MDH DATA ENTRY
WORK REQUEST

BREAST AND CERVICAL CANCER

Document Title/Name: FORM CMS1500

Data Entry Standard Job: CANHIC09

Data Entry Batch Name: L083

Date Delivered to Data Entry: 02/ 09 /2018

Number of Documents: 01

Fiscal Year: 2018

Date Batched: 02/ 09 /2018

FEB 09 2018

Prepared by: BD

OUTPUT TO FILE:

ENTER	VERIFY
1. _____ ___/__/____	1. _____ ___/___/___
2. _____ ___/___/___	2. _____ ___/___/___

DATE RECEIVED BY DATA ENTRY

HEALTH INSURANCE CLAIM FORM

EOB Denial

Gru, Felonius
125 Minion Lane
Minionville MD 21222

07 30 1967 X
X

X
X
X

SIGNATURE ON FILE

9997755555
Gru, Felonius
125 Minion Lane
Minionville MD
21222

07 30 1967 X

X

SIGNATURE ON FILE

I972

0

1

07 31 2017	07 31 2017	12	S8424	A	224.10 2
07 31 2017	07 31 2017	12	S8427	A	88.10 2

521983377 X GILL04 X 312.20

SIGNATURE ON FILE
02/02/2018

TOTAL IMAGE CARE INC
800 ARMY ROAD
TOWSON MD 212046701
1104253160

Allscripts

DMERC - 835 Remittances

Received Date: 02 Feb 2018

Customer Name: 1608052

User: JIMMY RENGEN

Claim Detail

Patient Demographics

Name: Gru, Felonius

Pat Acct:

Ins Id:

Claim Information

Claim Status: 4

Claim Num/ ICN: 18026738372000

Messages: MA01

Total Billed: $312.20

Total Prov Paid: $0.00

Rend Prov	Service Date	Proc	Mods	Billed	Allowed	Deduct	Coins	Rmrk	Grp Rc Qty	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	31 Jul - 31 Jul 2017	A9270		$88.10				N130	PR 204	$88.10		$0.00	$0.00
	31 Jul - 31 Jul 2017	A9270		$224.10				N130	PR 204	$224.10		$0.00	$0.00
				$312.20	$0.00	$0.00	$0.00			$312.20	$0.00	$0.00	$312.20

Name: [redacted]

Pat Acct: [redacted]

Ins Id: 219429780A

Claim Status: 4

Claim Num/ ICN: 18026720970000

Messages: N211

Total Billed: $289.20

Total Prov Paid: $0.00

Rend Prov	Service Date	Proc	Mods	Billed	Allowed	Deduct	Coins	Rmrk	Grp Rc Qty	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	25 Jan - 25 Jan 2017	A6545	AW RT LT	$289.20	$189.66		$37.93		PR 2 CO 29	[redacted]		$0.00	[redacted]
				$289.20	$189.66	$0.00	$37.93			[redacted]	$0.00	$0.00	[redacted]

Rmrk Grp Rc Glossary:

CO 29	Contractual Obligations The time limit for filing has expired.
CO 29	Refers to situations where the billed service is not covered by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
N130 PR 204	Refers to situations where the billed service is not covered by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc.
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
N211	Alert: You may not appeal this decision.
PR 2	Patient Responsibility Coinsurance Amount
PR 204	Patient Responsibility This service/equipment/drug is not covered under the patient's current benefit plan

JENKINSON Branch: HQ

Julius Zorn Inc.
P.O. Box 1088
Cuyahoga Falls, OH. 44223
1-800-222-4999
www.juzousa.com
sales@juzousa.com

Juzo® Since 1912

Invoice

01242654

Sold To:
TOTAL IMAGE CARE, INC.
1850 YORK ROAD STE I
TIMONIUM MD 21093

MARIANNE KELLY
Telephone 410-560-0614

Order Via
FAX

Shipping Instructions
UPS GROUND

Ship To:
TOTAL IMAGE CARE, INC.
STE I
1850 YORK RD
TIMONIUM MD 21093

Sales Order	Order Date	Ship Date	Terms	Purchase Order	Customer No.
01216979	12/01/17	12/04/17	60 DAYS	12/1/2017	1021094

Order Qty.	Item #	Description	Ship Qty	B/O Qty	Unit Price	Disc. Price	Net Amt.
1.00 EA	2001MXCGLSB10 II 11398	Soft, Sleeve, Max, Long, Silicone, Black	1.00	0.00	$ 37.35EA	$ 33.61 EA	$ 33.61
1.00 EA	2001MXCGLSB23 II 07668	Soft, Sleeve, Max, Long, Silicone, Chestnut	0.00	1.00	$ 37.35EA	$ 33.61 EA	$ 0.00
(4) 2.00 PR	2001ADFF57 III 12332	Soft, Knee, FF, Cinnamon	2.00	0.00	$ 39.95PR	$ 35.96 PR	$ 71.91
(2) 1.00 PR	2001ADFF10 III 07168	Soft, Knee, FF, Black	1.00	0.00	$ 39.95PR	$ 35.95 PR	$ 35.95
(2) 1.00 PR	2001ADFFSB57 III 14040	Soft, Knee, FF, Silicone, Cinnamon	1.00	0.00	$ 45.95PR	$ 41.35 PR	$ 41.35
1.00 EA	2001AC14 L 12490	Soft, Gauntlet, Beige	1.00	0.00	$ 13.35EA	$ 12.01 EA	$ 12.01
2.00 PR	2001ADFFSBSH06 IV 13759	Soft, Knee, FF, Short, Silicone, White	0.00	2.00	$ 45.95PR	$ 41.36 PR	$ 0.00
(2) 1.00 PR	2001ADFFSBSH14 IV 10845	Soft, Knee, FF, Short, Silicone, Beige	1.00	0.00	$ 45.95PR	$ 41.35 PR	$ 41.35
2.00 EA	2001CGLSB10 III 11387	Soft, Sleeve, Long, Silicone, Black	2.00	0.00	$ 37.35EA	$ 33.62 EA	$ 67.23
2.00 EA	2001AC10 M 12897	Soft, Gauntlet, Black	2.00	0.00	$ 13.35EA	$ 12.02 EA	$ 24.03
(2) 1.00 PR	2001ADFFSB14 III 10839	Soft, Knee, FF, Silicone, Beige	1.00	0.00	$ 45.95PR	$ 41.35 PR	$ 41.35
1.00 EA	2001MXCGLSB10 II 11398	Soft, Sleeve, Max, Long, Silicone, Black	1.00	0.00	$ 37.35EA	$ 33.61 EA	$ 33.61
1.00 EA	2001MXCGLSB00 II 23013	Soft, Sleeve, Max, Long, Silicone, Seasonal	0.00	1.00	$ 37.35EA	$ 33.61 EA	$ 0.00
1.00 EA	2SGD61 23178	Sleeve, Misty Gray	0.00	0.00	$ 0.00EA	$ 0.00 EA	$ 0.00
1.00 EA	NR	Non-Returnable/Non-Refundable	0.00	0.00	$ 0.00EA	$ 0.00 EA	$ 0.00
1.00 EA	2001AC10 M 12897	Soft, Gauntlet, Black	0.00	0.00	$ 13.35EA	$ 12.01 EA	$ 0.00
1.00 EA	2ACD61 23255	Hand, Misty Gray	0.00	0.00	$ 0.00EA	$ 0.00 EA	$ 0.00
1.00 EA	NR	Non-Returnable/Non-Refundable	0.00	0.00	$ 0.00EA	$ 0.00 EA	$ 0.00

MDH DATA ENTRY
WORK REQUEST

BREAST AND CERVICAL CANCER

Document Title/Name: FORM CMS1500

Data Entry Standard Job: CANHIC09

Data Entry Batch Name: M187

Date Delivered to Data Entry: 02/ 15 /2018

Number of Documents: 10

Fiscal Year: 2018

Date Batched: 02/ 15 /2018

FEB 15 2018

Prepared by: BD

OUTPUT TO FILE:

ENTER	VERIFY
1. _____ ___/__/____	1. _____ ___/___/___
2. _____ ___/___/___	2. _____ ___/___/___

DATE RECEIVED BY DATA ENTRY

MARYLAND MEDICAL ASSISTANCE
PREVENTION & HEALTH PROMOTION
PO BOX 13528
BALTIMORE MD 21203

M

HEALTH INSURANCE CLAIM FORM

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

XXX PICA XXX

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) 0000112222 CONTROL

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wilde, Lucy

3. PATIENT'S BIRTH DATE MM 12 DD 27 YY 1972 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Wilde, Lucy

5. PATIENT'S ADDRESS (No., Street): 125 Minion Lane

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

7. INSURED'S ADDRESS (No., Street): 125 Minion Lane

CITY: Minionville STATE: MD

9. RESERVED FOR NUCC USE

CITY: Minionville STATE: MD

ZIP CODE: 21222 TELEPHONE (Include Area Code): ( )

ZIP CODE: 21222 CANCER CONTROL TELEPHONE ( ) FEB 15 2018

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 12 DD 27 YY 1972 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

d. INSURANCE PLAN NAME OR PROGRAM NAME: UMR

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] 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: 08 11 17

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

17a. 17b. NPI

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

A. K529 B. Z8719 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 01 08 18	01 08 18	11		99214		AB	167 00	1		NPI	1447278320
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 472063332 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 11448

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

28. TOTAL CHARGE: $ 167 00

29. AMOUNT PAID: $ 137 00

30. Rsvd for NUCC Use: 30.00

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.)

DANIEL J CRABLE, MD

SIGNED DATE 02 09 18

32. SERVICE FACILITY LOCATION INFORMATION

MEDICAL ASSOCIATES OF GR
32 CORPORATE DR
GRANTSVILLE MD 21536-1259

a. 1265819866 b.

33. BILLING PROVIDER INFO & PH # (301) 8958750

SPECIALTY PHYSICIANS OF GARR
PO BOX 594
OAKLAND MD 21550-4594

a. 1265819866 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500

eRemittance - UMR (FORMERLY WAUSAU)

Payee :MD MARYLAND (3QYJ)
880 MEMORIAL DRIVE LOWER LEVEL
OAKLAND MD 215502155

Date: 01/22/2018
TIN: 472063332
TIN: 472063332
Reference ID: 9327611639
Amount: $343.55

Payor : UMR (FORMERLY WAUSAU) (39026) , (UMR01) , (39026)
PO BOX 30541
SALT LAKE CITY UT 841300541

Explanation of Payment

Claims: 2

(1)

Patient Name	Wilde, Lucy	Patient ID		Claim Status	1
Subscriber Name	Wilde, Lucy	Payer Claim ID	18010163406	Claim Amount	$167.00
Provider Name	CRABLE DANIEL	Provider Claim ID	11448	Paid Amount	$53.52
Claim Statement Dates	- - -	Received Date	-	Pt Responsibility	-

Claim Status Description : Processed as Primary

Serv Date	Units	Serv Code	Billed	Paid	Allowed	Adjustments
01/08/2018 - 01/08/2018		HC:99214	$167.00	$53.52	$83.52	CO-45: $83.48 PR-3: $30.00

Adjustment Group Codes
CO : Contractual Obligations
PR : Patient Responsibility

Adjustment Reason Codes
3 : Co-payment Amount
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)

HEALTH INSURANCE CLAIM FORM

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

PICA

M

MD DHMH CPHA C-13528 (48)
PO BOX 13528

BALTIMORE, MD 21203

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: 0000 33789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Ning, Eve

3. PATIENT'S BIRTH DATE: 09 08 1978 SEX: [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Ning, Eve

5. PATIENT'S ADDRESS (No., Street): 42 Wallaby Way

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

7. INSURED'S ADDRESS (No., Street): 42 Wallaby Way

CITY: WESTMINSTER STATE: MD

8. RESERVED FOR NUCC USE

CITY: WESTMINSTER STATE: MD

ZIP CODE: 21157-7345 TELEPHONE (Include Area Code): ( )

ZIP CODE: 21157-7345 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 [X] NO

a. INSURED'S DATE OF BIRTH: 09 08 1978 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: MD DHMH CPHA C-13528 (48)

d. INSURANCE PLAN NAME OR PROGRAM NAME: HIGHMARK MEDICARE PART B(

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, 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:

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: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN DYER CRNP., ROCHELLE

17a. 17b. NPI 1487619896

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. Z51.11 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO. 1018022402300

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 PROVID. ID.
01 17 18		11		93306		A	537.00	1		NPI	1659365682
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 27-1956453 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 41I14259384

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

28. TOTAL CHARGE: $ 537.00

29. AMOUNT PAID: $ 490.85

30. BALANCE DUE: 46.15

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.)

