

HEALTH INSURANCE CLAIM FORM

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SOUTH FLORIDA MUSCULOSKELETAL PO BOX 292277 DAVIE FL 33329

PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (I	NUCC) 02/12		V	,		/		1	PICA
	CHAMPVA	GRO	IID	FECA	OTHER	1a. INSURED'S I.D. NUMBER	(For Program in	Item 1)
	(Member ID	THEAL	TH PLAN -	BEKLUNG	X(D#)	10148120190	100		•
	(Wellberto					4. INSURED'S NAME (Last Nam		idle Initial)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S	DD Y	042		JOHNSON, KA		actio titiliary	>
JOHNSON, KAYLA ✓		02		943 HIP TO INSURE	A CONTRACT	7. INSURED'S ADDRESS (No.,			1
5. PATIENT'S ADDRESS (No., Street)			_	1 []					Y
10600 SW 65TH AVE			Spouse		ther	10600 SW 65	OTH AVE	lea	TATE
CITY	STATE	8. RESERVE	ED FOR NU	CC USE		CITY		51	
PINECREST	FL					PINECREST			FI
ZIP CODE TELEPHONE (Include Are	ea Code)					ZIP CODE		Include Area Co	9
33156-4035 (305 7932	2077	1			ĺ	33156-4035	(30	7932	077
9. OTHER INSURED'S NAME (Last Marge, First Name, Midd	lle Initial)	10. IS ATIE	NT'S COND	ITION RELATED	D TO:	11. INSURED'S POLICY GROU	IP OR FECA NUM	BER	
(K)		V				H1609016			2
a. OTHER INSURED'S POLICY OF AROUP NUMBER		a. EMPLOY	MENT? (Cur	rent or Previous	5)	a. INSURED'S DATE OF BIRTH	-1	SEX	
			YES	Xio		02 26 19	943 M	7 F	X
b. RESERVED FOR NUCC USE		b. AUTO AC		L_J	ACE (Cinio)	b. OTHER CLAIM ID (Designat	Long	and are	
			YES	Xio	ACE (State)		,		
c. RESERVED FOR NUCC USE		C.QTHER A		L		c. INSURANCE PLAN NAME O	DE PROGRAM NA	ME	
o. HESERVES I STENOVO SOL		. TYES XIO			SOUTH FLORIDA MUSCULOSKELETA				
L NOUBANGE OF AN MANE OF PROCESSAL MANE		101.01.11			1001	d is there another head		- ALLES	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM	CODES (De	esignated by NU	(CC)				
				•		YES XIO	If yes, complete		
READ BACK OF FORM BEFORE 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE					necessary	13. INSURED'S OR AUTHORIZ payment of medical benefits			
to process this claim. I also request payment of government	nt benefits either	to myself or to	the party wh	no accepts assign	nment	services described below.	•		, ,
below.				4					
SIGNATURE ON FI		D.	ATE 05	19/20)22	SIGNED SIGNA	TURE ON	FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANG	CY (LMP) 15.	OTHER DAT	E MM	DD Y	YY	16. DATES PATIENT UNABLE	TO WORK IN CU	RRENT OCCUP	PATION
QUAL.	QU	JAL.				FROM	то		200
17. NAME OF REFERRING PROVIDER OR OTHER SOUR	CE 17	a.			a 1	18. HOSPITALIZATION DATES	S RELATED TO CO	URRENT SERV	ICES YY
DN MARGARITA GARCES V	B . 17	b. NPI	5480	1475	21	FROM	то		
19. ADDITIONAL CLAIM INFORMATION (Designated by N						20. OUTSIDE LAB?		ARGES	
,						YES X	127 202	3	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R	elate A-L to ser	vice line belov	v (24E)	CD Ind. 0		22. RESUBMISSION			
M5451 M4306	~ 1			AND STREET, ST		CODE	ORIGINAL RE	F. NO.	
AV B. L	C. L G. I		-	D		23. PRIOR AUTHORIZATION	NUMBER		
F	K. 1			H. L.		6-6-23	3		
24. A. DATE(S) OF SERVICE B. C		EDURES, SE	RVICES, OF	SUPPLIES	E.	F. G.	H. I.	J	
From To PLACE OF MM DD YY SERVICE EN		lain Unusual C			DIAGNOSIS		Family ID.	REND	
MM DD YY MM DD YY SERVICE EN	A DETINO	PCS L	MODI	1 (4)1	POINTER	S CHARGES UNIT	S Plan' QUAL.	PHOVIL	ER ID. #
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							NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S		10. 2	7. ACCEPT ASS	SIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAI	D 30. Rsv	d for NUCC U
651015068 X	CD600	AQF	10	Xyes	NO	\$ 270 00		00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE	FACILITY LOC	CATION INFO	ORMATION		33. BILLING PROVIDER INF	0&PH# (3	05 232	9222
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	PROGF	RESSIV	E PH	YSICAL	THER	A PROGRESSIV			
apply to this bill and are made a part thereof.)				HWY SU					
DANIEL FOEN		FL 3			avvidatocosti lasti	MIAMI FL 3			
06/22/2022						a 187158862			
SIGNED OOT GATE 2023			1				F		



