## **Missing Claims Inquiry**

| Client Name:                           |   | Masters, Mates & Pilots Health & Benefits Plan |            |                        |     |  |           |      |  |  |
|--|---|--|------------|------------------------|-----|--|-----------|------|--|--|
| Claims type (Medicare or VA Crossover, |   |  | ver, Denta | ental, or Commercial): |     |  | are Cross | over |  |  |
| Provider Name:                         |   | Tushar Fuse 1                                  |            |                        |     |  |           |      |  |  |
| Tax ID:                                | 4 |  | NPI:       | 4                      |     |  |           |      |  |  |
| Patient (1) Info:                      |   |  |            |                        |     |  |           |      |  |  |
| Patient Name:                          |   | 4  |            |                        |     |  |           |      |  |  |
| Date of Birth:                         |   | 2025-04-01                                     |            |                        |     |  |           |      |  |  |
| Claim Info for Patient (1):            |   |  |            |                        |     |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |
| Patient (2) Info:                      |   |  |            |                        |     |  |           |      |  |  |
| Patient Name:                          |   | 4  |            |                        |     |  |           |      |  |  |
| Date of Birth:                         |   | 2025-04-01                                     |            |                        |     |  |           |      |  |  |
| Claim Info for Patient (2):            |   |  |            |                        |     |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |
| Patient (3) Info:                      |   |  |            |                        |     |  |           |      |  |  |
| Patient Name:                          |   | 4  |            |                        |     |  |           |      |  |  |
| Date of Birth:                         |   | 2025-04-01                                     |            |                        |     |  |           |      |  |  |
| Claim Info for Patient (3):            |   |  |            |                        |     |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | -17 |  |           |      |  |  |
| DOS 4                                  |   |  |            | Amount: \$             | 4   |  |           |      |  |  |