EVAN SELSKY MD.

SIGNED 02/06/18 DATE

32. SERVICE FACILITY LOCATION INFORMATION

CHG CARDIOLOGY
193 STONER AVE
WESTMINSTER, MD 21157-5680

a. b.

33. BILLING PROVIDER INFO & PH #: (410) 526-9700

CARROLL HEALTH GROUP
P.O. BOX 900
WESTMINSTER, MD 21158-0900

a. 1437473550 b.

NUCC Instruction Manual available at: www.nucc.org

41M20874590G48/PE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

PBN 10596 BANK DEPOSIT DATE 02/05/2018

CONTROL FEB 15 2018

PO BOX 3401
MECHANICSBURG, PA, 17055-1846

REMITT
Ad

PAYER BUSINESS CONTACT INFORMATION:
(877)235-8073

PAYER TECHNICAL CONTACT INFORMATION:
NOVITAS SOLUTIONS, INC. EDI SERVICES
WEBSITEEDI NOVITAS-SOLUTIONS.COM
(877)235-8073 ext. 1

CARROLL HEALTH GROUP LLC
P O BOX 900
WESTMINSTER, MD, 21158-0900

NPI #: 1437473550
DATE: 02/05/18
PAGE #: 1

CHECK/EFT: 884531520

Rend Prov	Serv Date	POS	NOs	Proc	Mods	Billed	Allowed	Deduct	Coins	StatGroup	RC-Amt	Prov Paid
Name: Ning, Eve		Hic:				Acnt: 41I14259384-2	ICN: 1018022402300			ASG: Y	MOA: MA01	
	01/17/18	11	1	93306		537.00	230.77	0.00	46.15	CO-45	306.23	180.93
										CO-253	3.69	
PT RESP	46.15	CLAIM TOTALS				537.00	230.77	0.00	46.15		309.92	180.93

ADJ TO TOTALS: PREV PD INTEREST 0.00 LATE FILING CHARGE 0.00 NET 180.93
ESTIMATED AMOUNT DUE: PAYMENT VARIANCE: -- PYMT VAR IND: Claim Status: 1

MESSAGES/REASONS:

2 Coinsurance Amount

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equ the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reduction that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

253 Sequestration - reduction in federal payment

CO Contractual Obligations

MA01 Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

PR Patient Responsibility

M

DHMH CTR CANCER SURVEILLANCE
PO BOX 13528

BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

FEB 1

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

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): 22244 lolololo

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Looper, Sheldon

3. PATIENT'S BIRTH DATE MM DD YY: 02 12 1971 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): 2311 N. Los Robles Ave, Apt.4

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

7. INSURED'S ADDRESS (No., Street): 2311 N. Los Robles Ave, Apt.4

CITY: FEDERALSBURG STATE: MD

8. RESERVED FOR NUCC USE

CITY: FEDERALSBURG STATE: MD

ZIP CODE: 21632 TELEPHONE (Include Area Code):

ZIP CODE: 21632 TELEPHONE (Include Area Code):

CANCER CONTROL

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

FEB 26 2018

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 SEX M [X] F

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: DHMH CTR CANC-DHMH CTR FOR C

d. INSURANCE PLAN NAME OR PROGRAM NAME: MDIPA UHC

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES NO 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 02 13 2018

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 MM DD YY QUAL.

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: DNKORAH M PULIMOOD

17a.

17b. NPI 1568598639

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: 000

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. C50212 B. Z170 C. Z803 D. L598
E. M545 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 Fam. Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1	04 11 17		22		99214		ABCD	168.00	1		NPI	1932438322
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 521874111 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 9532324483

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

28. TOTAL CHARGE: $ 168.00

29. AMOUNT PAID: $ 128.00

30. Rsvd for NUCC Use: 40.00

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.)

ROBERTA JOLINE LILLY

SIGNED 02 13 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION

SHORE REGIONAL BREAST CENT
219 S WASHINGTON STREET
EASTON MD 21601-2913
a. 1477530624 b. LU162301014

33. BILLING PROVIDER INFO & PH # (443) 462-5010

UM COMMUNITY MEDICAL GROUP
PO BOX 419244
BOSTON MA 02241-9244
a. 1477530624 b. LU162301014

EXPLANATION OF BENEFITS - UNITED HEALTH CARE

REMITTANCE DATE: 07/27/2017

BILLING PROVIDER: LILLY, ROBERTA JOLINE

PROVIDER NUMBER:

PATIENT NAME:

DOB:

SUBSCRIBER NAME: Cooper, Sheldon

PATIENT ADDRESS:

FEDERALSBURG, MD 21632

GROUP/POLICY NUMBER: 712403

MEDICARE ICN:

CLAIM NUMBER: P9532324491

INSURANCE CARRIER INFORMATION

1010603 UNITED HEALTH CARE
PO BOX 740829
ATLANTA, GA 30374

5000800 DHMH CTR CANCER SURVEILLANCE
PO BOX 13528
BALTIMORE, MD 21203

PROC	DESCRIPTION
99214	PR OFFICE/OUTPT VISIT

SERVICE INFORMATION:

DATE OF SERVICE	CODE	MODIFIER(S)	UNITS	BILLED	ALLOWED	NOT ALLOWED	DEDUCT	COPAY	COINS	PAID	PT RESP	INS ID
04/11/17	99214		1	$ 166.00	$ 95.00	$ 73.00	$ 0.00	$ 40.00	$ 0.00	$ 55.00	$ 0.00	101060
	Denial Codes: 3,45,MA67											
			1	$ 166.00	$ 95.00	$ 73.00	$ 0.00	$ 40.00	$ 0.00	$ 55.00	$ 0.00	

REASON CODE DESCRIPTION:

3 3-CO-PAYMENT AMOUNT

45 45-CHGS EXCD FEE SCH/MAX ALLOWABLE.

MA67 MA67-CORRECTION TO A PRIOR CLAIM.

REMARK CODES:

PAGE SUMMARY:

TOTAL PAID TO PROVIDER: $ 55.00

EXPLANATION OF BENEFITS - UNITED HEALTH CARE

REMITTANCE DATE: 07/31/2017

BILLING PROVIDER: LILLY, ROBERTA JOLINE

PROVIDER NUMBER:

PATIENT NAME: Cooper, Sheldon

DOB:

SUBSCRIBER NAME:

PATIENT ADDRESS:

FREDERICKSBURG, MD 21032

GROUP/POLICY NUMBER: 712403

MEDICARE ICN:

CLAIM NUMBER: P9532324481

INSURANCE CARRIER INFORMATION

1010603 UNITED HEALTH CARE
PO BOX 740815
ATLANTA, GA 30374

6000800 DHMH CTR CANCER SURVEILLANCE
PO BOX 13528
BALTIMORE, MD 21203

PROC DESCRIPTION

SERVICE INFORMATION:

DATE OF SERVICE	CODE	MODIFIER(S)	UNITS	BILLED	ALLOWED	NOT ALLOWED	DEDUCT	COPAY	COINS	PAID	PT RESP	INS ID
			1	$ 168.00	$ 95.00	$ 73.00	$ 0.00	$ 40.00	$ 0.00	$ 55.00	$ 0.00	

REASON CODE DESCRIPTION:

REMARK CODES:

PAGE SUMMARY:

TOTAL PAID TO PROVIDER: $ 0.00

M

4

DHMH CTR CANCER SURVEILLANCE
PO BOX 13528

BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoDb) 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): 111223333

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Huxtable, Claire

3. PATIENT'S BIRTH DATE MM DD YY: 02 12 1965 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 10 Stigwood Avenue

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

7. INSURED'S ADDRESS (No., Street): 10 Stigwood Avenue

CITY: FEDERALSBURG STATE: MD

8. RESERVED FOR NUCC USE

CITY: FEDERALSBURG STATE: MD

ZIP CODE: 21632 TELEPHONE (Include Area Code):

ZIP CODE: 21632 TELEPHONE (Include Area Code):

CANCER CONTRO

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

FEB 26 2018

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: DHMH CTR CANC-DHMH CTR FOR C

d. INSURANCE PLAN NAME OR PROGRAM NAME: MDIPA UHC

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO 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 02 13 2018

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 MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNKIM R HERMAN

17a.

17b NPI 1679757330

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): NONE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 000

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z08 B. Z853 C. L598 D. Z803
E. N651 F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24A. 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	10 17 17		22		99213		ABCD	109.00	1		NPI	1932438322
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 521874111 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 9536976553

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

28. TOTAL CHARGE: $ 109.00

29. AMOUNT PAID: $ 69.00

30. Rsvd for NUCC Use: 40.00

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.)

ROBERTA JOLINE LILLY

SIGNED 02 13 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION
SHORE REGIONAL BREAST CENT
219 S WASHINGTON STREET
EASTON MD 21601-2913
a. 1477530624 b. LU162301014

33. BILLING PROVIDER INFO & PH # (443) 462-5010
UM COMMUNITY MEDICAL GROUP
PO BOX 419244
BOSTON MA 02241-9244
a. 1477530624 b. LU162301014

EXPLANATION OF BENEFITS - UNITED HEALTH CARE

REMITTANCE DATE: 12/29/2017

BILLING PROVIDER: LILLY, ROBERTA JOLINE
PROVIDER NUMBER:

PATIENT NAME: Huxtable, Claire
DOB:
SUBSCRIBER NAME:
PATIENT ADDRESS:
FEDERALSBURG, MD 21632

GROUP/POLICY NUMBER: 712493
MEDICARE ICN:
CLAIM NUMBER: P9516976551

INSURANCE CARRIER INFORMATION

1010603 UNITED HEALTH CARE
PO BOX 740828
ATLANTA, GA 30374

6000800 DHMH CTR CANCER SURVEILLANCE
PO BOX 13528
BALTIMORE, MD 21203

PROC	DESCRIPTION
99213	PR OFFICE/OUTPT VISIT

SERVICE INFORMATION:

DATE OF SERVICE	CODE	MODIFIER(S)	UNITS	BILLED	ALLOWED	NOT ALLOWED	DEDUCT	COPAY	COINS	PAID	PT RESP	INS ID
10/17/17	99213		1	$ 109.00	$ 61.94	$ 47.06	$ 0.00	$ 40.00	$ 0.00	$ 21.94	$ 0.00	101000
Denial Codes: 3,45												
			1	$ 109.00	$ 61.94	$ 47.06	$ 0.00	$ 40.00	$ 0.00	$ 21.94	$ 0.00	

REASON CODE DESCRIPTION:

CO45 45-CHGS EXCD FEE SCH/MAX ALLOWABLE.
PR3 3-CO-PAYMENT AMOUNT

REMARK CODES:

PAGE SUMMARY:

TOTAL PAID TO PROVIDER: $ 21.94

EXPLANATION OF BENEFITS - UNITED HEALTH CARE

REMITTANCE DATE: 12/29/2017

BILLING PROVIDER: LILLY, ROBERTA JOLINE

PROVIDER NUMBER:

PATIENT NAME: Huxtable, Claire

DOB:

SUBSCRIBER NAME:

PATIENT ADDRESS:

FREDERICKSBURG, MD 21633

GROUP/POLICY NUMBER: 712403

MEDICARE ICN:

