

HIP - HEALTH INSURANCE PLAN OF GREATER NEW

						YORKOX 28		ANCE PLA	N OF	GREATER NEW		
HEALTH INSURAN							545 K, NY 10116	6				
APPROVED BY NATIONAL UNIFO	RM CLAIM COMMITTE	E (NUCC) 02/12	2				,			DIOA CT		
PICA 1. MEDICARE MEDICAID	TRICARE	CHAMP	VA OROLL	D 55/	CA OTHER	1a. INSURED'S I	D. NUMBER		/ F	PICA PICA		
(Medicare#) (Medicaid#)	(ID#/DoD#)	(Member	ID#) HEALT	P TH PLAN FEC BLK (ID#	LUNG	17912198	D. NUMBER		(For	Program in Item 1)		
2. PATIENT'S NAME (Last Name,	<u> </u>	<u> </u>	3. PATIENT'S		SEX	1 1	AMF (Last Nam	e First Name	Middle	Initial)		
DIAZ. CARMEN	MM D	D YY I	FX	4. INSURED'S NAME (Last Name, First Name, Middle Initial) DIAZ, CARMEN								
5. PATIENT'S ADDRESS (No., Str		09 03 1951 ML F X DIAZ, CARMEN 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)										
137-45 68TH DRIVE	Self X S	Spouse Child	Other	137-45 68TH DRIVE								
CITY	8. RESERVED	O FOR NUCC USE		CITY STATE								
FLUSHING NY						FLUSHING 1				NY		
IP CODE TELEPHONE (Include Area Code)						ZIP CODE TELEPHONE (Include Area Cod				ıde Area Code)		
11367						11367						
9. OTHER INSURED'S NAME (La	st Name, First Name, M	iddle Initial)	10. IS PATIEN	IT'S CONDITION F	RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY O	R GROUP NUMBER		a. EMPLOYMI	a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH SEX					
				X YES NO			MM DD YY 09 03 1951 M					
b. RESERVED FOR NUCC USE			b. AUTO ACC	IDENT?	PLACE (State)	b. OTHER CLAIN		d by NUCC)				
				X YES	NO NE							
c. RESERVED FOR NUCC USE			c. OTHER AC	c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME					
				X YES NO								
d. INSURANCE PLAN NAME OR I	PROGRAM NAME		10d. CLAIM C	ODES (Designated	by NUCC)	d. IS THERE AND	OTHER HEALTI	H BENEFIT P	LAN?			
						YES	X NO	If yes, comple	ete item	s 9, 9a, and 9d.		
READ E 12. PATIENT'S OR AUTHORIZED	IG & SIGNING TH		mation necessary	13. 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 requ						services desc		o trie uridersiç	gnea pri	ysician or supplier for		
below.												
SIGNED SIGNATURI	E ON FILE		DAT	E 10/01/201	3	SIGNED SIGNATURE ON FILE						
14. DATE OF CURRENT ILLNESS MM DD YY	, INJURY, or PREGNAI	1 1	OTHER DATE	MM _I DD	, YY	16. DATES PATIL	ENT UNABLE T	O WORK IN O	CURRE	NT OCCUPATION DD YY		
03 05 202 QL			UAL.	03 16	202	FROM 03	05 20)2 TO	03	09 202		
17. NAME OF REFERRING PROV	IDER OR OTHER SOU	1.0			3	18. HOSPITALIZA MM	DD 1 3/	Υ	MM	ENT SERVICES DD 3/3/		
ADDITIONAL OLAIM INICODM	ATION (Decimented by A	17	b. NPI			FROM 03	06 20		03	08 202		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES						
ADDITIONAL CLAIM INFORMATION						X YES	NO	10				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A I M545 B I M542 C I M25511						22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. <u>M545</u>	M791	23. PRIOR AUTH	IODIZATION NI	IMPED								
E	F	. G. l		н. l		23. PRIOR AUTE	IONIZATION INC	DIVIDEN				
I	J	. K. l C. D. PROC	ENLIDES SEDVI	L. l ICES, OR SUPPLII	ES E.	F.	G		T	J.		
From T	o PLACE OF	(Exp	lain Unusual Circ	umstances)	DIAGNOSIS	8	G. DAYS OR	H. I. EPSDT Family Plan QUAL.		RENDERING		
MM DD YY MM DI	O YY SERVICE E	MG CPT/HC	PCS	MODIFIER	POINTER	\$ CHARGES	UNITS	Plan QUAL.		PROVIDER ID. #		
10 01 18 10 0	1 18 11	99213	. 1		1234	100	UN	NPI	146	7420077		
10 01 18 10 0	1 10 11	99213	· · · · · · · · · · · · · · · · · · ·		1234	100	UN	INIT	140	7420877		
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								NPI				
								1				
								NPI				
25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S	ACCOUNT NO.	27. ACCEP	T ASSIGNMENT? claims, see back)	28. TOTAL CHAP	RGE 29	. AMOUNT PA	AID	30. Rsvd.for NUCC I		
				YES	X NO	\$ 100	\$					
31. SIGNATURE OF PHYSICIAN (ACILITY LOCAT	CILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # (
INCLUDING DEGREES OR CI (I certify that the statements on	ESIA SOLUT	SIA SOLUTIONS PC			HESIA SOLU	JTIONS PO	'					
apply to this bill and are made			2ND AVE	-				2 				
KOGAN, MIKHAIL, MD		FOREST	HILLS, NY 1	1375-1035		,						
IGNED 10/06/2018 DATE a. 166956			7467 b.	2046259	50	a. 1669567467 b.						



