1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AmeriHealth Of New Jersey
P.O. Box 41574
Philadelphia PA 19101-1574

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY STATE

8. PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY le STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE 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 [X] F [ ]

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME
AmeriHealth Of New Jersey

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

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 DATE 02/14/12

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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
McGrath Robert

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 715.16
2. 719.46
3. 729.5
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
None

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	14	12	02	14	12	11		L1843	LT	123	1620.00	1		NPI	
02	14	12	02	14	12	11		L1843	RT	123	1620.00	1		NPI	
														NPI	
														NPI	
														NPI	
														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
271385019 [X]

26. PATIENT'S ACCOUNT NO.
2275-1

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

28. TOTAL CHARGE
$ 3240.00

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.)

Robert McGrath D.O.
SIGNED 04/18/13 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Atlantic Spine & Joint Institute
654 West Cuthbert Blvd.
Haddon Township NJ 08108
a. b.

33. BILLING PROVIDER INFO & PH # (856) 854-3472
Robert C. McGrath DO
654 West Cuthbert Blvd
Haddon Township NJ 08108

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

AmeriHealth

AMERIHEALTH, INC.
P.O. BOX 59480
PHILADELPHIA, PA 19102-9480

0423UCDS06010000217
PAGE 1 OF 3

AmeriHealth HMO, Inc.
AmeriHealth Insurance Company of New Jersey
QCC Insurance d/b/a AmeriHealth Insurance Company

Code: AH 000080

ATLANTIC SPINE JOINT INSTITUTE
654 CUTHBERT BLVD
HADDON TWP NJ 08108-3642

Questions? Call:
1-800-275-2583

Provider ID:

NPI:

Inquire at: www.amerihealth.com
Submit inquiries to:
Provider Claim Inquiry
P.O. Box 6645
Wayne, PA 19087-6645

CHECK NBR 4/23/2012 **AMOUNT** **$3,242.13**

PAYMENT SUMMARY

NET CLAIM AMOUNT:	$3,240.00
LATE PAYMENT INTEREST PAID:	$2.13
TOTAL AMOUNT DISBURSED:	$3,242.13

THIRD PARTY ADMINISTRATOR (TPA) CLAIMS MUST BE SUBMITTED TO AMERIHEALTH ADMINISTRATORS● DIRECTLY. PLEASE USE THE CORRECT MEMBER IDENTIFICATION NUMBER WHEN SUBMITTING CLAIMS FOR AMERIHEALTH ADMINISTRATORS● (AHA) MEMBERS. MEMBER ID IS 8 DIGITS AND ENDS WITH TPA SUFFIX (EX. 12345678 TPA). ELECTRONIC CLAIM PAYER INFORMATION: ISA-08 = 54704 AND GS-03 = 54763
EFFECTIVE JANUARY 1, 2009, VALID NDCS (NATIONAL DRUG CODES) ARE REQUIRED ON ALL CLAIMS SUBMITTED FOR DRUGS WITH UNLISTED AND/OR NON-SPECIFIC DRUG CODES.
ELECTRONIC BILLING ENSURES FASTER PAYMENT. FOR EDI AND PAYER ID INFORMATION, CALL 856-638-2701 OR SEE: WWW.AMERIHEALTH.COM/PROVIDERS/CLAIMS_AND_BILLING
FOR NAVINET PORTAL REGISTRATION OR QUESTIONS, CALL OUR EBUSINESS PROVIDER HOTLINE AT 856-638-2701 (NJ); 302-661-6111 (DE);

RECEIVED
APR 30 2012

AmeriHealth

AmeriHealth HMO, Inc.
AmeriHealth Insurance Company of New Jersey
QCC Insurance d/b/a AmeriHealth Insurance Company

60-162
433

DATE 4/23/2012

CHECK NUMBER

AMERIHEALTH, INC.
P.O. BOX 59480
PHILADELPHIA, PA 19102-9480

CHECK SHELL IS PRINTED ON WHITE PAPER WITH A BLUE SCREEN. REVERSE SIDE HAS A WATERMARK.