CLAIM NUMBER: P9536976551

INSURANCE CARRIER INFORMATION

1010601 UNITED HEALTH CARE
PO BOX 740815
ATLANTA, GA 30374

6000800 DEPT OF CANCER SURVEILLANCE
PO BOX 13620
BALTIMORE, MD 21203

PROC DESCRIPTION

SERVICE INFORMATION:

DATE OF SERVICE	CODE	MODIFIER(S)	UNITS	BILLED	ALLOWED	NOT ALLOWED	DEDUCT	COPAY	COINS	PAID	PT RESP	INS ID
			1	$ 109.00	$ 61.94	$ 47.06	$ 0.00	$ 40.00	$ 0.00	$ 21.94	$ 0.00	

REASON CODE DESCRIPTION:

REMARK CODES:

PAGE SUMMARY:

$ 0.00

BCCDT/DHMH BREAST PROGRAM
PO BOX 13528
CENTER FOR CA PREVENTION
BALTIMORE MD 21203

M5

HEALTH INSURANCE CLAIM FORM

PICA — NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
[X] (Medicare #) [ ] (Medicaid #) [ ] (VA File #) [ ] (ID#/DoD#) [ ] (ID#) [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Simpson, Marge

3. PATIENT'S BIRTH DATE: 04 27 1969 M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Simpson, Marge

5. PATIENT'S ADDRESS (No., Street): 742 Evergreen Terrace

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

7. INSURED'S ADDRESS (No., Street): 742 Evergreen Terrace

CITY: SALISBURY STATE: MD

8. RESERVED FOR NUCC USE

CITY: SALISBURY STATE: MD

FEB 13 2018

ZIP CODE: 21801 TELEPHONE (Include Area Code):

ZIP CODE: 21801 TELEPHONE (Include Area Code):

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. 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 [X] NO

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

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

d. INSURANCE PLAN NAME OR PROGRAM NAME: BCCDT/DHMH BREAST PROGRAM

10d. CLAIM CODES (Designated by NUCC)

9a. RESERVED FOR NUCC USE

9b. RESERVED FOR NUCC USE

9c. RESERVED FOR NUCC USE

9d. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED HEALTHCARE HMO

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE: READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 2/6/2018

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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ANDREA M ZOCKOLL CRNP

17a. [ ]

17b. NPI 1881054989

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. C50.412 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24A. DATES OF SERVICE From MM DD YY	To MM DD YY	24B. PLACE OF SERVICE	24C. EMG	24D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	24E. DIAGNOSIS POINTER	24F. $ CHARGES	24G. DAYS OR UNITS	24H. EPSDT Family Plan	24I. ID. QUAL.	24J. RENDERING PROVIDER ID. #
01 11 18	01 11 18	22		38525		A	988 00	1		ZZ	208600000X 1285628693
01 11 18	01 11 18	22		38900		A	350 00	1		ZZ	208600000X 1285628693

25. FEDERAL TAX I.D. NUMBER: 520900485 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 147177P52992

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 1338 00

29. AMOUNT PAID: $ 0 00

622.41

30. BALANCE DUE: $

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.)

JOHN P REILLY MD

2/6/2018

32. SERVICE FACILITY LOCATION INFORMATION:
PENINSULA REGIONAL MEDICAL C
100 EAST CARROLL STREET
SALISBURY MD 21801-5422

33. BILLING PROVIDER INFO & PH #: 410 548-2600
PENINSULA SURGICAL GROUP
P.O. BOX 3317
SALISBURY MD 21802-3317

a. 1780689463 b.

a. 1962484428 b. 978541800

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM HCFA-1500 (12-90)

Remit Report

Payer Name: UNITED HEALTHCARE INSURANCE COMPANY (PH#:8778423210)
Provider Name: PENINSULA SURGICAL GROUP
Provider City, State Zip: SALISBURY, MD 21802
Check Date: 2/6/2018

Provider NPI: 1962484428
Provider Address: PO BOX 3317
Check/EFT #: 1TR17009695 Payment Type: ACH
Check Amount: $2,066.97

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT/CO-PAY	COINS	GRP/RC-AMT	PROV PD
NAME: Simpson, Marge	HIC:			ACNT:		ICN: 6957598873 0315996095		ASG:		MOA: MA15	
CNTL #: 01	1/11-1/11/2018			38525		$988.00	$470.77	PR-1 $470.77	$0.00	CO - 45 $517.23	$0.00
PT RESP: $470.77		Forwarded To:			CLAIM TOTALS:	$988.00	$470.77	$470.77	$0.00	$517.23	$0.00

ADJ TO TOTALS: PREV PD: DISCOUNT: $0.00 INTEREST: $0.00 LATE FILING CHARGE: $0.00 NET: $0.00

OTHER CLAIM REL IDENTIFICATION:
(BB) A036737497
(CE) OCI
(1L) 8U7696

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT/CO-PAY	COINS	GRP/RC-AMT	PROV PD
NAME: Simpson, Marge	HIC:			ACNT:		ICN: 6957598873 0315996127		ASG:		MOA: MA15	
CNTL #: 02	1/11-1/11/2018			38900		$350.00	$151.63	PR-1 $151.63	$0.00	CO - 45 $198.37	$0.00
PT RESP: $151.63		Forwarded To:			CLAIM TOTALS:	$350.00	$151.63	$151.63	$0.00	$198.37	$0.00

ADJ TO TOTALS: PREV PD: DISCOUNT: $0.00 INTEREST: $0.00 LATE FILING CHARGE: $0.00 NET: $0.00

OTHER CLAIM REL IDENTIFICATION:
(1L) 8U7696
(BB) R154FF1ECB
(CE) OCI

TOTALS:	# OF CLAIMS	DISCOUNT	INTEREST	BILLED AMT	ALLOWED AMT	DEDUCT/CO-PAY AMT	COINS AMT	TOTAL RC-AMOUNT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	2	$0.00	$0.00	$1,338.00	$622.40	$622.40	$0.00	$715.60	$0.00	$0.00	$2,066.97

PROVIDER ADJ DETAILS:	PLB REASON CODE	FCN/OTHER IDENTIFIER	AMOUNT

Glossary:	GROUP REASON CODES, (GRP/RC) AND MOA
1	Deductible Amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
CO	Contractual Obligation
MA15	Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
PR	Patient Responsibility

Remittance Advice Provided By Greenway Clearinghouse.

Payer Name: UNITED HEALTHCARE INSURANCE COMPANY (PH#:8778423210)
Provider Name: PENINSULA SURGICAL GROUP
Provider City, State Zip: SALISBURY, MD 21802
Check Date: 2/6/2018

Provider NPI: 1962484428
Provider Address: PO BOX 3317
Check/EFT #: 1TR17009695 Payment Type: ACH
Check Amount: $2,066.97

Disclaimer, the information displayed on the remittance advice has been derived from the 835 remittance advice transaction received from our payers or payer networks. For balancing purposes, the patient responsibility for this claim will be calculated from the service line information reported for deductibles, co-insurance and co-payment.

Peninsula Regional Medical Center - Radiology

Report Status: Final Results

Patient Information:

Name: Simpson, Marge **PatientID:** **Sex:** Female **DOB:**
Address: 742 Evergreen Terrace **Phone #:** **SSN:**
SALISBURY, MD 21801

Date of Exam: 01/11/2018 11:03:47
Date Reported: 01/11/2018 **Information:** O
Ordering Provider: REILLY, JOHN P

Report Name	Facility

NM LYMPHATICS AND LYMPH NODE IMAG

1/11/2018 11:03 AM EST

NM LYMPHOSCINTIGRAPHY SCAN

INDICATION: sentinel node for breast cancer

TECHNIQUE: Images of the chest were obtained following subcutaneous injection of sulfur colloid.

FINDINGS: There is a hot spot in the left axilla.

IMPRESSION:
SUCCESSFUL NUCLEAR MEDICINE LYMPHOSCINTIGRAPHY SCAN.

ELECTRONICALLY SIGNED BY Andrew Vennos, MD
1/11/2018 4:46 PM EST

Peninsula Regional Medical Center - Transcription

Report Status: Final Results

Patient Information:

Name: Simpson, Marge **PatientID:** **Sex:** Female **DOB:**
Address: **Phone #:** **SSN:**
SALISBURY, MD 21801

Date Received:
Date Reported: 01/11/2018 **Physician:** REILLY, JOHN P **Information:** E

Report Name

OPERATIVE REPORT

Name of patient:

MRN: 950090215

DOB:

Weight: 60.5 kg

BMI: Body mass index is 26.43 kg/(m^2).

Date of surgery: 1/11/2018

Surgeon: John P. Reilly, MD

Assistant: Kaitlyn Ayerle, PA-S

Preoperative Diagnosis: Left breast cancer

Postoperative Diagnosis: Same

Anesthesia: GET

Procedure: Left axillary sentinel lymph node biopsy X2, blue dye injection for lymphatic mapping

Indications: Patient is a -year-old female recently diagnosed with left breast cancer

Findings: Sentinel lymph node #1: 2698 counts per 10 seconds, hot and blue; sentinel lymph node #2: 1339 counts per 10 seconds, hot and blue; background count: 48 counts per 10 seconds. Both nodes were slightly enlarged.

Procedure Details

The patient was identified by armband and the procedure was verified. Patient was in the supine position. A procedural pause was initiated to confirm the patient procedure.

The left periareolar area was prepped with alcohol and then 5 mL of diluted methylene blue dye was injected in the subareolar plexus. The nipple areolar complex was massaged for several minutes to aid in passage of the dyeThe patient was prepped and draped in the usual sterile fashion.

The lower left axillary skin was anesthetized and a transverse incision was made. Dissection was continued down with electrocautery to the axillary fascia. The neoprobe was used to identify a hot area. Further dissection revealed a blue node. A suture was placed in the nose for retraction and it was dissected circumferentially with blunt dissection and electrocautery. Clips were placed on some feeding lymphatics. Once the node was excised, ex vivo counts were obtained as above.

The axilla was scanned again and a second hot area was identified. A blue channel was identified which led us to a second lymph node. This node was somewhat larger. It was dissected circumferentially with electrocautery and blunt dissection clipping feeding lymphatics as above. The node was excised and counts were obtained. The background count was then obtained, as there were no other focal hot areas. The wound was irrigated and checked meticulously for hemostasis. The axillary fascia was closed with interrupted 3-0 Vicryl stitches. Skin was closed with a running subcuticular 4-0 Monocryl stitch. The skin was cleaned and LiquiBand was applied. The patient remained anesthetized for Dr. Arrington's portion of the procedure.

Estimated Blood Loss: No blood loss documented.

Specimens: Left axillary sentinel lymph node #1: Left axillary sentinel lymph node #2

Complications: None

Disposition: Remained intubated

Condition: stable

Electronically signed by REILLY, JOHN P, MD 1/11/2018 4:39 PM
Authenticated by: REILLY, JOHN P 2018-01-11 16:65:21:10

1

HEALTH INSURANCE CLAIM FORM

BCCDT/DHMH BREAST PROGRAM
PO BOX 13528
CENTER FOR CA PREVENTION
BALTIMORE MD 21203

M 5

MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
[X]

1a. INSURED'S I.D. NUMBER: 234567890

2. PATIENT'S NAME: Buffay, Phoebe

3. PATIENT'S BIRTH DATE: 04 27 1972 SEX: X

4. INSURED'S NAME: Buffay, Phoebe

5. PATIENT'S ADDRESS: 5 Morton St., Apt. 14

6. PATIENT RELATIONSHIP TO INSURED: Self X

7. INSURED'S ADDRESS: 5 Morton St., Apt. 14

CITY: SALISBURY STATE: MD

8. RESERVED FOR NUCC USE

ZIP CODE: 21801

TELEPHONE: -

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. EMPLOYMENT? [ ] YES [X] NO

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

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

10d. CLAIM CODES (Designated by NUCC)

a. INSURED'S DATE OF BIRTH: 04 27 1972 SEX: X

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: BCCDT/DHMH BREAST PROGRAM

9. OTHER INSURED'S POLICY OR GROUP NUMBER

9a. RESERVED FOR NUCC USE

9b. RESERVED FOR NUCC USE

9c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED HEALTHCARE HMO

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] 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.