AETNA MEDICARE HMO P.O. BOX 292277

DAVIE, FL 33329-2277

HEALTH INSURANCE CLAIM FORM

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

XX PICA	TOTAL OLD IN C		(1.000) 02/12		V)						PICA XXX
. MEDICARE MEDICA	ID TRIC	ARE	CHAMPVA	GROU	P F AN F		THER 1	a. NSURED'S I.D. NU	IMBER		(For Progran	in Item 1)
(Medicare#) (Medicaid	d#) (ID#/L	DoD#)	(Member ID	F) (ID#)	H HLAN DE	X (III	D#)	10148378840	00			
2. PATIENT'S NAME (Last Nam	ne, First Name, I	Middle Initial)		3. PATIENT'S	BIRTH DATE	SEX	200	I, INSURED'S NAME (Last Name	e, First Name,	Middle Initial)	
BERMUDEZ, MAR				08 0	5 1957 №	(annual contract of the contra	X	SAME	OC (No. 6	Para at \		
5. PATIENT'S ADDRESS (No.,				-	ELATIONSHIP T	January 1 1	-, l'	7. INSURED'S ADDRE	55 (NO., 5	Sireet)		
2600 S UNIVERSI	TY DR AF	T 225	ISTATE	Self X S	FOR NUCC US			SAME				STATE
DANIE			FL	o. nesenvel	7 FOR 11000 00	· Lon	ľ	SAME				SAM
DAVIE ZIP CODE	TELEPHON	E (Include A					12	ZIP CODE		TELEPHON	E (Include Area	Code)
33328-1466	(754)	422-49	934	1		22		SAME		() SAME	E
OTHER INSURED'S NAME	/			10. IS PATIEN	IT'S CONDITION	RELATED TO:	-	11. INSURED'S POLIC	Y GROUI	OR FECA N	JMBER	
				A								
a. OTHER INSURED'S POLICY	Y OR GROUP N	IUMBER		a. EMPLOYM	ENT? (Current or		1	a. INSURED'S DATE (YY		SEX	[57
					sussessed fro	X NO		08 05				FX
o. RESERVED FOR NUCC US	SE			b. AUTO ACC		PLACE (S	State)	b. OTHER GLAIM ID (Designate	d by NUCC)		
				OTHER AC	non-mark floor	X NO	1	A INCUDANCE DI ANI	NAME OF	DDOGDAMI	VAME	
. RESERVED FOR NUCC US	E			c. OTHER AC		X NO	C. INSURANCE PLAN NAME OR PROGRAM NAME AETNA MEDICARE HMO					
LINSURANCE PLAN NAME (OR PROGRAM	NAME		10d CLAIM C		IES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				LAN?		
I. INSULATION PLANTAME	on nounam	TAP TO THE		100, 027,111	ODEC (Doing)	,		YES X NO If yes, complete items 9, 9a, and 9d.				
			RE COMPLETING					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize				
 PATIENT'S OR AUTHORIZ to process this claim. I also 								payment of medica services described		to the undersig	gned physician	or supplier for