MEDICARE NEW YORK (QUEENS)

PO BOX 2870 NEW YORK, NY 10116

ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 MEDICARE MEDICAID TRICARE CHAMPVA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1) (Medicaid#) (Member ID#) X (ID#) 095325688A 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SEX 17 1942 HUDSON, LUTHER мХ F HUDSON, LUTHER 10 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 87-40 FRANCIS LEWIS ROAD 87-40 FRANCIS LEWIS ROAD 8. RESERVED FOR NUCC USE STATE STATE PATIENT AND INSURED INFORMATION **QUEENS** NY **QUEENS** NY ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) 11427 11427 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 a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) SEX MX F X NO 10 17 1942 b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? b. OTHER CLAIM ID (Designated by NUCC) PLACE (State) YES NO c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME X NO YES d. INSURANCE PLAN NAME OR PROGRAM NAME 10d, CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X NO If yes, complete items 9, 9a, and 9d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary 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 services described below. SIGNATURE ON FILE 10/01/2018 SIGNATURE ON FILE DATE 15. OTHER DATE QUAL 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY 17a. 17b. NPI 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES X NO ADDITIONAL CLAIM INFORMATION 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. ORIGINAL REF. NO M5136 M129 M545 M5414 D. 23. PRIOR AUTHORIZATION NUMBER F G. 24. A Ε G. DAYS OR UNITS DATE(S) OF SERVICE В PROCEDURES, SERVICES, OR SUPPLIES PHYSICIAN OR SUPPLIER INFORMATION From Τo PLACE OF (Explain Unusual Circumstances) DIAGNOSIS RENDERING ID. SERVICE MODIFIER **POINTER** PROVIDER ID. QUA 209101 01 10 01 18 10 18 99213 1234 100 UN NPI 1831100130 NPI NPI NPI NPI 28. TOTAL CHARGE 29. AMOUNT PAID 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO 30. Rsvd.for NUCC Use YES X NO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # **INCLUDING DEGREES OR CREDENTIALS** ALL ISLAND ANESTHESIA ALL ISLAND ANESTHESIA (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 108-18 72ND AVENUE **FOREST HILLS, NY 11375-1035** UPADHYAYILA, SEKHAR, MD 10/06/2018 1235379918 205100380 1235379918 SIGNED