SIGNED: SIGNATURE ON FILE DATE: 2/6/2018

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: MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ANDREA M ZOCKOLL CRNP

17a. [ ] 17b. NPI 1881054989

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)): A. C50.412 B. C. D. E. F. G. H. I. J. K. L.

ICD Ind. 0

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24A. DATES OF SERVICE From	To	24B. PLACE OF SERVICE	24C. EMG	24D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	24E. DIAGNOSIS POINTER	24F. $ CHARGES	24G. DAYS OR UNITS	24H. EPSDT Family Plan	24I. ID. QUAL.	24J. RENDERING PROVIDER ID.
01 11 18	01 11 18	22		38525		A	988 00	1		ZZ	208600000X 1285628693
01 11 18	01 11 18	22		38900		A	350 00	1		ZZ	208600000X 1285628693

25. FEDERAL TAX I.D. NUMBER: 520900485 SSN EIN: X

26. PATIENT'S ACCOUNT NO.: 147177P52992

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

28. TOTAL CHARGE: 1338 00

29. AMOUNT PAID: 0 00

622.40

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.)

JOHN P REILLY MD

DATE: 2/6/2018

32. SERVICE FACILITY LOCATION INFORMATION:
PENINSULA REGIONAL MEDICAL C
100 EAST CARROLL STREET
SALISBURY MD 21801-5422
1780689463

33. BILLING PROVIDER INFO & PH #:
PENINSULA SURGICAL GROUP 410 548-2600
P.O. BOX 3317
SALISBURY MD 21802-3317
1962484428 978541800

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (12-90)

Peninsula Regional Medical Center
Department of Pathology
100 East Carroll Street
Salisbury, MD 21801-9981
Tel: (410) 543-7389 Fax: (410) 543-7595

SURGICAL PATHOLOGY REPORT

Patient Name:	Buffaut, Phoebe	Accession #:	**S18-519**
Hospital #:		Surgery Date:	1/11/2018
Age/Sex	F DOB:	Location:	S5A
Account #:		Physician:	REILLY,JOHN P
		Copy To:	ARRINGTON,JASON

Final Pathologic Diagnosis

1. Left axillary sentinel lymph node # 1, biopsy:
   Sentinel lymph node with no metastatic carcinoma identified (0/1).

2. Left axillary sentinel lymph node # 2, biopsy:
   Sentinel lymph node with no metastatic carcinoma identified (0/1).

3. Right subareolar breast, incisional biopsy:
   Fragments of breast tissue with no carcinoma identified.

4. Left subareolar breast, incisional biopsy:
   Fragment of breast tissue with no carcinoma identified.

Comment

Based on all available information, the staging for this patient's left breast carcinoma is as follows: pT1bN0 (sn).

ka/1/15/2018

Electronic Signature
ERIC J. WEAVER, MD, PhD

Clinical History

Malignant neoplasm of upper-outer quadrant of female breast, unspecified estrogen receptor status (C50.412).

Gross Description

Received in four parts.

Part 1 labeled "sentinel lymph node # 1 left axillary". Received in formalin is a 1.8cm in greatest dimension tan-pink to blue-dyed lymph node with adherent adipose tissue. The specimen is serially sectioned at 2mm intervals and is entirely submitted in one cassette.

Part 2 labeled "sentinel lymph node # 2 left axilla". Received in formalin are two fragments of tan-yellow fibroadipose tissue aggregating to 3.3 x 2.3 x 1.2cm. The fragments are sectioned to demonstrate a 3.0cm in greatest dimension tan-pink to blue-dyed lymph node. The lymph node is serially sectioned at 2mm intervals and is entirely submitted in cassettes 2A-2C. (3 cassettes)

Part 3 labeled "right subareolar breast". Received in formalin are two fragments of tan-yellow fibroadipose tissue measuring 1.4 x 1.4 x 0.7cm and 1.5 x 1.4 x 0.3cm. The fragments are serially sectioned and are entirely submitted in cassettes 3A and 3B. (2 cassettes)

Time of tissue removal: 1611 on 1/11/18
Time placed in formalin: 11:58 on 1/12/18
Ischemic time: > 1 hour
Formalin fixation time: 6 hours

Buffay, Phoebe **Surgical Pathology Report** S18-519

Part 4 labeled "left subareolar breast". Received in formalin is a 2.0 x 1.6 x 0.7cm fragment of tan-yellow to blue-dyed fibroadipose tissue. The fragment is serially sectioned and entirely submitted in cassettes 4A and 4B. (2 cassettes)

Time of tissue removal: 1626 on 1/11/18
Time placed in formalin: 1200 on 1/12/18
Ischemic time: > 1 hour
Formalin fixation time: 6 hours

ka/1/12/2018 AR

EOB ATTACHED

DHMH BCCP
PO BOX 13528
BALTIMORE MD21203

M

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [X] FECA BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER: 000012345

2. PATIENT'S NAME: Bellum, Sara J

3. PATIENT'S BIRTH DATE: 02 08 1975 SEX: M [ ] F [X]

4. INSURED'S NAME: Bellum, Sara

5. PATIENT'S ADDRESS: Greensleeves Valley Ln.
CITY: EASTON STATE: MD
ZIP CODE: 21601 TELEPHONE:

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

7. INSURED'S ADDRESS: Greensleeves Valley Ln.
CITY: EASTON STATE: MD
ZIP CODE: 21601 TELEPHONE:

FEB 13 2018

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME:

9a. OTHER INSURED'S POLICY OR GROUP NUMBER:

9b. RESERVED FOR NUCC USE:

9c. RESERVED FOR NUCC USE:

9d. INSURANCE PLAN NAME OR PROGRAM NAME: DHMH BCCP

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]
c. OTHER ACCIDENT? YES [ ] NO [X]

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

11a. INSURED'S DATE OF BIRTH: MM DD YY SEX: M [ ] F [ ]

11b. OTHER CLAIM ID (Designated by NUCC):

11c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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.
SIGNED: SIGNATURE ON FILE DATE:

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: MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN LILLY, ROBERTA
17a. [ ]
17b. NPI 1932438322

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 12 18 17 TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0
A. D0511 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	24B. PLACE OF SERVICE	24C. EMG	24D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	24E. DIAGNOSIS POINTER	24F. $ CHARGES	24G. DAYS OR UNITS	24H. EPSDT Family Plan	24I. ID. QUAL.	24J. RENDERING PROVIDER ID. #
12 18 17	12 18 17	22		88307	26	A	1552.00	008		NPI	1235231796
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX ID NUMBER: 52-1047776 SSN EIN: EIN [X]

26. PATIENT'S ACCOUNT NO.: 1580002535606

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

28. TOTAL CHARGE: $ 1552.00

29. AMOUNT PAID: $ 143.49

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.)
DAVID DANNER M.D.
SIGNED: 2018 07 18

32. SERVICE FACILITY LOCATION INFORMATION:
MEMORIAL HOSPITAL
219 S WASHINGTON ST
EASTON MD 21601-2913
a. b.

33. BILLING PROVIDER INFO & PH #: (410-931-0486
CHESAPEAKE PATHOLOGY ASSOC.
P.O. BOX 43130
BALTIMORE MD 21236-0130
a. 1720163850 b.

NUCC Instructions Available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM HCFA-1500 (12-90)

MED

TM-SUPP

3

WCMS-1500CS-12

NOVITAS SOLUTIONS, INC.
PO BOX 3401
MECHANICSBURG, PA 170551846

MEDICARE
REMITTANCE
NOTICE

CHESAPEAKE PATHOLOGY ASSOCIA
P.O. BOX 43130
BALTIMORE MD 21236

PROVIDER #: 1720163850
DATE: 01/17/2018
CHECK/EFT#: 884507553

PAGE#: 1

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
NAME Bellurk, Sara		HIC			ACNT 1580002535606		ICN 1018003335470		ASG Y	MOA	MA01
1235231/90 1218	121817 22	8	88307 26		1552.00	717.44	.00	143.49	CO-45	834.56	562.47
			(88307)						CO-253	11.48	
PT RESP 143.49		MB	CLAIM TOTALS		1552.00	717.44	.00	143.49		846.04	562.47
ADJ TO TOTALS: PREV PD			INTEREST		.00	LATE FILING CHARGE			.00	NET	562.47

GLOSSARY : GROUP, REASON, MOA, REMARK AND REASON CODES

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)

253 Sequestration - reduction in federal payment

MA01 Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

CO Contractual Obligations

PR Patient Responsibility

DHMH BCCP
PO BOX 13528

BALTIMORE MD21203

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [X] FECA BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER: 000054321

2. PATIENT'S NAME: Frozen, Elsa

3. PATIENT'S BIRTH DATE: 02 08 1989 SEX: M [ ] F [X]

4. INSURED'S NAME: Frozen, Elsa

5. PATIENT'S ADDRESS: 6 Arendelle Way

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

7. INSURED'S ADDRESS: 6 Arendelle Way

CITY: EASTON STATE: MD

8. RESERVED FOR NUCC USE

CITY: EASTON STATE: MD

FEB 13 2018

ZIP CODE: 21601 TELEPHONE:

ZIP CODE: 21601 TELEPHONE:

9. OTHER INSURED'S NAME:

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

9a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

9b. RESERVED FOR NUCC USE

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

9c. RESERVED FOR NUCC USE

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

10d. CLAIM CODES (Designated by NUCC)

11a. INSURED'S DATE OF BIRTH: SEX:

11b. OTHER CLAIM ID (Designated by NUCC):

11c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

9d. INSURANCE PLAN NAME OR PROGRAM NAME: DHMH BCCP

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO 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:

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN LILLY, ROBERTA

17a. [ ]

17b. NPI 1932438322

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 10 24 17 TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. D0590 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24A. 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 24 17	10 24 17	22		88360	26	A	318.00	002		NPI	1083720528
10 24 17	10 24 17	22		88305	26	A	248.00	002		NPI	1083720528
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 52-1047776 SSN EIN: [X]

26. PATIENT'S ACCOUNT NO.: 1580002520282

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

28. TOTAL CHARGE: $ 566.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

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.)

REINHARDT SAHMEL M.D.

SIGNED: 2007 18

32. SERVICE FACILITY LOCATION INFORMATION

MEMORIAL HOSPITAL
219 S WASHINGTON ST
EASTON MD 21601-2913

a. 1720163850 b.