below.				•								
SIGNED SIGNATUI	RE ON FI	LE		DA	TE 07/03/2	023		SIGNED				
4. DATE OF CURRENT ILLN	IESS, INJURY,	or PREGNAN	NCY (LMP) 15.	OTHER DATE	MM E	D YY		16. DATES PATIENT	UNABLE			CUPATION
	QUAL.	/	GO	ming in the				FROM	a a manusco	T(Diagra
17. NAME OF REFERRING P		Q SOU						18. HOSPITALIZATIO	DATES	77		YY
DN BEN JOSEPH 19. ADDITIONAL CLAIM INFO		signated by h		NPI 155	8723924			FROM 20. OUTSIDE LAB?		T(CHARGES	
19. ADDITIONAL CLAIM INFO	DAMATION (De	agration by r	1000)					<u> </u>	NO M		2023o oc	1
21 DIAGNOSIS OR NATURE	OF ILLNESS C	R INJURY F	Relate A-L to sen	ice line below ((24E) ICD Inc			22. RESUBMISSION CODE	11,	P- 000		
M25.561			c. L		ICD IN	a. U		CODE	1	ORIGINAL	REF. NO.	
V			. G. L					23. PRIOR AUTHORI			Manual	
I.	J. L		K. L			. L		6-16	7-23	3		
24. A. DATE(S) OF SER	VICE To	B. PLACE OF		DURES, SERV	VICES, OR SUPI		E. NOSIS	F.	G. DAYS	H. I. EPSDT ID.	BE	J. INDERING
MM DD YY MM	DD YY		MG CPT/HCF		MODIFIER		NTER	\$ CHARGES	UNITS			VIDER ID. #
						POR LIN				1 2 1 2 2		11050
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	PERMIT				274	STATE OF THE PARTY.				Branker		
06 30 2023 06		3 11	9711 26. PATIENT'S			B ASSIGNM	IENTO	126 00 28. TOTAL CHARGE		NPI 29. AMOUNT F		11352 Rsvd for NUCC U
	DEN 35				YE	EPT ASSIGNM jovt. claims, see ba	ick)				1	Have for NOCC U
650851735 31. SIGNATURE OF PHYSIC	IAN OR SUPPL	JER	OIMO004		TION INFORMA	lone Land		33. BILLING PROVID	, 00	\$ APH# /	0 00	0.4242
INCLUDING DEGREES ((I certify that the statemen	OR CREDENTIA	LS						DECEMBER OF STREET		1	954) 38	2-4343
apply to this bill and are n			5200 S I	ort Therapy and Performance University Drive Suite 105				ORTHOSPORT INC 5200 S UNIVERSITY DRIVE SUITE 105				
Nancy Croughwell DPT, PT Davie, F				L 33328-5316				DAVIE, FL 33328-5316				
07/03/2023 SIGNED	DAT	E	a.		b.			a. 16896938		b.		
NUCC Instruction Man	THE RESERVE AND PARTY AND PARTY.	AND DESCRIPTION OF THE PARTY NAMED IN	nuce org	PI	EASE PRINT	OR TYPE	Married Control	The state of the s	THE RESERVE THE PERSON NAMED IN	OMB-0938	-1197 FOR	M 1500 (02-1



