Medicare Part B New Jersey *

NJ

HEALTH INSURANCE CLAIM FORM

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

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[X] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [ ] (ID#)	8EF9X75HC34
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ALFONSO, MICHAEL L	3. PATIENT'S BIRTH DATE MM DD YY: 04 14 1953 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ALFONSO, MICHAEL L	
5. PATIENT'S ADDRESS (No., Street) 54 MEDA PL	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street) 54 MEDA PL	
CITY: MIDLAND PARK — STATE: NJ	8. RESERVED FOR NUCC USE
CITY: MIDLAND PARK — STATE: NJ	
ZIP CODE: 074321410 — TELEPHONE (Include Area Code): (973) 4780115	
ZIP CODE: 074321410 — TELEPHONE (Include Area Code): (973) 4780115	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) ALFONSO, MICHAEL L	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER NONE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER YHZ71687990	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX: 04 14 1953 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	
d. INSURANCE PLAN NAME OR PROGRAM NAME MERCY HP OF NJ (HORIZON NJ HEALTH)	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 01|27|2025

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 DN ELKATTAWY, IBRAHIM	17a. 17b. NPI 1861980138	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) $21,218 ESANO ACA 2X4		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES: 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. L97522 B. E11621 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 01 24 2025 01 24 2025	11		Q4275	JZ	A B	21218 00	8		NPI	1861980138
2 01 24 2025 01 24 2025	11		15275		A B	156 17	1		NPI	1861980138
3									NPI	
4									NPI	
5									NPI	
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
223580952 [ ] [X]	506383543	[X] YES [ ] NO	$ 21374 17	$ 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (201) 5239489
ELKATTAWY, IBRAHIM 1861980138 SIGNED 01|27|2025 DATE	NEW JERSEY FOOT ANKLE CENTERS 550 KINDERKAMACK ROAD SUITE 201 ORADELL NJ 07649-1500 a. 1255361515 b.	NEW JERSEY FOOT ANKLE CENTERS, P.C. 550 KINDERKAMACK ROAD SUITE 201 ORADELL NJ 076491500 a. 1255361515 b.