33. BILLING PROVIDER INFO & PH #: (410-931-0486

CHESAPEAKE PATHOLOGY ASSOC.
P.O. BOX 43130
BALTIMORE MD 21236-0130

NUCC Instructions Available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

MEDTM-SUPP

2

NOVITAS SOLUTIONS, INC.
PO BOX 3401
MECHANICSBURG, PA 170551846

MEDICARE
REMITTANCE
NOTICE

CHESAPEAKE PATHOLOGY ASSOCIA
P.O. BOX 43130
BALTIMORE MD 21236

PROVIDER #: 1720163850
DATE: 11/21/2017
CHECK/EFT#: 884437228

PAGE#: 1

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
NAME Frozen, Elsa			HIC		ACNT 1580002520282			ICN 1017311367550		ASG Y	MOA MA01	
1083720528	1024 102417	22	2	88360	26	318.00	117.04	.00	23.41	CO-45	200.96	91.76
				(88360)						CO-253	1.87	
1083720528	1024 102417	22	2	88305	26	248.00	81.22	.00	16.24	CO-45	166.78	63.68
				(88305)						CO-253	1.30	
PT RESP	39.65	MB		CLAIM TOTALS		566.00	198.26	.00	39.65		370.91	155.44
ADJ TO TOTALS: PREV PD				INTEREST		.00	LATE FILING CHARGE			.00	NET	155.44

GLOSSARY : GROUP, REASON, MOA, REMARK AND REASON CODES

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)

253 Sequestration - reduction in federal payment

MA01 Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

CO Contractual Obligations

PR Patient Responsibility

HEALTH INSURANCE CLAIM FORM

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

PICA

STATE OF MD DHMH
ATTN: CTR FOR CANCER PREVENTION AND CONTI
PO BOX 13528
BALTIMORE, MD 21203

M

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: 0000 13131

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Munster, Lily

3. PATIENT'S BIRTH DATE: 10 27 1950 SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 1313 Mockingbird Lane

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

7. INSURED'S ADDRESS (No., Street): SAME

FEB 13 2018

CITY: EASTON STATE: MD

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 21601 TELEPHONE (Include Area Code):

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

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 [X] NO

a. INSURED'S DATE OF BIRTH: 10 27 1950 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE OF MD DHMH

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO 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: 01 03 2018

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: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN KEVIN STITELY

17a. 17b. NPI 1669453742

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. C50 412 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 01 03 18	01 03 18	11		96523		A	49 00	1		NPI	1386641082
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 521934955 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: BHO009367

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

28. TOTAL CHARGE: $ 49 00

29. AMOUNT PAID: $

30. BALANCE DUE: 29.38

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.)

David H Smith M.D

DAVID H SMITH MD

SIGNED 01 29 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION:
BAY HEMATOLOGY ONCOLOGY
8221 TEAL DRIVE SUITE 406
EASTON MD 21601-7215
a. 1043321532 b.

33. BILLING PROVIDER INFO & PH #: 410 8205945
BAY HEMATOLOGY ONCOLOGY
8221 TEAL DRIVE SUITE 301
EASTON MD 21601-7215
a. 1043321532 b.

NOVITAS SOLUTIONS, INC.
PO BOX 3401
MECHANICSBURG, PA 170551846

BAY HEMATOLOGY ONCOLOGY PA
STE 301
EASTON, MD 216017215

REMITTANCE ADVICE

Check Number: 336376920
Check Date: 01/23/2018
NPI: 1043321532
Federal Tax ID: 521934955

Claim Status: Processed as Primary

Patient: Munster, Lily HICN: Acct: BHO009367 ICN: 1018010007400 ASG: Y MOA: MA01

Provider(s): SMITH MD, DAVID H

Rend. Provider	Service Date(s)	POS	NOS	Procedure Code	Procedure Mods	Billed	Allowed	Pt-Responsibility Deduct	Pt-Responsibility Co-Ins	Adjustments Grp.RC	Adjustments Amount	Remarks	Paid
1386641082	1/3/2018	11	1	96523		49.00	29.38	29.38	0.00	CO-45	19.62		0.00
Patient Responsibility: $29.38					Claim Totals:	$49.00	$29.38	$29.38	$0.00		$19.62		$0.00

Previous Paid: $0.00 Interest: $0.00 Late Filing Charge: $0.00

Not Paid = $0.00

Group Codes

CO Contractual Obligations

Adjustment Codes

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

Remark Codes

MA01 Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

Powered by

STATE OF MD DHMH
ATTN: CTR FOR CANCER PREVENTION AND CONTR
PO BOX 13528
BALTIMORE, MD 21203

M 9

HEALTH INSURANCE CLAIM FORM

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

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: 9876543321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Potts, Pepper

3. PATIENT'S BIRTH DATE MM DD YY: 03 16 1978 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 200 Park Avenue

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

7. INSURED'S ADDRESS (No., Street): SAME

FEB 13 2018

CITY: OLNEY STATE: MD

8. RESERVED FOR NUCC USE

CITY:

ZIP CODE: 20832 TELEPHONE (Include Area Code):

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

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 [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 03 16 1978 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE OF MD DHMH

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO 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: 10 11 2017

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 MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a 17b NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. C50 911 B. M81 0 C. D50 9 D. C50 219
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 10 11 17	10 11 17	11		99213	25	ABC	150 00	1		NPI	1386641082
2 10 11 17	10 11 17	11		99213	CM	A	50 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 521934955 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: BAY046417

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See Back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 200 00

29. AMOUNT PAID: $

30. BALANCE DUE: $65.14

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.

DAVID H. SMITH MD

01 29 2018

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:
BAY HEMATOLOGY ONCOLOGY
8221 TEAL DRIVE SUITE 301
EASTON MD 21601-7215
a. 1043321532 b.

33. BILLING PROVIDER INFO & PH #: 410 8205945
BAY HEMATOLOGY ONCOLOGY
8221 TEAL DRIVE SUITE 301
EASTON MD 21601-7215
a. 1043321532 b.

NUCC Instruction Manual available at: www.nucc.org

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

NOVITAS SOLUTIONS, INC.
PO BOX 3401
MECHANICSBURG, PA 170551846

BAY HEMATOLOGY ONCOLOGY PA
STE 301
EASTON, MD 216017215

REMITTANCE ADVICE

Check Number: 884516159
Check Date: 01/24/2018
NPI: 1043321532
Federal Tax ID: 521934955

Claim Status: Processed as Primary

Patient: Potts, Pepper HICN: Acct: BAY046417 ICN: 1018010007500 ASG: Y MOA: MA01

Provider(s): SMITH MD, DAVID H

Rend. Provider	Service Date(s)	POS	NOS	Procedure		Billed	Allowed	Pt-Responsibility		Adjustments		Remarks	Paid
				Code	Mods			Deduct	Co-Ins	Grp.RC	Amount		
1386641082	10/11/2017	11	1	99213	25	150.00	75.70	0.00	15.14	CO-45	74.30		59.35
										CO-253	1.21		
Patient Responsibility: $15.14					Claim Totals:	$150.00	$75.70	$0.00	$15.14		$75.51		$59.35

Previous Paid: $0.00 Interest: $0.00 Late Filing Charge: $0.00 **Net Paid = $59.35**

Group Codes

CO	Contractual Obligations

Adjustment Codes

253	Sequestration - reduction in federal payment
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

Remark Codes

MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

Powered by

MDH DATA ENTRY
WORK REQUEST

BREAST AND CERVICAL CANCER

Document Title/Name: FORM CMS1500

Data Entry Standard Job: CANHIC09

Data Entry Batch Name: N374

Date Delivered to Data Entry: 02/ 15 /2018

Number of Documents: 10

Fiscal Year: 2018

FEB 15 2018

Date Batched: 02/ 15 /2018

Prepared by: BD

OUTPUT TO FILE:

ENTER	VERIFY
1. _____ ___/__/____	1. _____ ___/___/___
2. _____ ___/___/___	2. _____ ___/___/___

DATE RECEIVED BY DATA ENTRY

HEALTH INSURANCE CLAIM FORM

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

PICA

DHMH FAMILY HEALTH ADMINISTRATION
CENTER FOR CANCER SURVEILLANCE CONTROL
P O BOX 13528
BALTIMORE MD 21203

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: 987654323

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Pebbles

3. PATIENT'S BIRTH DATE MM DD YY: 01 04 1979 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Flintstone, Pebbles

5. PATIENT'S ADDRESS (No., Street): 301 Cobblestone Way

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

7. INSURED'S ADDRESS (No., Street): 301 Cobblestone Way

CITY: GLEN BURNIE STATE: MD

8. RESERVED FOR NUCC USE

CITY: GLEN BURNIE STATE: MD

ZIP CODE: 21061 TELEPHONE (Include Area Code): ( )

ZIP CODE: 21061 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 SEX M [ ] F [ ]

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

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: SOF DATE: 07/25/2016

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: SOF

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

A. C50919 B. R911 C. Z79811 D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 21D2037439

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. #
02 06 2018	02 06 2018	11	N	99214		ABC	189 00	1		NPI	1043267354
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 521874111 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 77959F11910842A4B

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

28. TOTAL CHARGE: $ 189 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.)

HARVINDER SINGH MD

SIGNED: DATE: 02/12/2018

32. SERVICE FACILITY LOCATION INFORMATION

UMCMG
305 Hospital Drive
Glen Burnie MD 21061

a. b.

33. BILLING PROVIDER INFO & PH # ( )

UNIVERSITY OF MD COMMUNITY MED
P.O. Box 419244
Boston, MA 02241-9244

a. 1477530624 b.

NUCC Instruction Manual available at: www.nucc.org

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

DEPT OF HLTH/CANCER CONTRL CEN
PO BOX 13528
BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

XXX CA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 987654324

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): McConnell, Mindy

3. PATIENT'S BIRTH DATE: 08 10 1978 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): McConnell, Mindy

5. PATIENT'S ADDRESS (No., Street): 11619 Pine Street

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

7. INSURED'S ADDRESS (No., Street): 11619 Pine Street

CITY: LAUREL STATE: MD

8. RESERVED FOR NUCC USE

CITY: LAUREL STATE: MD

ZIP CODE: 20708 TELEPHONE (Include Area Code):

ZIP CODE: 20708 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: 08 10 1978 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: DEPT OF HLTH/CANCER CONTRL CE

d. INSURANCE PLAN NAME OR PROGRAM NAME: No secondary coverage

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: 01172018

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): 01 17 2018 QUAL. 431

15. OTHER DATE: QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN AZEEZ ABIODUN

17a. 1G OTH000

17b. NPI 1831133909

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 01 17 2018 TO 01 19 2018

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

A. J690 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 01 17 18	01 17 18	21		74176	26	A	231 00	1		NPI	214490500 1619268448
2 01 17 18	01 17 18	21		71045	26	A	26 00	1		NPI	214490500 1619268448
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200349812 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 5681692-3028

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

28. TOTAL CHARGE: $ 257 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $

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.)

SANA ALI MD

SIGNED: DATE: 02 07 2018

32. SERVICE FACILITY LOCATION INFORMATION:

DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK RD
LANHAM MD 20706-3574

a. 1730136532 b. 210051

33. BILLING PROVIDER INFO & PH #: (443) 2742900

DIAGNOSTIC IMAGING ASSOCIATES
PO BOX 79915
BALTIMORE MD 21279-0915

a. 1477591873 b. 541439467

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

P 26 CC-PATTIM (3028- 1)

DEPT OF HLTH/CANCER CONTRL CEN
PO BOX 13528
BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

XXX

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 987605 4324

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): McConnell, Mindy

3. PATIENT'S BIRTH DATE: 08 10 1978 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): McConnell, Mindy

5. PATIENT'S ADDRESS (No., Street): 11019 Pine Street

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

7. INSURED'S ADDRESS (No., Street): 11019 Pine Street

CITY: LAUREL STATE: MD

8. RESERVED FOR NUCC USE

CITY: LAUREL STATE: MD

ZIP CODE: 20708 TELEPHONE (Include Area Code):

ZIP CODE: 20708 TELEPHONE (Include Area Code):

FEB 15 2018 CONTROL

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

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 08 10 1978 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: DEPT OF HLTH/CANCER CONTRL CEN

d. INSURANCE PLAN NAME OR PROGRAM NAME: No secondary coverage

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: 01172018

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): 01 17 2018 QUAL. 431

15. OTHER DATE: QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN AZEEZ ABIODUN

17a. 1G OTH000

17b. NPI 1831133909

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 01 17 2018 TO 01 19 2018

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

A. J690 B. R55 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 01 18 18	01 18 18	21		78580	26	A	107 00	1		NPI	403810000 1164440970
2 01 19 18	01 19 18	21		70552	26	B	235 00	1		NPI	403810000 1164440970
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200349812 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 5681692-3028

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

28. TOTAL CHARGE: $ 342 00

29. AMOUNT PAID: $ 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.)

MYLES KOBY MD

SIGNED 02 07 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION:

DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK RD
LANHAM MD 20706-3574

a. 1730136532 b. 210051

33. BILLING PROVIDER INFO & PH #: (443) 2742900

DIAGNOSTIC IMAGING ASSOCIATES
PO BOX 79915
BALTIMORE MD 21279-0915

a. 1477591873 b. 541439467

P 25 CC-PATTTM (3028- 1)

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE

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

DEPT OF HLTH/CANCER CONTRL CEN
PO BOX 13528
BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

XXX ICA

4

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 987654325

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bunker, Edith

3. PATIENT'S BIRTH DATE: 08 10 1932 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bunker, Edith

5. PATIENT'S ADDRESS (No., Street): 704 Hauser Street

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

7. INSURED'S ADDRESS (No., Street): 704 Hauser Street

CITY: LAUREL STATE: MD

8. RESERVED FOR NUCC USE

CITY: LAUREL STATE: MD

ZIP CODE: 20708 TELEPHONE (Include Area Code):

ZIP CODE: 20708 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: 08 10 1932 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

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: DEPT OF HLTH/CANCER CONTRL CEI

d. INSURANCE PLAN NAME OR PROGRAM NAME: No secondary coverage

10d. CLAIM CODES (Designated by NUCC)

9. 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: 09252017

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): 09 25 2017 QUAL. 431

15. OTHER DATE: MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN JOSE MENDOZA

17a. 1G OTH000

17b. NPI 1982648036

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

A. C50412 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.
1	09 25 17	09 25 17	22		36561		A	998 00	1		NPI	406933100 1447268404
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 200349812 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 5521490-3028

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

28. TOTAL CHARGE: $ 998 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE

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.)

