S B. S42.251S C. ICD Ed. 0		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMO D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM (Early Rel) I. I.D. QUAL. J. RENDERING PROVIDER ID. #	
Chronic Care Management 01 31 21 01 31 21 11 00000 AB 63.41 1 NPI 1588699532			
25. FEDERAL TAX I.D. NUMBER 680477806 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. PT00071058	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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 # E: 9456919806 BOOMERANG HEALTHCARE PO BOX 888584 Los Angeles, CA 900888584 a. 1922198779 b.			



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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TEST, CHERIE		3. PATIENT'S BIRTH DATE MM DD YY 01 01 1958 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 111 ONE LANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY BOCA RATON		7. INSURED'S ADDRESS (No., Street)	
STATE FL		CITY	
ZIP CODE 33431		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (Include Area Code) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER 04/05/06	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY 01 01 1958 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. OTHER CLAIM ID (Designated by NUCC)	
b. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME LIEN	
c. RESERVED FOR NUCC USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items 9, 10a, and 10b.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17a. <input type="checkbox"/> NP1		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. S43.004S B. S42.251S C. ICD Ed. 0 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMO D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OR UNITS H. ICD Ed. (Early Ref) I. ID. QUAL. J. RENDERING PROVIDER ID. #	
Chronic Care Management 01 31 21 01 31 21 11 00000 AB 63.41 1 NPI 1588699532			
25. FEDERAL TAX I.D. NUMBER 680477806 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. PT00071058	
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 63.41 29. AMOUNT PAID \$ 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)) 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. 1922198779	
		33. BILLING PROVIDER INFO & PH # P: 9456919806 BOOMERANG HEALTHCARE PO BOX 888584 Los Angeles, CA 900888584	



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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#)		FOCIL LAW	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ROSAS, ALEJANDRO		3. PATIENT'S BIRTH DATE MM DD YY 06 22 2000 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ROSAS, ALEJANDRO		5. PATIENT'S ADDRESS (No., Street) 4716 WONG ST	
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) 4716 WONG ST	
CITY GUADALUPE		STATE CA	
ZIP CODE 934341723		TELEPHONE (Include Area Code) ()	
8. RESERVED FOR NUCC USE		CITY GUADALUPE	
STATE CA		ZIP CODE 934341723	
TELEPHONE (Include Area Code) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 07/19/2021	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY 06 22 2000 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. OTHER CLAIM ID (Designated by NUCC)	
b. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. RESERVED FOR NUCC USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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. Signature On File SIGNED 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. Signature On File SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE QUAL. 439 MM DD YY 07 19 21	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 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) A. F0781 B. M792 C. M7918 D. G44309 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 To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
02 27 23 02 27 23 11 99214 25 ABCD 1000 00 1 NPI 1407297005			
02 27 23 02 27 23 11 64405 B 2000 00 1 NPI 1407297005			
02 27 23 02 27 23 11 64450 B 2000 00 1 NPI 1407297005			
02 27 23 02 27 23 11 20552 BC 700 00 1 NPI 1407297005			
02 27 23 02 27 23 11 96365 D 1000 00 1 NPI 1407297005			
02 27 23 02 27 23 11 NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 204889115 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 447147	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 6700 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.) AMAR ANAND, MD 08 10 24 SIGNED 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.			