PAY TO THE ORDER OF **ATLANTIC SPINE JOINT INSTITUTE**
654 CUTHBERT BLVD
HADDON TWP NJ 08108-3642

PAY EXACTLY
THREE THOUSAND TWO HUNDRED FORTY TWO AND 13/100 DOLLARS

$*****3242.13***
VOID 6 MONTHS FROM ISSUE DATE

PNC BANK, NATIONAL ASSOCIATION
JEANNETTE, PA

AUTHORIZED SIGNATURE

⑈3702127010⑈ ⑆043301627⑆ 1017286783⑈

AmeriHealth

AmeriHealth HMO, Inc.
AmeriHealth Insurance Company of New Jersey
QCC Insurance d/b/a AmeriHealth Insurance Company

PAY TO: ATLANTIC SPINE JOINT INSTITUTE

PAY TO ID:
NPI:
CHECK NUMBER:

DOCUMENT ID:
DATE: 4/23/2012
PAGE: 2 OF 3

BILLING PROVIDER ID:

BILLING PROVIDER NAME: ATLANTIC SPINE JOINT INSTITUTE

PPO PATIENT NAME: PT ACCT INSURED NAME USI: SS/CLM NBR:

DATES OF SERVICE	PROC/REV/APC	POS	TOT UNITS	AMOUNT BILLED	ALLOWED AMOUNT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	REMARK CODE(S)	AMOUNT PAID
2/14/12	L1843-LT	12	1	$1,620.00	$1,620.00	$0.00	$0.00	$0.00	$0.00	$0.00	M21	$1,620.00
2/14/12	L1843-RT	12	1	$1,620.00	$1,620.00	$0.00	$0.00	$0.00	$0.00	$0.00	M21	$1,620.00

TOTAL FOR THIS CLAIM

WITHHOLD	PROV NON-COV	PENALTY	AMOUNT BILLED	ALLOWED AMOUNT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	OTHER INS PAY	AMOUNT PAID	INTEREST
$0.00	$0.00	$0.00	$3,240.00	$3,240.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,240.00	$2.13

EXPLANATION OF REMARKS: (M21) CLAIM FOR SERVICES/ITEMS PROVIDED IN A HOME MUST INDICATE THE PLACE OF RESIDENCE.

TOTAL FOR ATLANTIC SPINE JOINT INSTITUTE

WITHHOLD	PROV NON-COV	PENALTY	AMOUNT BILLED	ALLOWED AMOUNT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	OTHER INS PAY	AMOUNT PAID
$0.00	$0.00	$0.00	$3,240.00	$3,240.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,240.00

TOTAL FOR PPO

WITHHOLD	PROV NON-COV	PENALTY	AMOUNT BILLED	ALLOWED AMOUNT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	OTHER INS PAY	AMOUNT PAID	INTEREST
$0.00	$0.00	$0.00	$3,240.00	$3,240.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,240.00	$2.13

TOTAL PAYMENT

WITHHOLD	PROV NON-COV	PENALTY	AMOUNT BILLED	ALLOWED AMOUNT	MEM NON-COV	DEDUCTIBLE	CO-PAYMENT	COINSURANCE	MEM RESP	OTHER INS PAY	AMOUNT PAID	INTEREST
$0.00	$0.00	$0.00	$3,240.00	$3,240.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,240.00	$2.13

POS KEY:

12 HOME HEALTH

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Aetna
P.O.Box 981106
El Paso TX 79998

PICA | PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F X

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY | STATE

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | 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 X

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: Aetna

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes*, return to and complete item 9 a-d.

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 03/31/11

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

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: McGrath Robert

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 715.16
2. 729.5
3. 719.46
4. 739.3

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: None

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. #
03	31	11	03	31	11	11		L1843	LT	1234	1650.00	1		NPI	
03	31	11	03	31	11	11		L1843	RT	1234	1650.00	1		NPI	
														NPI	
														NPI	
														NPI	
														NPI	

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

26. PATIENT'S ACCOUNT NO. 1381-1

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

28. TOTAL CHARGE $ 3300.00

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.)