ALOZIE UNEZE MD

SIGNED 02 07 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION:
DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK RD
LANHAM MD 20706-3574
a. 1730136532 b. 210051

33. BILLING PROVIDER INFO & PH #: (443) 2742900
DIAGNOSTIC IMAGING ASSOCIATES
PO BOX 79915
BALTIMORE MD 21279-0915
a. 1477591873 b. 541439467

NUCC Instruction Manual available at: www.nucc.org

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

P 24 CC PATTIM (3028- 1)

HEALTH INSURANCE CLAIM FORM

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

PICA

DHMH CANCER PREVENTION AND CONTROL
P O BOX 13528
BALTIMORE MD 21203

5

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: 9876543210

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Kramden, Alice

3. PATIENT'S BIRTH DATE MM 09 DD 20 YY 1938 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Kramden, Alice 701

5. PATIENT'S ADDRESS (No., Street): 328 Chauncey St.

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

7. INSURED'S ADDRESS (No., Street): 328 Chauncey St.

CANCER CONTROL FEB 16 2018

CITY: OCEAN CITY STATE: MD

8. RESERVED FOR NUCC USE

CITY: OCEAN CITY STATE: MD

ZIP CODE: 21842 TELEPHONE (Include Area Code):

ZIP CODE: 21842 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: 00

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM 09 DD 20 YY 1938 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: CENTER FOR CANCER PREVENTION AND CONTROL

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO 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: 02 08 18

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 MM DD YY QUAL.

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. 17b. NPI

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 [X] NO $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z85 3 B. Z90 13 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.
1 01 26 18	01 26 18	22		19342	LT	A B	2406 00	1		NPI	1902843105
2 01 26 18	01 26 18	22		19342	59 51 RT	A B	2406 00	1		NPI	1902843105
3 01 26 18	01 26 18	22		19330	59 51 LT	A B	1373 00	1		NPI	1902843105
4 01 26 18	01 26 18	22		19330	59 51 RT	A B	1373 00	1		NPI	1902843105
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 52 2041862 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 382156

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

28. TOTAL CHARGE $ 7558 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE 7558 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.)

CHRISTOPHER J PELLEGRINO 02 08 18

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

PENINSULA REGIONAL MEDICAL CENTER
100 EAST CARROLL STREET
SALISBURY MD 21801 5422

a. 1780689463 b.

33. BILLING PROVIDER INFO & PH # (410 546 0464)

PENINSULA PLASTIC SURGERY P C
314 WEST CARROLL STREET SUITE 1
SALISBURY MD 21801 5409

a. 1598710485 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Peninsula Regional Medical Center

OPERATIVE NOTE

ACCOUNT NUMBER: 7214518192

NAME: Kramden, Alice
DATE OF BIRTH:
MED REC NUMBER: 950185610
ADMISSION DATE: 01/26/2018
SURGEON: Christopher J. Pellegrino, MD, Plastic Surgery
ASSISTANT: Julie Parrish, PA-C
SURGERY DATE: 01/26/2018
DATE OF DICTATION: 01/26/2018

PREOPERATIVE DIAGNOSIS: Bilateral breast cancer status post bilateral tissue expander placement.

POSTOPERATIVE DIAGNOSIS: Bilateral breast cancer status post bilateral tissue expander placement.

OPERATION: Stage II bilateral breast reconstruction with removal of tissue expanders and placement of permanent gel prostheses.

ANESTHESIA: General LMA.

INDICATIONS: This patient is a · year-old female who underwent bilateral mastectomies and tissue expander placement. The patient underwent successful course of tissue expansion. Postoperatively, the patient underwent courses of both chemotherapy and radiation therapy to the right breast. She has progressed well. There is some more firmness on the right side secondary to radiation changes.

DESCRIPTION OF PROCEDURE: The patient was marked in the holding area, then taken to the operative suite, placed in the supine position and placed under general anesthesia. The entire chest was prepped with ChloraPrep solution and draped in the usual sterile fashion. The right side was approached first. An incision was made over the right mastectomy scar and dissection was carried down through the muscle to the capsule. The capsule was entered and the right-sided tissue expander was removed from the pocket. The pocket was modified by scoring the capsule inferiorly and laterally and medially. Bleeding was controlled with electrocautery. The pocket was flushed with triple antibiotic solution, and a new silicone gel prosthesis was placed. The prosthesis is a Natrelle Inspira 295 mL implant. A #15 Jackson Pratt drain was placed in the pocket and brought through a separate stab incision laterally and secured with a silk suture. The incision was temporarily closed with staples. The left side was approached in identical fashion and a similar 295 mL silicone implant was placed on the left side. The patient was placed in a sitting upright position to assess symmetry and then placed back in the supine position. The incisions were closed in layers with 3-0 Vicryl to approximate the muscle and capsule layers; 3-0 Monocryl running intracuticular sutures were placed to close the skin. Xeroform and gauze pads were placed. The patient was put in a surgical bra for postoperative dressing. The patient tolerated the procedures well with no complication.

NAME: Kramden, Alice PRMC ORMAIN ORN OR
MED REC #: 950185610
ACCOUNT #: 7214518192

ESTIMATED BLOOD LOSS: 50 mL.

The patient was taken to the recovery room.

DRAFT UNTIL AUTHENTICATED BY: Christopher J. Pellegrino, MD

D: 01/26/2018 11:22 AM T: 01/26/2018 12:00 PM/lr

CC: Christopher J. Pellegrino, MD, Admitting Physician
Admitting Physician Copy

DEPT OF HLTH/CANCER CONTRL CEN
PO BOX 13528
BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

XXX ICA

1. MEDICARE (Medicare) | MEDICAID [X] (Medicaid) | TRICARE (ID#/DoDB) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER: 9871654327

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Petrie, Laura

3. PATIENT'S BIRTH DATE: 08 10 1958 | SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Petrie, Laura

5. PATIENT'S ADDRESS (No., Street): 148 Bonnie Meadow Rd.

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

7. INSURED'S ADDRESS (No., Street): 148 Bonnie Meadow Rd.

LANHAM CONTROL FEB 15 2018

CITY: LAUREL | STATE: MD

8. RESERVED FOR NUCC USE

CITY: LAUREL | STATE: MD

ZIP CODE: 20708 | TELEPHONE (Include Area Code):

ZIP CODE: 20708 | 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: 08 10 1958 | 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: DEPT OF HLTH/CANCER CONTRL CE

d. INSURANCE PLAN NAME OR PROGRAM NAME: No secondary coverage

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: 02052018

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): 02 05 2018 QUAL. 431

15. OTHER DATE: QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN JOSE MENDOZA

17a. 1G OTH000

17b. NPI 1982648036

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 49609-0101-01 45.00 F2

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

A. C50412

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 02 05 18	02 05 18	11		78815		A	3510 00	1		NPI	699322201 1568480358
2 02 05 18	02 05 18	11		A9552		A	165 00	1		NPI	699322201 1568480358
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 272128707 | SSN | EIN [X]

26. PATIENT'S ACCOUNT NO.: 5698505-3028

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 3675 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $

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.)

GERMAN TAMPE MD

SIGNED 02 07 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION:

LANHAM OUTPATIENT IMAGING
8116 GOODLUCK RD
LANHAM MD 20706-3502

a. 1750618393 b. 210051

33. BILLING PROVIDER INFO & PH #: (443) 2742900

(DIAGNOSTIC IMAGING, LLC
PO BOX 17439
BALTIMORE MD 21297-0508

a. 1033434808 b. 541439467

NUCC Instruction Manual on reverse, www.nucc.org (3028- 1) PLEASE PRINT OR TYPE

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

P.44 CI GEORGE

DEPT OF HLTH/CANCER CONTRL CEN
PO BOX 13528
BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

XXX ICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 987654327

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Fauzia, Qeannie

3. PATIENT'S BIRTH DATE: 08 10 1950 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Fauzia, Qeannie

5. PATIENT'S ADDRESS (No., Street): 1020 Palm Drive

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

7. INSURED'S ADDRESS (No., Street): 1020 Palm Drive

CITY: LAUREL STATE: MD

8. RESERVED FOR NUCC USE

CITY: LAUREL STATE: MD

ZIP CODE: 20708 TELEPHONE (Include Area Code):

ZIP CODE: 20708 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: 08 10 1950 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE

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

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: DEPT OF HLTH/CANCER CONTRL CEN

d. INSURANCE PLAN NAME OR PROGRAM NAME: No secondary coverage

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: 01172018

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): 01 17 2018 QUAL. 431

15. OTHER DATE: MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN TRACEY ROYER

17a. 1G OTH000

17b. NPI 1225401227

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

A. C50412 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 01 17 18	01 17 18	11		77059		A	2326 00	1		NPI	404552100 1073543609
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 272128707 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 5669910-3028

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

28. TOTAL CHARGE: $ 2326 00

29. AMOUNT PAID: $ 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.)

JOSHUA PLEASURE MD

SIGNED 02 07 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION:
LANHAM OUTPATIENT IMAGING
8116 GOODLUCK RD
LANHAM MD 20706-3502
a. 1750618393 b. 210051

33. BILLING PROVIDER INFO & PH #: (443) 2742900
DIAGNOSTIC IMAGING, LLC
PO BOX 17439
BALTIMORE MD 21297-0508
a. 1033434808 b. 541439467

P-43 CC-PATTIM (3028- 1)

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

DEPT OF HLTH/CANCER CONTRL CEN
PO BOX 13528
BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

XXX CA

8

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (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): 9876654239

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Ocavo, Lynette

3. PATIENT'S BIRTH DATE: 08 10 1980 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Ocavo, Lynette

5. PATIENT'S ADDRESS (No., Street): 4355 Wisteria Lane

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

7. INSURED'S ADDRESS (No., Street): 4355 Wisteria Lane

CITY: LAUREL STATE: MD

6. RESERVED FOR NUCC USE

CITY: LAUREL STATE: MD

ZIP CODE: 20708 TELEPHONE (Include Area Code):

ZIP CODE: 20708 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: 08 10 1980 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: DEPT OF HLTH/CANCER CONTRL CEN

d. INSURANCE PLAN NAME OR PROGRAM NAME: No secondary coverage

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: 01172018

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): 01 17 2018 QUAL. 431

15. OTHER DATE: QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN TRACEY ROYER

17a. 1G OTH000

17b. NPI 1225401227

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): 00019-1333-11 100.00 ML

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

A. C50412 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

	24A. 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	01 17 18	01 17 18	11		74177		A	1008 00	1		NPI	446504100 1790773612
2	01 17 18	01 17 18	11		71260		A	800 00	1		NPI	446504100 1790773612
3	01 17 18	01 17 18	11		Q9967		A	200 00	100		NPI	446504100 1790773612
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 272128707 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 5669910-3028