HEALTH INSURA							PO BOX 9		`	YORK) - HCFA ONI	_Y
PICA 1. MEDICARE MEDICA	ID TRICA	ARE	CHAMPVA	GROUP — HEALTH F	FECA	OTHER	1a. INSURED'S	I.D. NUMBE	R		(For Program i	PICA
(Medicare#) (Medicaid 2. PATIENT'S NAME (Last Nam	<u> </u>	<u> </u>	(Member ID#)	(ID#) ATIENT'S BIF	(ID#)	114277979						
SANCHEZ, CARMELC 5. PATIENT'S ADDRESS (No.,		PATIENT'S BIRTH DATE SEX MM DD YY 08 08 1947 M X F										
1056 SENECA AVENU	S	Self X Spor	use Child	1056 SENECA AVENUE								
RIDGEWOOD	NY	ESERVED FO	OR NUCC USE		CITY RIDGEW(OOD				NY NY		
IP CODE	TELEPHONE	(Include Area C	ode)				ZIP CODE		TEL	EPHONI (E (Include Area C	ode)
11385 OTHER INSURED'S NAME (Last Name, First	Name, Middle In	itial) 10. I	S PATIENT'S	CONDITION REL	ATED TO:	11385 11. INSURED'S	POLICY GR	OUP OR F	ECA NU	JMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				MPLOYMEN	Γ? (Current or Prev	a. INSURED'S DATE OF BIRTH MM DD YY 08 08 1947 M X						
RESERVED FOR NUCC US	=		b. A	b. AUTO ACCIDENT? PLACE (State)			00 00 1041					
D. RESERVED FOR NUCC USE								C. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME					DDES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.							
REAI PATIENT'S OR AUTHORIZE to process this claim. I also re below.	ED PERSON'S SI		thorize the releas	e of any medi	cal or other informa		payment of I		fits to the u		SIGNATURE I au ned physician or s	
SIGNED SIGNATURE ON FILE DATE 10/01/2018							SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY QUAL QUAL						YY	FROM	1 1		TO	URRENT OCCUP MM DD	
'. NAME OF REFERRING PR	17a. 17b. NP				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO TO 20. OUTSIDE LAB? \$ CHARGES					YICES YY		
9. ADDITIONAL CLAIM INFOF ADDITIONAL CL II. DIAGNOSIS OR NATURE C	AIM INFORM	MATION	Δ-I to service lin	e helow (24F)	<u> </u>	T	YES	X NO		\$ 0	HARGES	
. <u>M461</u>	c. <u>M2</u>	25552	D. L	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER								
. L	F. L		G. L K. L		H. L. L. L.							
4. A. DATE(S) OF SERVI From IM DD YY MM	To PL	B. C. [LACE OF ERVICE EMG		usual Circums	S, OR SUPPLIES stances) MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGE	G DA' OF UNI	i. H. YS EPSDT R Family TS Plan	I. ID. QUAL.	J RENDI PROVID	ERING
0 01 18 10	01 18	11	99213			1234	100	l UI	V	NPI	1467420877	7
										NPI		
										NPI		
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	<u> </u>			1 1			<u> </u>	<u> </u>		NPI		
	i									NPI		
5. FEDERAL TAX I.D. NUMBE	R SSN E	EIN 26. PA	ATIENT'S ACCO	UNT NO.	27. ACCEPT A	SSIGNMENT?	28. TOTAL CHA	ARGE	29. AMO	NPI UNT PA	ID 30. Rsvd	I.for NUCC U
H CIONATURE OF BUNGLEY	N OB OURS! ISS			VI.004710:	YES	X NO	\$ 100	00/1055	\$	/		
 SIGNATURE OF PHYSICIA INCLUDING DEGREES OR (I certify that the statements apply to this bill and are made 	CREDENTIALS on the reverse	Al	NESTHESIA 08-18 72ND /	SOLUTIO AVE			33. BILLING PF	THESIA SC		(NS PC) :	
KOGAN, MIKHAIL, M				HILLS, NY 11375-1035			,					
SIGNED 10/06/2018 DATE a. 1669567				D.	204625950	a. 1669567467 b.						



	MEDICARE NEW YORK (QUEENS)							
HEALTH INSURANCE CLAIM FORM	PO BOX 2870							
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	NEW YORK, NY 10116							
PICA	PICA TITLE							
1. MEDICARE MEDICAID TRICARE CHAMPV	A GROUP FECA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)							
(Medicare#) (Medicaid#) (ID#/DoD#) (Member I)#) (ID#) X (ID#) 070200865A							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
SIMON, RUTH	10 23 1926 M SIMON, RUTH							
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street)							
62-59 108TH	Self X Spouse Child Other 62-59 108TH							
CITY	8. RESERVED FOR NUCC USE CITY STATE							
FOREST HILLS NY	FOREST HILLS NY							
ZIP CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Include Area Code)							
11375	11375							
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							
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) a. INSURED'S DATE OF BIRTH SEX MM DD YY							
DESERVED FOR MURAL VICE	YES X NO 10 23 1926 M F X							
). RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)							
	YES X NO							
RESERVED FOR NUCC USE	c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME							
	YES X NO							
I. 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 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either below.	release of any medical or other information necessary payment of medical benefits to the undersigned physician or supplier for							
SIGNED SIGNATURE ON FILE	DATE							
4. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. MM DD YY	OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY							
MM DD YY QUAL.	AL MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY							
178								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES							
ADDITIONAL CLAIM INFORMATION	YES X NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	ce line below (24E) ICD Ind. 22. RESUBMISSION CODE ORIGINAL REF. NO.							
A M25561 B M461 C.L	M5417 D M48061							
E. L G. L	H. L 23. PRIOR AUTHORIZATION NUMBER							
I. L. J. L. K. L	L. L.							
24. A. DATE(S) OF SERVICE B. C. D. PROCE	DURES, SERVICES, OR SUPPLIES E. F. G. H. I. J.							
From To	DURES, SERVICES, OR SUPPLIES E. F. G. H. I. J. in Unusual Circumstances) DIAGNOSIS DIAGNOSIS OR Family ID. RENDERING CS MODIFIER POINTER \$ CHARGES UNITS Plan QUAL. PROVIDER ID. #							
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10 01 18 10 01 18 11 99213	1234 100 UN NPI 1831100130							
	NPI NPI							
	NPI NPI							
	NPI NPI							
	NPI NPI							
	NPI NPI							
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	CCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd.for NUCC Us							
	YES X NO \$ 100 \$							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FA	CILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()							
(I certify that the statements on the reverse ALL ISLA	ND ANESTHESIA ALL ISLAND ANESTHESIA							
	ND AVENUE							
UPADHYAYILA, SEKHAR, MD FOREST	HILLS, NY 11375-1035 ,							
SIGNED 10/06/2018 DATE a. 1235379	918 ^{b.} 205100380 ^{a.} 1235379918 ^{b.}							