GUARDIAN LAW

200 SANDY SPRINGS PL
ATLANTA, GA 30328-5917

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ( ) (Medicare #) MEDICAID ( ) (Medicaid #) TRICARE CHAMPUS ( ) (Sponsor's SSN) CHAMPVA ( ) (Member ID#) GROUP HEALTH PLAN ( ) (SSN or ID) FECA BLK LUNG ( ) (SSN) OTHER (X) (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MVA04062025

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REPTA, DANIEL

3. PATIENT'S BIRTH DATE MM DD YY: 10081976 SEX M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REPTA, DANIEL

5. PATIENT'S ADDRESS (No., Street): 3338 HILL POND DR

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

7. INSURED'S ADDRESS (No., Street): 3338 HILL POND DR

CITY: Buford STATE: GA

8. PATIENT STATUS: Single ( ) Married (X) Other ( )

CITY: Buford STATE: GA

ZIP CODE: 30519 TELEPHONE (Include Area Code): ( )

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE: 30519 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: 10081976 SEX M (X) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ( ) F ( )

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

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) *If yes*, return to and complete item 9 a-d.

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: 09172025

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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: BARBARA PERSAUD

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. G44.319
2. M25.561
3. M25.562
4. M54.16

22. MEDICAID 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 06172025	06172025	11		99202		1234	1505.00	1		NPI	1831186857
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 883646709

26. PATIENT'S ACCOUNT NO.: 243308A

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

28. TOTAL CHARGE: $ 1505.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 1505.00

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.)

BARBARA MCMILLAN-PERSAUD

SIGNED 09172025 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ATLAS BRASELTON
3515 BRASELTON HWY STE E-2
DACULA, GA 30019

a. b.

33. BILLING PROVIDER INFO & PH # (6786915651)

BARBARA MCMILLAN-PERSAUD
5855 JIMMY CARTER BLVD STE 210
NORCROSS, GA 30071-2984

a1831186857 b.

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

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b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

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17b. NPI

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1. M54.2
2. M54.6
3. M54.59
4. M25.561

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1	07222025		07222025			11		99214		1234	1750.00	1		NPI	1831186857
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 883646709 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 254383A

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

28. TOTAL CHARGE: $ 1750.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 1750.00

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.)

BARBARA MCMILLAN-PERSAUD

SIGNED 09172025 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ATLAS SPINE AND REHAB INC
5855 JIMMY CARTER BLVD SUITE
NORCROSS, GA 30071-2984

a. NPI b.

33. BILLING PROVIDER INFO & PH # (6786915651)

BARBARA MCMILLAN-PERSAUD
5855 JIMMY CARTER BLVD STE 210
NORCROSS, GA 30071-2984

a 1831186857 b.

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b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

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

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1 08052025	08052025	11		99214		1234	1750.00	1		NPI	1831186857
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 883646709

26. PATIENT'S ACCOUNT NO.: 258938A

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

28. TOTAL CHARGE: $ 1750.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 1750.00

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.)

BARBARA MCMILLAN-PERSAUD

SIGNED 09172025 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ATLAS SPINE AND REHAB INC
5855 JIMMY CARTER BLVD SUITE
NORCROSS, GA 30071-2984

a. NPI b.

33. BILLING PROVIDER INFO & PH # (6786915651)

BARBARA MCMILLAN-PERSAUD
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a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10081976 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

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25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 883646709

26. PATIENT'S ACCOUNT NO.: 264614A

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

28. TOTAL CHARGE: $ 1470.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 1470.00

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4. M25.561

22. MEDICAID 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	09052025		09052025			10		99213		1234	1470.00	1		NPI	1831186857
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: 883646709 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 266202A

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

28. TOTAL CHARGE: $ 1470.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 1470.00

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.)

BARBARA MCMILLAN-PERSAUD

SIGNED 09172025 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ATLAS SPINE AND REHAB INC
5855 JIMMY CARTER BLVD SUITE
NORCROSS, GA 30071-2984

a. NPI b.

33. BILLING PROVIDER INFO & PH # (6786915651)

BARBARA MCMILLAN-PERSAUD
5855 JIMMY CARTER BLVD STE 210
NORCROSS, GA 30071-2984

a 1831186857 b.

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

GUARDIAN LAW

200 SANDY SPRINGS PL
ATLANTA, GA 30328-5917

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MVA04062025

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REPTA, DANIEL

3. PATIENT'S BIRTH DATE MM DD YY: 10081976 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REPTA, DANIEL

5. PATIENT'S ADDRESS (No., Street): 3338 HILL POND DR

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

7. INSURED'S ADDRESS (No., Street): 3338 HILL POND DR

CITY: Buford STATE: GA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: Buford STATE: GA

ZIP CODE: 30519 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 30519 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: 10081976 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

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

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: 09172025

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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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: BARBARA PERSAUD

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. M54.2
2. M54.6
3. M54.59
4. M25.561

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

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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 09102025	09102025	11		99214		1234	1750.00	1		NPI	1831186857
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 883646709

26. PATIENT'S ACCOUNT NO.: 271240A

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

28. TOTAL CHARGE: $ 1750.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 1750.00

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.)

BARBARA MCMILLAN-PERSAUD

SIGNED 09172025 DATE

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