Robert McGrath D.O.
SIGNED 04/18/13 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Atlantic Spine & Joint Institute
654 West Cuthbert Blvd.
Haddon Township NJ 08108
a

33. BILLING PROVIDER INFO & PH # (856) 854-3472
Robert C. McGrath DO
654 West Cuthbert Blvd
Haddon Township NJ 08108
a

Payer: AETNA
For questions regarding this ERA, please contact the payer
Remittance Date: 04/25/2011
Trace/Check: [redacted]
Remittance Information Only via Automated Clearinghouse
To: ATLANTIC SPINE JOINT ([redacted])

Name: [redacted] Account: [redacted] HIC: [redacted] ICN: [redacted] Claim: [redacted] Status: Processed as Primary

Procedure	Units Paid	Original Units	Proc. Date	Charge	Allowed	Pat. Portion	Deductible	Co-Insurance	Disallowed	Reason	Paid
97530.GP	2	-	03/31/2011	154.00	154.00	0.00	0.00	0.00	0.00	-	154.00
97110.GP	2	-	03/31/2011	154.00	154.00	0.00	0.00	0.00	0.00	-	154.00
(Completed) (Re-Post) + Subtotal:				308.00	308.00	0.00	0.00	0.00	0.00		308.00

Name: [redacted] Account: [redacted] HIC: [redacted] ICN: [redacted] Claim: [redacted] Status: Processed as Primary

Procedure	Units Paid	Original Units	Proc. Date	Charge	Allowed	Pat. Portion	Deductible	Co-Insurance	Disallowed	Reason	Paid
97530.GP	2	-	03/29/2011	154.00	154.00	0.00	0.00	0.00	0.00	-	154.00
97110.GP	2	-	03/29/2011	154.00	154.00	0.00	0.00	0.00	0.00	-	154.00
(Completed) (Re-Post) + Subtotal:				308.00	308.00	0.00	0.00	0.00	0.00		308.00

Name: [redacted] Account: [redacted] HIC: [redacted] ICN: [redacted] Claim: [redacted] Status: Processed as Primary

Procedure	Units Paid	Original Units	Proc. Date	Charge	Allowed	Pat. Portion	Deductible	Co-Insurance	Disallowed	Reason	Paid
97530.GP	2	-	03/30/2011	154.00	154.00	0.00	0.00	0.00	0.00	-	154.00
97110.GP	2	-	03/30/2011	154.00	154.00	0.00	0.00	0.00	0.00	-	154.00
(Completed) (Re-Post) + Subtotal:				308.00	308.00	0.00	0.00	0.00	0.00		308.00

Name: [redacted] Account: [redacted] HIC: [redacted] ICN: [redacted] Claim: [redacted] Status: Processed as Primary

Procedure	Units Paid	Original Units	Proc. Date	Charge	Allowed	Pat. Portion	Deductible	Co-Insurance	Disallowed	Reason	Paid
L1843.RT	1	-	03/31/2011	1650.00	1113.00	870.90	0.00	333.90	537.00	PR-45	779.10
Remarks: N130											
L1843.LT	1	-	03/31/2011	1650.00	1113.00	870.90	0.00	333.90	537.00	PR-45	779.10
Remarks: N130											
(Completed) (Re-Post) + Subtotal:				3300.00	2226.00	1741.80	0.00	667.80	1074.00		1558.20

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MEDICARE
P O BOX 890031
CAMP HILL PA 17089 0030

PICA

PICA

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(Member ID#)	(SSN or ID)	(SSN)	(ID)	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
	3 1 M X F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self X Spouse Child Other	
CITY / STATE	8. PATIENT STATUS	CITY / STATE
	Single Married X Other	
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / 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
		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
	YES X NO	M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
M F	YES X NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO *If yes*, return to and complete item 9 a-d.

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 16 13

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
MCGRATH ROBERT	17b. NPI	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES
		YES X NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 715.16
2. 719.46
3. 729.5
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

NONE

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. #
01 16 13 01 16 13	12		L1843	LT KX	123	1620 00	1		NPI	
01 16 13 01 16 13	12		L1843	RT KX	123	1620 00	1		NPI	
									NPI	
									NPI	
									NPI	
									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
X	3287 1	X YES NO	$ 3240 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 # (856) 854 3472
ROBERT MCGRATH D O	ATLANTIC SPINE JOINT INSTITUTE 654 WEST CUTHBERT BLVD HADDON TOWNSHIP NJ 08108	ROBERT C MCGRATH DO 654 WEST CUTHBERT BLVD HADDON TOWNSHIP NJ 08108
SIGNED 04 18 13 DATE	a. b.	a. b.

