# HEALTH INSURANCE CLAIM FORM

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

PICA

SOUTH FLORIDA MUSCULOSKELETAL CA
PO BOX 292277
DAVIE FL 33329

CARRIER

PICA

| | | |
|---|---|---|
| 1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID#) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1): 101481201900 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JOHNSON, KAYLA | 3. PATIENT'S BIRTH DATE MM DD YY: 02 26 1943 SEX: F X | 4. INSURED'S NAME (Last Name, First Name, Middle Initial): JOHNSON, KAYLA |
| 5. PATIENT'S ADDRESS (No., Street): 10600 SW 65TH AVE | 6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse X / Child / Other | 7. INSURED'S ADDRESS (No., Street): 10600 SW 65TH AVE |
| CITY: PINECREST STATE: FL | 8. RESERVED FOR NUCC USE | CITY: PINECREST STATE: FL |
| ZIP CODE: 33156-4035 TELEPHONE (Include Area Code): ( 305 7932077 | | ZIP CODE: 33156-4035 TELEPHONE (Include Area Code): ( 305 7932077 |
| 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: H1609016 |
| 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: 02 26 1943 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: SOUTH FLORIDA MUSCULOSKELETAL |
| 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 05/19/2022

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 MARGARITA GARCES | 17a. 17b. NPI 1548247521 | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 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. 0<br>A. M5451 B. M4306 C. D.<br>E. F. G. H.<br>I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER 6-6-23 |

JUN 27 2023

| 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 06142023 06142023 | 11 | | 97161 | GP | AB | 210 00 | 1 | | NPI | 1144939828 |
| 2 06142023 06142023 | 11 | | 97110 | GP | AB | 60 00 | 1 | | NPI | 1144939828 |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

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| 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 |
|---|---|---|---|---|---|
| 651015068 X | CD600AQF | YES X / NO | $ 270 00 | $ 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 # ( 305 2329222 |
|---|---|---|
| DANIEL FOEN<br>SIGNED 06/22/2023 DATE | PROGRESSIVE PHYSICAL THERA<br>12651 S DIXIE HWY SUITE 20<br>MIAMI FL 33156-5975<br>a. 1871588624 | PROGRESSIVE PHYSICAL THERAPY<br>12651 S DIXIE HWY<br>MIAMI FL 33156-5975<br>a. 1871588624 |

PHYSICIAN OR SUPPLIER INFORMATION

AETNA MEDICARE HMO
P.O. BOX 292277
DAVIE, FL 33329-2277

# HEALTH INSURANCE CLAIM FORM

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

XXX PICA

PICA XXX

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) | 101483788400 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | BERMUDEZ, MARIA, C | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | SAME |
| 3. PATIENT'S BIRTH DATE MM DD YY / SEX | 08 05 1957 M [ ] F [X] | | |
| 5. PATIENT'S ADDRESS (No., Street) | 2600 S UNIVERSITY DR APT 225 | 7. INSURED'S ADDRESS (No., Street) | SAME |
| 6. PATIENT RELATIONSHIP TO INSURED | Self [X] Spouse [ ] Child [ ] Other [ ] | | |
| CITY | DAVIE | CITY | SAME |
| STATE | FL | STATE | SAM |
| ZIP CODE | 33328-1466 | ZIP CODE | SAME |
| TELEPHONE (Include Area Code) | (754) 422-4934 | TELEPHONE (Include Area Code) | ( ) SAME |
| 8. RESERVED FOR NUCC USE | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. INSURED'S DATE OF BIRTH MM DD YY / SEX | 08 05 1957 M [ ] F [X] |
| b. RESERVED FOR NUCC USE | | b. OTHER CLAIM ID (Designated by NUCC) | |
| c. RESERVED FOR NUCC USE | | c. INSURANCE PLAN NAME OR PROGRAM NAME | AETNA MEDICARE HMO |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. CLAIM CODES (Designated by NUCC) | |
| 10. IS PATIENT'S CONDITION RELATED TO: | a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d. |
| | b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State) | | |
| | c. OTHER ACCIDENT? [ ] YES [X] NO | | |

**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 07/03/2023

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

| | | |
|---|---|---|
| 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. | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| DN BEN JOSEPH MD | 17b. NPI 1558723924 | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? [ ] YES [X] NO / $ CHARGES JUL 10 2023 0 00 |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 | | 22. RESUBMISSION CODE / ORIGINAL REF. NO. |
| A. M25.561 B. M25.562 C. D. E. F. G. H. I. J. K. L. | | 23. PRIOR AUTHORIZATION NUMBER 6-16-23 |

| 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 06 21 2023 | 06 21 2023 | 11 | | 97110 | | AB | 94 50 | 3 | | NPI | 1841411352 |
| 2 06 21 2023 | 06 21 2023 | 11 | | 97162 | | AB | 87 50 | 1 | | NPI | 1841411352 |
| 3 06 23 2023 | 06 23 2023 | 11 | | 97110 | | AB | 126 00 | 4 | | NPI | 1841411352 |
| 4 06 26 2023 | 06 26 2023 | 11 | | 97110 | | B | 126 00 | 4 | | NPI | 1841411352 |
| 5 06 28 2023 | 06 28 2023 | 11 | | 97110 | | B | 126 00 | 4 | | NPI | 1841411352 |
| 6 06 30 2023 | 06 30 2023 | 11 | | 97110 | | B | 126 00 | 4 | | NPI | 1841411352 |

