

HEALTH INSURANCE CLAIM FORM

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

FL MEDICARE PART B FIRST COAST PO BOX 44117 -CARRIER

JACKSONVILLE FL 322314117

XXX PICA	AND THE STATE OF T			77			PICA XXX					
1. MEDICARE MEDICAID TRICARE	CHAMPV	A GROU	P TH PLAN	FECA BLK LUI	OT	HER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
X (Medicare#) (Medicaid#) (ID#/DoD#)	(Member II	O#) (ID#)		(ID#)	(ID)#)	5PR1HH2DW20					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial))	3. PATIENT'S MM D	BIRTH DAT	E	SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
MORALES, HENRIETTA 12 1933 M FX												
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED					7. INSURED'S ADDRESS (No., Street)						
3817 RIVER GROVE CT	Self S	Spouse	Child	Other	7							
CITY	STATE	8. RESERVED	FOR NUC	C USE			CITY STATE					
TAMPA						Charles and Charle						
ZIP CODE TELEPHONE (Include Ar						ZIP CODE TELEPHONE (Include Area Code)						
336101649						()						
	10 IS BATISHT'S CONDITION BELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER						
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					NONE					
- OTHER HAURENIA BOLIOV OR COOLIN HINDER		- FARI OVAFAITO (Ourrent de Brasiliana)										
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)					a. INSURED'S DATE OF BIRTH SEX					
		<u> </u>	YES	X NO	0		M F					
b. RESERVED FOR NUCC USE		b. AUTO ACC	IDENT?		PLACE (Sta	ate)	ZIP CODE TELEPHONE (Include Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER NONE a. INSURED'S DATE OF BIRTH MM					
			YES	X NO								
c. RESERVED FOR NUCC USE	_	c. OTHER AC	CIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME					
			YES	X NO	0							
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM C	ODES (Desi	ignated 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							13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize					
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of governmen 						ary	payment of medical benefits to the undersigned physician or supplier for services described below.					
below.	Joholio Giller	to myour or to th	o party will	accopio do	o.griment		activices described below.					
SIGNATURE ON FILE		DAT	_				SIGNATURE ON FILE					
	CV (LMD) 15 (E	- 100 - 100 C. 1			SIGNED SITE OF THE PARTY OF THE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANC	QUA	OTHER DATE	MM !	DD	YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY					
QUAL.							FROM TO					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		1G					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY					
DN IMEE M DOWNING 17b. NPI 1750970885 FROM TO												
19. ADDITIONAL CLAIM INFORMATION (Designated by NU	JCC)						20. OUTSIDE LAB? \$ CHARGES					
ESANO ACA 4X6,24 SQUARE CM, INVOICE PRICE \$63648												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)							22. RESUBMISSION ORIGINAL REF. NO.					
A. L89323 B. K5904 C. L10 D. Z7401												
E. L. F. L.	G. L		_	D		_	23. PRIOR AUTHORIZATION NUMBER					
	б. L			н		_						
24. A. DATE(S) OF SERVICE B. C.		DURES, SERVI	CES, OR SU	JPPLIES	E.	_	F. G. H. I. J. DAYS EPSÖT ID DENIDEDING					
From To PLACE OF	(Expla	in Unusual Circu	umstances)		DIAGNO		DAYS EPSOT ID. RENDERING Family QUAL. PROVIDER ID. #					
MM DD YY MM DD YY SERVICE EM	G CPT/HCP	CS	MODIFIE	H	POINT	EH	\$ CHARGES UNITS Plan QUAL PROVIDER ID. #					
	1 000			STATE OF THE PARTY OF	-	1	G2 993402374					
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01 22 25 01 22 25 12	15271				A		\$\text{CHARGES} & \text{CHARGES} & \text					
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01 22 25 01 22 25 12	97605	5 59			A		146 00 1 NPI 1750970885					
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01 22 25 01 22 25 12	Q4275	5			A	1	63648 00 24 NPI 1750970885					
							G2 993402374					
01 22 25 01 22 25 12	A6550				A	1	400 00 1 NPI 1750970885					
01 22 23 01 22 23 12	110000						G2 993402374					
01 22 25 21 22 25 12	77000				1 7	1	400,00 1					
01 22 25 01 22 25 12 25. FEDERAL TAX I.D. NUMBER SSN EIN 20	A7000		27 4/	CCEPT AS	A	Т2	400000 1 NPI 1750970885 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use					
Secure to Agree the Santa and programment of the Santa and Santa a	(For govt. claims, see back)				1.6							
330102071	14			YES	NO		\$ 00000 CC \$					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	2. SERVICE FA	CILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # (813) 6003559					
(I certify that the statements on the reverse							Oasis Care Clinic Inc					
apply to this bill and are made a part thereof.)	ER GROVE CT					13107 BEE BLOSSOM PL						
TMEE M DOWNING	336101649					RIVERVIEW FL 335794080						
TIBE II DOWNING,	650 b.					a 1457192650 b G2 993402374						
OIGNED DATE					-							



