

ID: 129769

Image Number: 193 01 0717 20013

Name: 193 01 0717 20013

Bin: 393 - Original Documents

Cabinet: FEP

Received Date: 01/13/2020

Client - Carrier #:

Batch #:

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   xmlns:xsd="http://www.w3.org/2001/XMLSchema"
   xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
 - <Metadata>
     <EMail>gdfang8m@gmail.com</EMail>
     <ContactAuthorized>N</ContactAuthorized>
     <SubscriberID>R59133986</SubscriberID>
     <SubscriberFirstName>GUODONG</SubscriberFirstName>
     <SubscriberLastName>FANG</SubscriberLastName>
    <DigitalVerification > N 
/DigitalVerification >
    <DigitalVerificationDate>
   </Metadata>
 - <Files>
    <Claim>202001134462C.pdf</Claim>
     <Image>202001134462I01.pdf</Image>
   </Files>
 </FEPSubmission>
    ⊨#₫
    45.
    FM4
    10
```



Federal Employee Program **OVERSEAS MEDICAL CLAIM FORM**

Please see the instructions on the reverse side of this form before completing

ENROLLMENT CODE IDENTIFICATION NUMBER 104 950122006

(Including Area Code)

PLEASE TYPE OR PRINT.						"	U 4	כואן	9	1 3 3	1918	3 6
or at that could be			° 1. PA	TIENT I	NFORMAT	ION:	to to Sa	3 Sec. 25.	100		1	
1A. PATIENT'S NAME GUOD	ong Fang			I	1B. PATIENT			01/28				
	First Name, Middle Ini	tial, Last Name							onth/Day/Y			
	Male	Female	1D. PATI	ENT'S RE	LATIONSHIP	TO CON	TRACT HO	LDER [■ Sel	f Spouse	De	pendent
1E. NAME OF CONTRACT HO	LDER Guodon		Middle Initial, L	ast Name			F. CONTRA	ACT HOLDI	ER'S		3/1946 tonth/Day/Y	
1G. CONTRACT HOLDER'S C	URRENT MAILING	ADDRESS						1H. EMAII	L ADDF		<u> </u>	<u> </u>
7201 Dubuque Ct., Ro		0855 State and Count	try or ZIP					gdfang	8m@g	gmail.con	<u>n</u>	
2A. IS PATIENT COVERED U	NDER OTHER HEA	LTH INSU	RANCE? I	f yes, con	LTH INSUF	RANCE	K below.	Yes ■	No		in and and and and and and and and and an	3,
2B. NAME AND ADDRESS OF	INSURING COMP.	ANY <u>Med</u>	icare Pa	art B								
2C. POLICY OR IDENTIFICAT NUMBER OF OTHER COVER		J0-GP1	3	2D. NA	ME OF CONT	RACTHO	DLDER G			diddle Inidel, Last I	Name	
2E. TYPE Family	2F. TYPE OF	Medical	■ Ye	s No	21. CONTRA	CT HOLE	ER DATE	OF BIRTH		/28/1946	j	
OF POLICY Individual	COVERAGE	Dental		s No	2J. EMPLOY	ER OF C	ONTRACT	HOLDER		Month/Day∧	ear	
2G. EFFECTIVE DATE	2H. TERMINA			3 🔲 110	-							
06/01/2018					2K. EMPLOY	MENT 9	TATUS F	Active E	mplove	e 🔳 Re	tired En	nlovee
Naohth/Day/Year		Month/Day/Y		3 DIA	GNOSIS		ن وې تن د					
3A. DESCRIBE REASON FOR		<u> </u>	<u> </u>	J. DIA	3140010					RK RELATE		
Routine care, illness, injury, or Fever and sore throat	symptoms requiring	treatment ((e.g., coug	h, sore thr	oat).	OR CO	NDITION?	٦	□ Y∈	s 🔳	No	
3C. COMPLETE FOR CARE R		DENTAL IN	JURIES	Date of A	ccident		Time of A	Accident			AM	РМ
Location Home	Auto 🔲 Other	If Other	er is selec			- ,	•	_		u		
				4. CHA		.1*9.18		trad of president	1.	Tes the	. E	, s , d
4. CHARGES Please list below	r: Begin and End da	te for charg	es that are	e being cla	imed			NII INAI	BER OF	:		