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

28. TOTAL CHARGE: $ 2008 00

29. AMOUNT PAID: $ 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.)

ERIC YUN MD

SIGNED 02 07 2018 DATE

32. SERVICE FACILITY LOCATION INFORMATION:
LANHAM OUTPATIENT IMAGING
8116 GOODLUCK RD
LANHAM MD 20706-3502
a. 1750618393 b. 210051

33. BILLING PROVIDER INFO & PH #: (443) 2742900
(DIAGNOSTIC IMAGING, LLC
PO BOX 17439
BALTIMORE MD 21297-0508
a. 1033434808 b. 541439467

P.42 CC-PATTIM (3028- 1)

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (08-05)

UNIGEN CONTROL
FEB 15 2018

DHMH CTR CANCER SURVEILLANCE
PO BOX 13528

BALTIMORE, MD 21203

HEALTH INSURANCE CLAIM FORM

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

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: 987654328

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bradshaw, Carrie

3. PATIENT'S BIRTH DATE MM DD YY: 11 23 1977 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 845 East 73rd Street

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

7. INSURED'S ADDRESS (No., Street): 845 East 73rd Street

CITY: COCKEYSVILLE STATE: MD

8. RESERVED FOR NUCC USE

CITY: COCKEYSVILLE STATE: MD

ZIP CODE: 21030 TELEPHONE (Include Area Code):

ZIP CODE: 21030 TELEPHONE (Include Area Code):

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER: NONE

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: DHMH CTR CANC-DHMH CTR FOR C

d. INSURANCE PLAN NAME OR PROGRAM NAME: EMERGENCY MEDICAL ASSISTANCE

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO 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: 02 10 2018

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.: 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DNRIMA J COUZI

17a. 17b. NPI 1356401608

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): JCLK.

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES: 000

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. C50411 B. Z170 C. C773 D. G629
E. E119 F. Z86718 G. Z7901 H. Z9221
I. Z7984 J. Z79811 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 02 18		22		99214		ABCD	168.00	1		NPI	1881094647
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 371704041 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 9538802090

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

28. TOTAL CHARGE: $ 168.00

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.)

ERIN ELIZABETH CRONIN

SIGNED: DATE: 02 10 2018

32. SERVICE FACILITY LOCATION INFORMATION
SJMC-OP
7601 OSLER DR
TOWSON MD 21204-7700
a. 1124374079 b. LU339304600

33. BILLING PROVIDER INFO & PH # (410) 337-3953
UM ST. JOSEPH MEDICAL GROUP
PO BOX 417651
BOSTON MA 02241-7651
a. 1770836785 b. LU339304600

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

DHMH DIVISION OF CANCER CONTROL
PO BOX 13528
BALTIMORE, MD 21203

10

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ] — [X]
1a. INSURED'S I.D. NUMBER: 9871654322
2. PATIENT'S NAME: Hansen, Sydney
3. PATIENT'S BIRTH DATE: 02 03 1980 SEX: F [X]
4. INSURED'S NAME: SAME
5. PATIENT'S ADDRESS: 10 Providence Place
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS: SAME
CITY: HAVRE DE GRACE STATE: MD
8. RESERVED FOR NUCC USE
ZIP CODE: 21078 TELEPHONE: ( )
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
9a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
6. INSURED'S DATE OF BIRTH: 02 03 1980 SEX: F [X]
9b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
9c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: DHMH DIVISION OF CANCER CONTR
9d. 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: 01 10 2018

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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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
A. C50 912 B. Z85 3 C. D72 829 D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24A. DATES 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.
01 10 18	01 10 18	11		99214		ABC	221 00	1		NPI	1518156959
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 275156680 SSN EIN [X]
26. PATIENT'S ACCOUNT NO.: SC004649
27. ACCEPT ASSIGNMENT? (For Govt. Claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: 221 00
29. AMOUNT PAID
30. BALANCE DUE
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.)
VENKATA PARSA MD
02 09 2018
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION:
SWAN CREEK VILLAGE CENTER
2027 PULASKI HIGHWAY SUITE 2
HAVRE DE GRACE MD 21078-2147
a. 1699067058 b.
33. BILLING PROVIDER INFO & PH #: 866 2835507
UPPER CHESAPEAKE HEMATOLO
PO BOX 741676
ATLANTA GA 30374-1676
a. 1699067058 b.

CANCER CONTROL
FEB 15 2018

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB 0938-1197 FORM 1500 (12-90)
WCMS-1500CS-12

MDH DATA ENTRY
WORK REQUEST

BREAST AND CERVICAL CANCER

Document Title/Name: FORM CMS1500

Data Entry Standard Job: CANHIC09

Data Entry Batch Name: P121

Date Delivered to Data Entry: 02/ 09 /2018

Number of Documents: 10

Fiscal Year: 2018

Date Batched: 02/ 09 /2018

Prepared by: BD

OUTPUT TO FILE:

ENTER	VERIFY
1. _____ ___/__/____	1. _____ ___/___/___
2. _____ ___/___/___	2. _____ ___/___/___

DATE RECEIVED BY DATA ENTRY

THIS CLAIM IS A REFILING OF A PREVIOUSLY FILED CLAIM

BREAST CANCER SCREENING
PO BOX 13528
BALTIMORE MD 21203

HEALTH INSURANCE CLAIM FORM

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

Lev:1

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 00011 2222

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gunderson, Marge

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 1971 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Gunderson, Marge

5. PATIENT'S ADDRESS (No., Street): 123 Fargo Lane

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

7. INSURED'S ADDRESS (No., Street): 123 Fargo Lane

CITY: OLNEY STATE: MD

8. RESERVED FOR NUCC USE

CITY: OLNEY STATE: MD

ZIP CODE: 20832 TELEPHONE (Include Area Code):

ZIP CODE: 20832 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: 06 21 1971 M [ ] F [X]

b. RESERVED FOR NUCC USE

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

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: BREAST CANCER SCREENING

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] 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: 12/01/2017

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN BOBBY DAVID

17a. 1G

17b. NPI 1114993771

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

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

A. N63.10 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. #
ANESTHESIA TIME: 11:01 - 11:51											
1 12 01 17	12 01 17	22	N	00400	AA QS	A	700.00	50	N	NPI	1700827227
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 7612309/FCA79838

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

28. TOTAL CHARGE: $ 700.00

29. AMOUNT PAID: $

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.

ROGER SHERE-WOLFE, MD 01/21/2018

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: WASHINGTON ADVENTIST HOSPITAL, 7600 CARROLL AVENUE, TAKOMA PARK MD 209126367

a. b.

33. BILLING PROVIDER INFO & PH #: 888 276-1910 FIRST COLONIES ANESTHESIA ASSOC LI, PO BOX 791344, BALTIMORE MD 212791344

a. 1740218767 b.

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

Lev: 1

HEALTH INSURANCE CLAIM FORM

MEDICARE [X] MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

1a. INSURED'S I.D. NUMBER: 0000264321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Ward, Vivian

3. PATIENT'S BIRTH DATE: 01 23 1968 SEX: [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Ward, Vivian

5. PATIENT'S ADDRESS (No., Street): 500 Park Avenue

6. PATIENT RELATIONSHIP TO INSURED: Self [X]

7. INSURED'S ADDRESS (No., Street): 500 Park Avenue

CITY: HYATTSVILLE STATE: MD

8. RESERVED FOR NUCC USE

CITY: HYATTSVILLE MD

ZIP CODE: 20783 TELEPHONE (Include Area Code):

ZIP CODE: 20783

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:

9a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

11a. INSURED'S DATE OF BIRTH: 01 23 1968 SEX: X

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

b. OTHER CLAIM ID (Designated by NUCC):

9b. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: BREAST CANCER SCREENING

9c. RESERVED FOR NUCC USE

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: SIGNATURE ON FILE DATE: 01/18/2018

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: SIGNATURE ON FILE

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

15. OTHER DATE: QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN CYNTHIA PLATE

17a. 1G

17b. NPI 1972579753

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line): 0

Z45.2 C50.919

22. RESUBMISSION CODE: 1

23. PRIOR AUTHORIZATION NUMBER:

24A. DATE(S) OF SERVICE From	To	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	RENDERING PROVIDER ID. #
ANESTHESIA TIME: 10:40 - 11:32										
01 18 18	01 18 18	22	N	00532	AA	AB	800.00	52	N	1932183290

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 7845062/FCA81970

27. ACCEPT ASSIGNMENT? [X] YES [ ] NO

28. TOTAL CHARGE: 800.00

29. AMOUNT PAID:

30. BALANCE DUE:

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS: SHAO HUA YANG, MD 01/25/2018

32. SERVICE FACILITY LOCATION INFORMATION: WASHINGTON ADVENTIST HOSPITAL, 7600 CARROLL AVENUE, TAKOMA PARK MD 209126367

33. BILLING PROVIDER INFO & PH #: 888 276-1910
FIRST COLONIES ANESTHESIA ASSOC LI
PO BOX 791344
BALTIMORE MD 212791344
1740218767

PLEASE PRINT OR TYPE

RECEIVED CANCER CONTROL 2018

THIS CLAIM IS A REFILING OF PREVIOUSLY FILED CLAIM

HEALTH INSURANCE CLAIM FORM

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

PICA

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

Lev: 1

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 111447777

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Adler, Grace

3. PATIENT'S BIRTH DATE MM DD YY: 08 22 1964 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Adler, Grace

5. PATIENT'S ADDRESS (No., Street): 155 Riverside Drive, #9G

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

7. INSURED'S ADDRESS (No., Street): 155 Riverside Drive, #9G

CITY: FLINTSTONE STATE: MD

8. RESERVED FOR NUCC USE

CITY: FLINTSTONE STATE: MD

ZIP CODE: 21530 TELEPHONE (Include Area Code):

ZIP CODE: 21530

CANCER CONTROL
FEB 26 2018

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 [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 08 22 1964 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: BREAST CANCER SCREENING

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO 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: 11/03/2017

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN NEIL ROSENSHEIN

17a. 1G

17b. NPI 1134162738

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 03 17 TO 11 06 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. R87.613 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ANESTHESIA TIME: 08:44 - 11:05											
1 11 03 17	11 03 17	21	N	00840	QZ	A	1600.00	141	N	NPI	1851780894
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 7688004/FCA78455

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 1600.00

29. AMOUNT PAID: $

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.)
JHEMIKA WATSON
02/05/2018
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
MERITUS MEDICAL CENTER
11116 MEDICAL CAMPUS ROA
HAGERSTOWN MD 217426710
a. b.

33. BILLING PROVIDER INFO & PH # 888 276-1910
FIRST COLONIES ANESTHESIA ASSOC LI
PO BOX 791344
BALTIMORE MD 212791344
a. 1740218767 b.

THIS CLAIM IS A REFILING OF PREVIOUSLY FILED CLAIM

HEALTH INSURANCE CLAIM FORM

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

PICA

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

Lev: 1

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER: 2224466666

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): House, Gregory

3. PATIENT'S BIRTH DATE MM DD YY: 09 05 1965 SEX M [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): House, Gregory

5. PATIENT'S ADDRESS (No., Street): 221 B Baker Street

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

7. INSURED'S ADDRESS (No., Street): 221 B Baker Street

CITY: PIKESVILLE | STATE: MD

8. RESERVED FOR NUCC USE

CITY: PIKESVILLE | STATE: MD

ZIP CODE: 21208 | TELEPHONE (Include Area Code):

ZIP CODE: 21208

CANCER CONTROL
FEB 26 2018

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: FEB 26 2018

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: 09 05 1965 SEX M [X]

b. RESERVED FOR NUCC USE

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

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: BREAST CANCER SCREENING

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] 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: 12/15/2017

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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN NASSIF SOUEID

17a. 1G

17b. NPI 1871514968

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

A. C50.811 B. I10 C. D50.9 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. #
ANESTHESIA TIME: 08:41 - 13:51											
1 12 15 17	12 15 17	22	N	01610	QZ	ABC	2600.00	310	N	NPI	1124066857
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 7685627/FCA80421

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

28. TOTAL CHARGE: $ 2600.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

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.)
SALLY SALVATORI, CRNA
02/04/2018
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST JOSEPH MEDICAL CENTER
7601 OSLER DRIVE
TOWSON MD 212047700
a. b.