HEALTH INSURANCE CLAIM FORM

SOUTH FLORIDA MUSCULOSKELETAL CARE.COM, INC. P.O. BOX 292277,

DAVIE, FL 33329

PICA MEDICARE MEDICAID	Participation .	CHAMPVA	GROUP HEALTH PLAN	PECA OTHER	1a. INSURED'S LD. NUMBE		PICA TO Program in Item 1)
(Medicare #) (Medicaid	1	1 familiary and 1	PATIENT'S BIRTH DAT	BLK LUNG X (IDIF)	101668485600		14 (a. 1100)
OORNA DIAZ, M	ARIA		06 13 193	9 _M F X	4. INSURED'S NAME (Last ADORNA DIAZ,	MARIA	Initial)
220 SW 10TH S	T REAR		- Interest	Child Other	7. INSURED'S ADDRESS (F 2220 SW 10TH		
IAMI, US		FL	RESERVED FOR NUC	USE	MIAMI, US		STATE FL
3135	TELEPHONE (Inc				33135	TELEPHONE (Inclu	de Area Code)
OTHER INSURED'S NAME (L	ast Name, First Nam	e, Middle Initial) 10	IS PATIENT'S CONDI	TION RELATED TO:	11. INSURED'S POLICY OF H1609-043	OUP OR FECA NUMBER	
THER INSURED'S POLICY	OR GROUP NUMBE	R	EMPLOYMENT? (Curre	nt or Previous) NO	a INSURED'S DATE OF BI		SEX F [X]
ESERVED FOR NUCC USE		b.	AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (Design		F.A.
ESERVED FOR NUCC USE		C.	OTHER ACCIDENT?	X NO	c. INSURANCE PLAN NAME	E OR PROGRAM NAME	
SURANCE PLAN NAME OF	PROGRAM NAME	10	YES CLAIM CODES (Desi	NO grated by NUCC)	SOUTH FLORID		ELETAL CAR
REA	BACK OF FORM I	DESCRIPTION OF THE PROPERTY OF	and \$40 more than the same of		YES X NO	If yes, complete items	
to process this claim. I also noted	Quest payment of g	TURE I authorize the release overriment benefits either to	e of any medical or oth myself or to the party w	r information necessary no accepts assignment	13. INSURED'S OR AUTHOR payment of medical bene services described below	to the undersigned pho-	TURE I authorize ysician or supplier for
Signature			06/2 DATE	1/23	Signed	ature on Fil	Le
	UAL. 431	QUAL	ER DATE MM	DD YY	16. DATES PATIENT UNABLE MM DD FROM	E TO WORK IN CURREN	IT OCCUPATION DD YY
NAME OF REFERRING PRO LEYANY FLI	VIDER OR OTHER	SOURCE 178.	1497203	516	18. HOSPITALIZATION DAT	ES RELATED TO CURRE	NT SERVICES DD YY
ADDITIONAL CLAIM INFORM	ATION (Designated	by NUCC)		4	PROM 20. OUTSIDE LAB?	\$ CHARGE	S
DIAGNOSIS OR NATURE OF M25512	ILLNESS OR INJU	RY. Relate A-L to service li	ne below (24E) IOD	Ind. 0	YES X NO CODE		5
	B	C. L		D. L.	23 PRIOR AUTHORIZATION	ORIGINAL REF. NO.	The state of the s
DATE(S) OF SERVICE		C D PROCEDU	RES. SERVICES, OR S	1	F. G		
DD YY MM C	D YY SERVIC	F (Explain)	Jnusual Circumstances) J MODIFIER	DIAGNOSIS		B EPROT ID.	J. RENDERING PROVIDER ID. #
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			I I	7 72 72 72 72 72	The second	NPI	
				JOD		NPI	
			The second	440			the second second second second second second
EDERAL TAX LD. NUMBER	SSN EIN	26. PATIENT'S ACCO	373 ×	CEPT ASSIGNMENT?	28. TOTAL CHARGE 204 00	29. AMOUNT PAID	30. Revd for NUCC us
GNATURE OF PHYSICIAN NOLUDING DEGREES OR Coeffly that the statements or poply to this bill and are made inature on Fill TRID ARRIETA	REDENTIALS of the reverse a part thereof.)	SUNCARE THE	RAPY INC	ATION NO	33 BILING PROVIDER INFO SUNCARE THERAF 15524 NW 77TH MIAMI LAKE, FI	PAPH # (305)	231-5266
					10 Company (10 Com		