274

| 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 |
|---|---|---|---|---|---|
| 650851735 [ ] [X] | OIM000474459 | [ ] YES [X] NO | $ 686 00 | $ 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 # ( 954) 382-4343 |
|---|---|---|
| Nancy Croughwell DPT, PT 07/03/2023 SIGNED DATE | Orthosport Therapy and Performance 5200 S University Drive Suite 105 Davie, FL 33328-5316 a. NPI b. | ORTHOSPORT INC 5200 S UNIVERSITY DRIVE SUITE 105 DAVIE, FL 33328-5316 a. 1689693848 b. |

PHYSICIAN OR SUPPLIER INFORMATION

# HEALTH INSURANCE CLAIM FORM

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

PICA

SOUTH FLORIDA MUSCULOSKELETAL CARE.COM, INC-H
P.O. BOX 292277,
DAVIE, FL 33329

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CARRIER

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|---|---|
| 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): 101668485600 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ADORNA DIAZ, MARIA | 3. PATIENT'S BIRTH DATE: 06 13 1939 SEX: M [ ] F [X] |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial): ADORNA DIAZ, MARIA | |
| 5. PATIENT'S ADDRESS (No., Street): 2220 SW 10TH ST REAR | 6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ] |
| 7. INSURED'S ADDRESS (No., Street): 2220 SW 10TH ST REAR | |
| CITY: MIAMI, US STATE: FL | 8. RESERVED FOR NUCC USE |
| CITY: MIAMI, US STATE: FL | |
| ZIP CODE: 33135 TELEPHONE (Include Area Code): ( ) - | |
| ZIP CODE: 33135 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: H1609-043 | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X] |
| a. INSURED'S DATE OF BIRTH: 06 13 1939 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: SOUTH FLORIDA MUSCULOSKELETAL CAR | |
| 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: 06/21/23

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

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|---|---|
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 04 11 23 QUAL. 431 | 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 LEYANY FLEITES | 17a. 17b. NPI 1497203616 |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | 20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: JUL 03 2023 |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0<br>A. M25512 B. 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 05 23 23 | 05 23 23 | 11 | | 97110 | GP | A | 96 00 | 2 | | NPI | 1235164831 |
| 2 05 23 23 | 05 23 23 | 11 | | 97112 | GP | A | 48 00 | 1 | | NPI | 1235164831 |
| 3 05 23 23 | 05 23 23 | 11 | | 97140 | GP | A | 60 00 | 1 | | NPI | 1235164831 |
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| 25. FEDERAL TAX I.D. NUMBER: 650662258 SSN EIN [X] | 26. PATIENT'S ACCOUNT NO.: 40102324873 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ] | 28. TOTAL CHARGE: $ 204 00 | 29. AMOUNT PAID: $ 0 00 | 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.)<br>Signature on File<br>ASTRID ARRIETA, RPT<br>SIGNED 06/21/23 DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>SUNCARE THERAPY INC<br>15524 NW 77TH CT<br>MIAMI LAKE, FL 33016-5804<br>a. b. | | 33. BILLING PROVIDER INFO & PH. # ( 305 ) 231-5266<br>SUNCARE THERAPY INC<br>15524 NW 77TH CT<br>MIAMI LAKE, FL 33016-5804<br>a. 1376508440 b. | | |

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-DS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# HEALTH INSURANCE CLAIM FORM

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

PICA

SOUTH FLORIDA MUSCULOSKELETAL CARE.COM, INC-H
P.O. BOX 292277,
DAVIE, FL 33329

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): 101691226300 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ABAD, DIGNA V | | | 3. PATIENT'S BIRTH DATE: 09 06 1942 | SEX: M F X | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial): ABAD, DIGNA |
| 5. PATIENT'S ADDRESS (No., Street): 7000 NW 186TH STREET, APT 524A | | | 6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other | | | | 7. INSURED'S ADDRESS (No., Street): 7000 NW 186TH STREET, APT 524A |
| CITY: HIALEAH, US | STATE: FL | | 8. RESERVED FOR NUCC USE | | | | CITY: HIALEAH, US STATE: FL |
| ZIP CODE: 33015 | TELEPHONE (Include Area Code): (786) 857-2931 | | | | | | ZIP CODE: 33015 TELEPHONE (Include Area Code): (786) 857-2931 |
| 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: H1609-043 |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | a. EMPLOYMENT? (Current or Previous) YES NO X | | | | a. INSURED'S DATE OF BIRTH: 09 06 1942 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: SOUTH FLORIDA MUSCULOSKELETAL CAR |
| 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: 06/21/23

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: 05 01 21 QUAL. 431 | 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 ANAY PUNTONET | 17a. 17b. NPI 1669849741 | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? YES NO X $ CHARGES: JUL 03 2023 |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0<br>A. S46011A B. C. D.<br>E. F. G. H.<br>I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>23. PRIOR AUTHORIZATION NUMBER: 5-22-23 |

| 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 05 30 23 | 05 30 23 | 11 | | 97162 | GP | A | 180 00 | 1 | | NPI | 1235164831 |
| 2 | | | | | | | | | | NPI | |
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| 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 |
|---|---|---|---|---|---|---|---|
| 650662258 | | X | 400322Z4873 | X YES NO | $ 180 00 | $ 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. # (305) 231-5266 |
|---|---|---|
| Signature on File<br>ASTRID ARRIETA, RPT<br>SIGNED 06/21/23 DATE | SUNCARE THERAPY INC<br>15524 NW 77TH CT<br>MIAMI LAKE, FL 33016-5804<br>a. b. | SUNCARE THERAPY INC<br>15524 NW 77TH CT<br>MIAMI LAKE, FL 33016-5804<br>a. 1376508440 b. |