BEGIN DATE 06/12/201	9 END DATE	06/1	2/2019	тот	AL CHARGES	270	0.50 RM	_	IZED BI	4 .	with F	<u> X</u>
K Total Man Day Little	79 A	r i 5.	REIMB	URSEN	MENT INFO	DRMA'	TION ."	, <u>42</u> , 43, 141	W. J.	i de		4 6
6A. CONTRACT HOLDER RE	IMBURSEMENT IN						***************************************	المناسطان في موامل بطارد	····			
	Select type of reimbursement: (Skip to 5C to authorize reimbursement to be issued to provider)											
Note: Omission or errors in pa				check in U	S Dollars	L	Currency	on Bills Ele	ctronic i	Funds Trans	fer	
5B. COMPLETE FOR BANK V												
Name on Bank Account (Contra						Bank Nam	ne					
Complete Bank Address (Stree	t)											
City		State		Zip	Code		Cou	ntry				
Routing Number (ABA/SWIFT												
Account Number (Local Bank/	IBAN)								\prod		\coprod	
5C. AUTHORIZATION FOR AS	SIGNMENT OF BI	ENEFITS (E	Benefits ca	n only be	assigned to one	e provide	r for each c	laim. Do no	ot comp	ete this sect	ion if	
requesting a bank wire) I, the u Provider Name Guodong	-	ze and requ	lest Careri	irst BlueCr	oss Blue Snield	o to make	payment re	or benefits (ue nere	ein to:		
		<u> </u>										
—	201 Dubuque (140			000	<u> </u>	0	HEA			
City Rockville State MD Zip Code 20855 Country USA												
Signature of Contract Holder or Spouse 10/10/10/19 Date 1/13/2020												
I certify the above is complet	e and correct and the	natlam da	r imina hene		NATURE or charges incu	rred by th	ne patient n	amed abov	e. Authr	ndzation is h	ereby o	iven
I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in the patient's care, to release to CareFirst BlueCross BlueShield, any medical information which they deem necessary to adjudicate this claim. Submission acts as signature for e-Claims (240) 620-3675												
0:	iture of Contract Ho	Ider or Paris	ent	-4/-15	Date		_ ·	``		none Phone	Numbe	
CUT0159-1S 10/18 Signa	ware or communicated the	JULI OF LATE	or it		Date					0-4-1		



Federal Employee Program.

Explanation of Benefits

THIS IS NOT A BILL

GUODONG FANG 7201 DUBUQUE CT DERWOOD MD 20855 MAILROOM ADMINISTRATOR PO BOX 14112 LEXINGTON, KY 40512-4112 202-484-1650 1-888-999-9862 TDD NUMBER 202-479-3546 WWW.FEPBLUE.ORG

EXPLANATION OF BENEFITS AT A GLANCE					
Benefit Check Enclosed	Benefit Check Enclosed				
Patient Name:	GUODONG FANG				
Dates of Service:	06/12/2019 - 06/12/2019				
You Owe the Provider:	\$1.45				

ID Number: R59133986 Claim Number: 9352G00205PB Claim Paid On: 01/08/2020 Claim Received On: 12/18/2019 Claim Processed On: 01/08/2020 Patient Acct No: 04183655

Check Number:

730144972

Dates of Service: 06/12/2019 - 06/12/2019

Provider: TONGREN HOSPITAL SHANGHAI JIAO TONG

Type: NON-PARTICIPATING PROVIDER

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deduct	Coinsurance Or Copay	Medicare/ Other Ins.	What We Paid	You Owe The Provider
PRESCRIPTION DRUG	39.11	1	209)	 			
MEDICAL CARE	1.45	1.45]	; L		1.45	1.45
TOTALS:	40.56	1.45	,	, 0.00	0.00	0.00	1.45	1.45