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

FL MEDICARE PART B FIRST COAST PO BOX 44117 CARRIER

JACKSONVILLE FL 322314117

XXX PICA											PICA XXX	
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X (Medicare#) (Medicaid#) [ID#/DoD#)	(Member II	D#) (ID#)		ID#)	(ID#)	5PR1HH2DW20					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MORALES, HENRIETTA 3. PATIENT'S BIRTH DATE YY 12 12 1933 M F X							4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., St	6. PATIENT RI	ELATIONSHIP	TO INSURI	ED	7. INSURED'S ADDRESS (No., Street)							
3817 RIVER GROVE CT Self Spouse Child					ld O	ther						
CITY STATE			8. RESERVED	FOR NUCC U	SE		CITY STATE					
TAMPA	*	FL										
ZIP CODE					ZIP CODE	, TE	LEPHON	E (Include A	rea Code)			
336101649												
9. OTHER INSURED'S NAME (La	10. IS PATIEN	T'S CONDITIO	N RELATE	D TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER NONE							
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYME	ENT? (Current of	or Previous)		a. INSURED'S DATE OF BIRTH SEX					
			Г	YES	X NO		MM DD YY					
b. RESERVED FOR NUCC USE			b. AUTO ACCI			CF (State)	b. OTHER CLAIM ID (Designated by NUCC)					
			Г	YES	X NO							
c. RESERVED FOR NUCC USE			c. OTHER ACC				c. INSURANCE PLAN NAMI	E OR PR	OGRAM N	IAME	rea Code)	
YES X NO												
d. INSURANCE PLAN NAME OR	PROGRAM NAME		10d. CLAIM CO	DDES (Designa		CC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
							YES X NO	If ye	s, comple	te items 9, 9a	CT 1980 (160)	
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							INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for					
to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.							services described below	٧.				
SIGNATURE ON FILE DATE							SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY QUAL. MM DD YY							16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO TO					
17. NAME OF REFERRING PRO		JRCE 17a	1G				18. HOSPITALIZATION DAT	ES RELA	ATED TO	CURRENT S	ERVICES	
DN IMEE M DOWNING 175. NPI 1750970885							FROM TO YY					
19. ADDITIONAL CLAIM INFORM			1730	7370003			20. OUTSIDE LAB? \$ CHARGES					
ESANO ACA 4X6,2	4 SOLIARE CI	M. TNVOTO	E PRICE	\$63648	2		YES X NO	1				
21. DIAGNOSIS OR NATURE OF							22. RESUBMISSION CODE					
T100222 F5004 T10 77401						1	ORIGINAL REF. NO.					
							23. PRIOR AUTHORIZATION NUMBER					
1.1	F. L	_ G. L K. I		– H								
24. A. DATE(S) OF SERVICE			DURES, SERVIC	CES, OR SUPP	PLIES	E.	F0	a. H	. 1.		J.	
From T MM DD YY MM D	O PLACE OF D YY SERVICE E		in Unusual Circu CS I	mstances) MODIFIER		POINTER	0	YS EPSI Pam ITS Pla	ily ID.		ENDERING OVIDER ID. #	
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5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)						28. TOTAL CHARGE		OUNT PA	2000	Rsvd for NUCC Use		
993402374	X	44		X YES	S N	0	\$ 400 00	\$	0	00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION							33. BILLING PROVIDER INF		10 -	/	3559	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse						Oasis Care C						
apply to this bill and are made a part thereof.) 3817 RIVER GROVE CT						13107 BEE BLOSSOM PL						
IMEE M DOWNING,	336101				RIVERVIEW FL 335794080							
SIGNED	2650 b.				a.1457192650 b.G2 993402374							