HEALTH INSURANCE CLAIM FORM

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

PICA

HIP - HEALTH INSURANCE PLAN OF GREATER NEW YORK
PO BOX 2845
NEW YORK, NY 10116

CARRIER

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): 17912198

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DIAZ, CARMEN

3. PATIENT'S BIRTH DATE MM DD YY: 09 03 1951 SEX M ( ) F (X)

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

5. PATIENT'S ADDRESS (No., Street): 137-45 68TH DRIVE

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

7. INSURED'S ADDRESS (No., Street): 137-45 68TH DRIVE

CITY: FLUSHING STATE: NY

8. RESERVED FOR NUCC USE

CITY: FLUSHING STATE: NY

ZIP CODE: 11367 TELEPHONE (Include Area Code): ( )

ZIP CODE: 11367 TELEPHONE (Include Area Code): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

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

b. AUTO ACCIDENT? (X) YES ( ) NO PLACE (State) NE

c. OTHER ACCIDENT? (X) YES ( ) NO

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. INSURED'S DATE OF BIRTH MM DD YY: 09 03 1951 SEX M ( ) F (X)

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME:

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: 10/01/2018

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: 03 05 202 QUAL.

15. OTHER DATE QUAL. MM DD YY: 03 16 202

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 03 05 202 TO 03 09 202

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 3

17a. 17b. NPI: 3

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 03 06 3 202 TO 03 08 3 202

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB? (X) YES ( ) NO 3 $ CHARGES 10 3

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

A. M545 B. M542 C. M25511 D. M791
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 10	01	18	10	01	18	11		99213		1234	100	UN		NPI	1467420877
2														NPI	
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) ( ) YES (X) NO

28. TOTAL CHARGE $ 100

29. AMOUNT PAID $

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.)

KOGAN, MIKHAIL, MD

SIGNED 10/06/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ANESTHESIA SOLUTIONS PC
108-18 72ND AVE
FOREST HILLS, NY 11375-1035

a. 1669567467 b. 204625950

33. BILLING PROVIDER INFO & PH # ( )

ANESTHESIA SOLUTIONS PC
,

a. 1669567467 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

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

PICA

MEDICARE NEW YORK (QUEENS)

PO BOX 2870
NEW YORK, NY 10116

CARRIER

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): 095325688A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HUDSON, LUTHER

3. PATIENT'S BIRTH DATE MM DD YY: 10 17 1942 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 87-40 FRANCIS LEWIS ROAD

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

7. INSURED'S ADDRESS (No., Street): 87-40 FRANCIS LEWIS ROAD

CITY: QUEENS STATE: NY

8. RESERVED FOR NUCC USE

CITY: QUEENS STATE: NY

ZIP CODE: 11427 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:

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: 10 17 1942 SEX 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:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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: 10/01/2018

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:

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): ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:

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

A. M545 B. M5136 C. M5414 D. M129
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

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	10	01	18	10	01	18	11		99213		1234	100	UN		NPI	209101 1831100130
2															NPI	
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) YES [ ] NO [X]

28. TOTAL CHARGE $ 100

29. AMOUNT PAID $

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.)

UPADHYAYILA, SEKHAR, MD

SIGNED 10/06/2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ALL ISLAND ANESTHESIA
108-18 72ND AVENUE
FOREST HILLS, NY 11375-1035

a. 1235379918 b. 205100380

33. BILLING PROVIDER INFO & PH # ( )

ALL ISLAND ANESTHESIA
,

a. 1235379918 b.

HEALTH INSURANCE CLAIM FORM

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

PICA

HEALTHFIRST, INC (NEW YORK) - HCFA ONLY

PO BOX 958438
LAKE MARY, FL 32795

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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): 114277979
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SANCHEZ, CARMELO	3. PATIENT'S BIRTH DATE MM DD YY: 08 08 1947 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SANCHEZ, CARMELO
5. PATIENT'S ADDRESS (No., Street): 1056 SENECA AVENUE	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 1056 SENECA AVENUE
CITY: RIDGEWOOD STATE: NY	8. RESERVED FOR NUCC USE	CITY: RIDGEWOOD STATE: NY
ZIP CODE: 11385 TELEPHONE (Include Area Code): ( )		ZIP CODE: 11385 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
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: 08 08 1947 SEX 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	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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: 10/01/2018

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	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): ADDITIONAL CLAIM INFORMATION		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M461 B. M5412 C. M25552 D. M4696 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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 10 01 18 10 01 18	11		99213		1234	100	UN		NPI	1467420877
2									NPI	
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) YES [ ] NO [X]	28. TOTAL CHARGE $ 100	29. AMOUNT PAID $	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.) KOGAN, MIKHAIL, MD SIGNED 10/06/2018 DATE	32. SERVICE FACILITY LOCATION INFORMATION ANESTHESIA SOLUTIONS PC 108-18 72ND AVE FOREST HILLS, NY 11375-1035 a. 1669567467 b. 204625950	33. BILLING PROVIDER INFO & PH # ( ) ANESTHESIA SOLUTIONS PC , a. 1669567467 b.

HEALTH INSURANCE CLAIM FORM

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MEDICARE NEW YORK (QUEENS)

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NEW YORK, NY 10116

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1a. INSURED'S I.D. NUMBER (For Program in Item 1): 070200865A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SIMON, RUTH

3. PATIENT'S BIRTH DATE MM DD YY: 10 23 1926 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 62-59 108TH

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

7. INSURED'S ADDRESS (No., Street): 62-59 108TH

CITY: FOREST HILLS STATE: NY

8. RESERVED FOR NUCC USE

CITY: FOREST HILLS STATE: NY

ZIP CODE: 11375 TELEPHONE (Include Area Code): ( )

ZIP CODE: 11375 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:

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: 10 23 1926 SEX M [ ] F [X]

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:

10d. CLAIM CODES (Designated by NUCC):

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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): ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

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

A. M25561 B. M461 C. M5417 D. M48061
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															209101
10	01	18	10	01	18	11		99213		1234	100	UN		NPI	1831100130
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 100

29. AMOUNT PAID $

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.)

UPADHYAYILA, SEKHAR, MD

SIGNED 10/06/2018 DATE

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ALL ISLAND ANESTHESIA
108-18 72ND AVENUE
FOREST HILLS, NY 11375-1035

a. 1235379918 b. 205100380

33. BILLING PROVIDER INFO & PH # ( )

ALL ISLAND ANESTHESIA

,

a. 1235379918 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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