Dosprip Now wa	10-3	Val MA	AUSK	MARIE	on) lus	101 101	17C	1 100

209 WE ARE UNABLE TO PROCESS THIS CHARGE UNTIL WE RECEIVE MORE INFORMATION ABOUT THE PRESCRIBED DRUG. TO DETERMINE WHETHER BENEFITS ARE AVAILABLE, WE REQUIRE THE DRUG NAME, OR THE NATIONAL DRUG CODE (NDC), THE APPROPRIATE QUALIFIER, UNIT OF MEASURE, NUMBER OF UNITS, AND PRICE PER UNIT, PLEASE RESUBMIT THE CLAIM WITH THAT INFORMATION.

YOUR RESPONSIBILITY TO THE PROVIDER(S) IS

\$1.45. WE PAID

\$1.45. THE PROVIDER CAN COLLECT

\$1.45 FROM YOU FOR THESE SERVICES.

Summary of Out-of-Pocket Expenses for 2019						
,	Catastrophic Protection					
	Calendar Year Deductible	Preferred	Non-Preferred/ Preferred Total			
What You Have Paid						
Individual	\$0.00	\$431	\$431			
Family/Self+One	\$0.00	\$0	\$0			
Annual Maximum						
Individual	\$0.00	\$5,000	\$7,000			
Family/Self+One	\$0.00	\$0	\$0			

Your Out-of-Pocket Expenses On This Claim				
Calendar Year Deductible	\$0.00			
Per Admission Copay	\$0.00			
Coinsurance	\$0.00			
Copayment	\$0.00			
Non-covered Charges	\$0.00			
Percertification Penalty				
TOTAL:	\$0.00			

If you have questions, please call a customer service representative at your local Blue Cross and Blue Shield Plan. You may also request the diagnosis codes, the treatment codes, and the corresponding meanings of the codes for your claim. If you disagree with the decision on your claims or request for services, and wish to have the decision reconsidered, you must notify your Plan in writing within 6 months from the date of this decision, i.e. 07/08/2020. You may request copies, free of charge, of any relevant materials and Plan documents relating to your claim. Your Plan will not accept unauthorized reconsiderations from providers. See the Disputed Claims section of your Service Benefit Plan Brochure.

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j	上海市普陀区 门 诊 记				÷ ;	长征镇社区卫 姓名: 方閣栋 性别
	分		标准	地址	事	费别: 自費(本地) 临床诊断: 支气管堤 发票号: 18131388: 也 實得获皮试:
	É	1 Noi	10580	97		药品名称: (甲)贝羚胶 规格: 0.3g*12粒/F上; 单价: 41.2元
•	11 30区	格.	XI	· # 7=	3 ,	药品名称: (甲)佳美舒 规格: 0.25g+6粒/1 新 单 价: 35.25 元
	工作单位。	*>>	/ / /	19/56/6		對品名称: (甲)润肺會 規格: 250g/短 烟; 单 价: 38.2 元
-	药物过敏	日期	传染疾	· 拜	日柳	30.270
	E TAJ					1 1 1
	egid No.					
•	And the second s					¹ 审核: 调配: 317
	5 11, 11, 14,				,	

长征镇社区卫生服务中心配方笺

姓名: 方閣栋 性别: 男 年龄: 73岁 科室: 全科 費別: 自費(本地) 卡号: 310107150081224 临床诊断: 支气管炎 外方时间: 2019年06月12日 发票号: 18131388: 收款員: 俞丽昊 处方号: 4370106 實稿業皮试: 电话号码:

 规格: 0.38*12粒/ 上海笛允上制药有限公司	用量:	口服 ユ北 0.6 g 一天三次
7,000	用法: 用量: 類次:	口服 (1) 地 0.5 g 一天一次
對品名称: (甲)润肺膏(圖)G 规格: 250g/瓶 烟台渤海制药 单 价: 38.2 元 数 聲: 2 瓶	用法: 用量: 颏次:	口服 20 g 一天三次

核对:

医师: 孙诒

发药:

合计, 270,50

姓名: 方国栋 性別: 男 年齡: 73岁 科窟: 全科 处方时间: 2019年06月12日 青霉素皮试。 电话号码:

药品名称; (甲) 贝羚胶囊(市) G 规格: 0.3g*12粒/f 上海爾允上制药有限 2 埠 价; 41.2 元 数量; 3 册	频次:一天三次
药品名称: (甲) (生美舒(图) (阿奇霉素肠病 规格: 0.25g=6粒/1 浙红众益药业有限公司 单 价: 35.25 元 数量: 2. 盒	引 用 (0.5 g)
药品名称: (甲)润肺膏(氯)G 规格: 250g/瓶	用法: 口服 用量, 20 g 顶板: 一天三次

审核: 调配: 317

核对,

医师: 孙青

发药:

合计。 270.50

G. ... F: 19 :1 99. M. M.