PLEASE PRINT OR TYPE



HEALTH INSURANCE CLAIM FORM

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

MEDICARE MEDICAID TRICARE (Medicare #) (Medicaid #) ((D#/DoD#) PATIENT'S NAME (Last Name, First Name, Middle In	CHAMPVA (Member ID#)	HEALTH PLAN	BLK LUNG X (IDIF) SEX	1a. WSURED'S LD. NUI 1016912263		Program in Item 1)
BAD, DIGNA V	ioai)	09 06 1942		ABAD, DIGN		i dinina)
PATIENT'S ADDRESS (No., Street) 000 NW 186TH STREET, AP		Self X Spouse Ch		7. INSURED'S ADDRES 7000 NW 18	SS (No., Street) 6TH STREET, A	PT 524A
(ALEAH, US	STATE 8	RESERVED FOR NUCC U	JSE	HIALEAH, U	S	STATE FL
3015 TELEPHONE (Includ	e Area Code) -2931	/		ZIP CODE 33015	(786) 8	ude Area Code) 857-2931
OTHER INSURED'S NAME (Vast Name,	Middle Initial) 1	O. IS PATIENT'S CONDITION	ON RELATED TO:	11. INSURED'S POLICY H1609-043	Y GROUP OR FECA NUMBER	3
OTHER INSURED'S POLICY OF GROUP NUMBER	1	EMPLOYMENT? (Current YES	or Previous)	a. INSURED'S DATE O		SEX F X
RESERVED FOR NUCC USE	1	D. AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (D	ceignated by NUCC)	Acceptant of the Control of the Cont
RESERVED FOR NUCC USE	- (OTHER ACCIDENT?	X NO		NAME OR PROGRAM NAME LIDA MUSCULOSE	KELETAL CAF
INSURANCE PLAN NAME OR PROGRAM NAME		10d, CLAIM CODES (Design	nated by NUCC)	d IS THERE ANOTHER	R HEALTH BENEFIT PLAN?	ns 9. 9a and 9d.
READ BACK OF FORM BE PATIENT'S OR AUTHORIZED PERSON'S SIGNAT to process this claim. I also request payment of gov			information necessary accepts assignment	13. INSURED'S OR AUT	THORIZED PERSON'S SIGN, benefits to the undersigned p	ATURE I authorize
Signature on File		06/21		SIGNED	gnature on Fi	le
DATE OF CURRENT ILLNESS, INJURY or PREGI	NANCY (LMP) 15. O	THER DATE	DD YY	16. DATES PATIENT U	NABLE TO WORK IN CURRE	
NAME OF REFERRING PROVIDER OR OTHER S	OURCE 17a	16698497	41	18. HOSPITALIZATION MM DD	DATES RELATED TO CURR	RENT SERVICES
. ADDITIONAL CLAIM INFORMATION (Designated b				20. OUTSIDE LAB?	\$ CHARG	GES
DIAGNOSIS OR NATURE OF ILLNESS OR INJUR	Y Relate A-L to service	e line below (24E)	Ind. 0	YES X	NO JUL 0 3 20	23
S46011A B. L	C. L_		D. L.	23 PRIOR AUTHORIZA	ATION NUMBER	
A DATE(S) OF SERVICE B	K.L.	DURES, SERVICES, OR SU	L L	5-22-7	L3	-
From To PLACE OF M DD YY MM DD YY SERVICE	(Expla	in Unusual Circumstances	DIAGNOSII POINTER		DAYS FEOT ID.	RENDERING PROVIDER ID #
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				1	NPI	
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					NPI	the same with the part has the total had had
			.00	1	NPI	
	1	1	490	1	NPI	
650662258 SSN EIN	26. PATIENTS AI 4003222	4873 X	CEPT ASSIGNMENT?	28 TOTAL CHARGE 180	\$	30. Revd for NUCC
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) ignature on File STRID ARRIETA, RPT	33. BILLING PROVIDER INFO & PH. # (305) 231-5266 SUNCARE THERAPY INC 15524 NW 77TH CT MIAMI LAKE, FL 33016-5804					