33. BILLING PROVIDER INFO & PH #: 888 276-1910
FIRST COLONIES ANESTHESIA ASSOC LI
PO BOX 791344
BALTIMORE MD 212791344
a. 1740218767 b.

THIS CLAIM IS A REFILING OF A PREVIOUSLY FILED CLAIM

HEALTH INSURANCE CLAIM FORM

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

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

Lev:1

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 777889999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Marquez, Mini

3. PATIENT'S BIRTH DATE MM DD YY: 03 07 1980 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Marquez, Mini

5. PATIENT'S ADDRESS (No., Street): 126 Rent Ave.

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

7. INSURED'S ADDRESS (No., Street): 126 Rent Ave.

CITY: SILVER SPRING STATE: MD

6. RESERVED FOR NUCC USE

CITY: SILVER SPRING STATE: MD

ZIP CODE: 20902 TELEPHONE (Include Area Code):

ZIP CODE: 20902

CANCER CONTROL (240)

FEB 26 2018

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

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY: 03 07 1980 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

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: BREAST CANCER SCREENING

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] 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: 12/14/2017

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 MM DD YY QUAL.

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 CYNTHIA PLATE

17a. 1G

17b. NPI 1972579753

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

A. Z45.2 B. Z85.3 C. H40.9 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ANESTHESIA TIME: 11:39 - 12:21											
1 12 14 17	12 14 17	22	N	00400	AA P3	ABC	700.00	42	N	NPI	1417161209
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 7679453/FCA80373

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

28. TOTAL CHARGE: $ 700.00

29. AMOUNT PAID: $

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.)

NAEEM POURSHARIF, DO

02/03/2018

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

WASHINGTON ADVENTIST HOSPITAL
7600 CARROLL AVENUE
TAKOMA PARK MD 209126367

a. b.

33. BILLING PROVIDER INFO & PH # 888 276-1910

FIRST COLONIES ANESTHESIA ASSOC LI
PO BOX 791344
BALTIMORE MD 212791344

a. 1740218767 b.

TREATMENT FUND/CLM
PO BOX 13528
BALTIMORE MD 21203

HEALTH INSURANCE CLAIM FORM

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

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: 987654321
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Woodward, Amanda	3. PATIENT'S BIRTH DATE MM DD YY: 05 04 1980 SEX [ ] [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Woodward, Amanda
5. PATIENT'S ADDRESS (No., Street): 10 Melrose Place	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 10 Melrose Place
CITY: WESTMINSTER STATE: MD	8. RESERVED FOR NUCC USE	CITY: WESTMINSTER STATE: MD
ZIP CODE: 21158 TELEPHONE (Include Area Code):		ZIP CODE: 21158
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:
9a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY: 05 04 1980 SEX [ ] [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: TREATMENT FUND/CLM
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO 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: 01 22 2018

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: 01 22 18 QUAL 431	15. OTHER DATE MM DD YY QUAL	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN HOBART, DONA C.	17a. 17b. NPI 1740397991	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 01 22 18 TO 01 22 18
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0: A. C50912 B. I10 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 BX/EXC LYMPH NODE	OPEN DEEP AXILLARY NODE								G2	R106837
01 22 18 01 22 18	21		01610	QZ P3	A	1924 00	013		NPI	1255313961
2 PHYSICAL STATUS P3 (1 UNIT(S))										
TOTAL MODIFIER UNITS INCLUDED IN ABOVE CHARGE (* 1 *)									NPI	
3 UNITS 6. BASIC (1. CONDITIONAL CIRCUMSTANCES)										
7. TIME (104) MIN START: 11:32 STOP: 13:16									NPI	
13. TOTAL UNITS										
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 541759418 SSN EIN [ ] [X]	26. PATIENT'S ACCOUNT NO.: 652371860	27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 1924 00	29. AMOUNT PAID: $ 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 #	(517) 787-7438
BISCHOFF, JANET CRNA	CARROLL HOSP 200 MEMORIAL AVE WESTMINSTER MD 21157-5726		CARROLL COUNTY ANES ASSOC PO BOX 75193 BALTIMORE MD 21275-5193	
SIGNED 01/30/18	a. 1912904210 b.		a. 1174564884 b. G2 541759418	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02/12)

SH PAYMENT IS DUE AND APPRECIATED UPON RECEIPT - THANK YOU CCAA-304180

THIS CLAIM IS A REFILING OF PREVIOUSLY FILED CLAIM

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

HEALTH INSURANCE CLAIM FORM

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

Lev: 1

1. MEDICARE [ ] (Medicare#) [X] MEDICAID (Medicaid#) TRICARE [ ] (ID#/DoB#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Trammell, Catherine

3. PATIENT'S BIRTH DATE MM 07 DD 21 YY 1973 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Trammell, Catherine

5. PATIENT'S ADDRESS (No., Street): 12 Basic Instinct Way

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

7. INSURED'S ADDRESS (No., Street): 12 Basic Instinct Way

CITY: GERMANTOWN STATE: MD

8. RESERVED FOR NUCC USE

CITY: GERMANTOWN STATE: MD

ZIP CODE: 20874 TELEPHONE (Include Area Code):

ZIP CODE: 20874 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

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM 07 DD 21 YY 1973 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: BREAST CANCER SCREENING

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO 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: 12/07/2017

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN CYNTHIA PLATE

17a. 1G

17b. NPI 1972579753

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. C50.911 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ANESTHESIA TIME: 09:44 - 13:00											
1 12 07 17	12 07 17	22	N	00404	AA	A	1900.00	196	N	NPI	1386897718
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 7665072/FCA80258

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

28. TOTAL CHARGE: $ 1900.00

29. AMOUNT PAID: $

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.)

LARON N JOHNSON, MD

02/01/2018

32. SERVICE FACILITY LOCATION INFORMATION

WASHINGTON ADVENTIST HOSPITAL
7600 CARROLL AVENUE
TAKOMA PARK MD 209126367

a.

b.

33. BILLING PROVIDER INFO & PH #: 888 276-1910

FIRST COLONIES ANESTHESIA ASSOC LI
PO BOX 791344
BALTIMORE MD 212791344

a. 1740218767

b.

SIGNED DATE

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

5

Lev: 1

HEALTH INSURANCE CLAIM FORM

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

1. TYPE OF INSURANCE: MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID# DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 196665432

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Green, Rachel

3. PATIENT'S BIRTH DATE MM DD YY: 11 20 1966 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Green, Rachel

5. PATIENT'S ADDRESS (No., Street): 90 Bedford Street

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

7. INSURED'S ADDRESS (No., Street): 90 Bedford Street

CITY: HAGERSTOWN STATE: MD

8. RESERVED FOR NUCC USE

CITY: HAGERSTOWN STATE: MD

ZIP CODE: 21740 TELEPHONE (Include Area Code): - -

ZIP CODE: 21740 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: 11 20 1966 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

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: BREAST CANCER SCREENING

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] 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: 10/04/2017

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 MM DD YY QUAL.

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 SCOTT HAMILTON

17a. 1G

17b. NPI 1629059233

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

A. N84.1 B. Z30.430 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.
ANESTHESIA TIME: 08:25 - 09:18											
1 10 04 17	10 04 17	22	N	00952	QZ	AB	800.00	53	N	NPI	1760407464
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 7826247/FCA77052

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

28. TOTAL CHARGE: $ 800.00

29. AMOUNT PAID: $

30. BALANCE DUE

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.)

MARTIN RICHARDS, CRNA

01/23/2018

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

MERITUS MEDICAL CENTER
11116 MEDICAL CAMPUS ROA
HAGERSTOWN MD 217426710

a. b.

33. BILLING PROVIDER INFO & PH #: 888 276-1910

FIRST COLONIES ANESTHESIA ASSOC LL
PO BOX 791344
BALTIMORE MD 212791344

a. 1740218767 b.

RECEIVED
FEB 15 2018
CANCER CONTROL

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

P

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

Q

HEALTH INSURANCE CLAIM FORM

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

Lev: 1

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID# DoDB) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 0000012367

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gallagher, Mary Katherine

3. PATIENT'S BIRTH DATE MM DD YY: 07 21 1962 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Gallagher, Mary Katherine

5. PATIENT'S ADDRESS (No., Street): 30 Rockefeller Plaza

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

7. INSURED'S ADDRESS (No., Street): 30 Rockefeller Plaza

CITY: Germantown STATE: MD

8. RESERVED FOR NUCC USE

CITY: GERMANTOWN STATE: MD

ZIP CODE: 20874 TELEPHONE (Include Area Code):

ZIP CODE: 20874 TELEPHONE (Include Area Code):

FEB 15 2018

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 [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 07 21 1962 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: BREAST CANCER SCREENING

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO 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: 02/05/2018

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 MM DD YY QUAL.

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 CYNTHIA PLATE

17a. 1G

17b. NPI 1972579753

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 [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. Z45.2 B. C50.912 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: 1 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ANESTHESIA TIME: 15:03 - 15:56											
1 02 05 18	02 05 18	22	N	00532	AA QS P3	AB	900.00	53	N	NPI	1396929246
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 7924507/FCA82760.

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

28. TOTAL CHARGE: $ 900.00

29. AMOUNT PAID: $

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.): MARC S AZRAN, MD 02/09/2018

32. SERVICE FACILITY LOCATION INFORMATION: WASHINGTON ADVENTIST HOSPITAL, 7600 CARROLL AVENUE, TAKOMA PARK MD 209126367

33. BILLING PROVIDER INFO & PH #: 888 276-1910
FIRST COLONIES ANESTHESIA ASSOC LI
PO BOX 791344
BALTIMORE MD 212791344

a. 1740218767 b.

BREAST CANCER SCREENING
PO BOX 13528

BALTIMORE MD 21203

Lev: 1

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER: 0000716321

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Simmons, Mabel

3. PATIENT'S BIRTH DATE MM DD YY: 11 20 1969 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Simmons, Mabel

5. PATIENT'S ADDRESS (No., Street): 1197 Avon Ave SW

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

7. INSURED'S ADDRESS (No., Street): 1197 Avon Ave SW

CITY: HAGERSTOWN STATE: MD

6. RESERVED FOR NUCC USE

CITY: HAGERSTOWN STATE: MD

ZIP CODE: 21740 TELEPHONE (Include Area Code):

ZIP CODE: 21740 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 [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 11 20 1969 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: BREAST CANCER SCREENING

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO 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: 11/17/2017

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 MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN NEIL ROSENSHEIN

17a. 1G

17b. NPI 1134162738

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 17 17 TO 11 20 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. C53.9 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ANESTHESIA TIME: 13:10 - 15:30											
1 11 17 17	11 17 17	21	N	00846	QZ	A	1800.00	140	N	NPI	1518953215
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 200420553 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 7826243/FCA79110:

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 1800.00

29. AMOUNT PAID: $

30. BALANCE DUE

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.)

JAMES ROUPE, CRNA

01/23/2018

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

MERITUS MEDICAL CENTER
11116 MEDICAL CAMPUS ROA
HAGERSTOWN MD 217426710

a. b.

33. BILLING PROVIDER INFO & PH #: 888 276-1910

FIRST COLONIES ANESTHESIA ASSOC LL
PO BOX 791344
BALTIMORE MD 212791344

a. 1740218767 b.

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