TO: ATLANTIC SPINE AND JOINT C [illegible]

Name: Account: HIC: ICN: 1 Claim: Status: Processed as Primary, Forward to Additional Payer(s) (COLONIAL PENN LIFE INSURANCE CO)

Procedure	Units Paid	Original Units	Proc. Date	Charge	Allowed	Pat. Portion	Deductible	Co-Insurance	Disallowed	Reason	Paid
L1843.LT.KX	1	-	01/16/2013	1620.00	817.67	163.53	0.00	163.53	802.33	CO-45	654.14
L1843.RT.KX	1	-	01/16/2013	1620.00	817.67	163.54	0.00	163.54	802.33	CO-45	654.13
(Completed) (Rx - Post) + Subtotal:				3240.00	1635.34	327.07	0.00	327.07	1604.66		1308.27

Remarks: MA18, MA01

MP

COLONIAL PENN LIFE
INSURANCE COMPANY
11825 N. PENNSYLVANIA ST, CARMEL, IN 46032

CHECK NO.

MS

THE BANK OF NEW YORK MELLON
PHILADELPHIA, PA

62-4
311

PAY *FOUR HUNDRED FIFTY-ONE AND 40/100* ----------

DATE
02/11/2013

CHECK AMOUNT
**********451.40

TO THE ORDER OF

03165 ATLANTIC SPINE AND J
654 WEST CUTHBERT BLVD
HADDON TOWN, NJ 08108

VOID AFTER 180 DAYS — AUTHORIZED SIGNATURE

⑈0004113318⑈ ⑆031100047⑆ 2⑈969 822⑈

CHECK NUMBER: 0004113318 CHECK DATE: 02/11/2013 CPL /BCBBA/BCB /

PATIENT NAME	PAT.NO.	BILLED	APPRVD	DEDUCT	CO-INS	PAID
211773203-544691	2614-1-615 SERV.DT.- 01-14-2013	62.00	37.82	.00 RCVD.DT.-02/02/2013	7.56	7.56
212738049-611388	3287-1-616 SERV.DT.- 01-16-2013	1718.00	229.52	16.31* RCVD.DT.-02/04/2013	42.64	27.21
212738049-611389	3287-1-616 SERV.DT.- 01-14-2013	479.00	177.61	.00 RCVD.DT.-02/04/2013	35.52	20.09
212738049-611390	3287-1-616 SERV.DT.- 01-10-2013	468.00	164.30	.00 RCVD.DT.-02/04/2013	32.86	12.86
212738049-578009	3287-1-616 SERV.DT.- 01-16-2013	3240.00	1635.34	.00 RCVD.DT.-02/03/2013	327.07	327.07
212738049-675546	3287-1-617 SERV.DT.- 01-17-2013	308.00	130.69	.00 RCVD.DT.-02/06/2013	26.14	26.14
212738049-675547	3287-1-617 SERV.DT.- 01-17-2013	1718.00	229.52	.00 RCVD.DT.-02/06/2013	45.90	30.47

DATE: 02/09/13 CONTROL NO. 00006616 TOTAL PAID 451.40
THIS PATIENT'S COVERAGE DOES NOT PROVIDE A BENEFIT FOR THIS AMOUNT

FEB 14 2013

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MEDICARE
P O BOX 890031
CAMP HILL PA 17089 0030

PICA | PICA

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) I	3. PATIENT'S BIRTH DATE MM DD YY SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. PATIENT STATUS Single [X] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	CITY STATE
ZIP CODE 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 [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [X] F [ ]	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME DME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

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 03 28 13

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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 MCGRATH ROBERT	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 715.16 2. 719.46 3. 729.5 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER NONE

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. #
03 28 13	03 28 13	12		L1843	LT KX	123	1620 00	1		NPI	
03 28 13	03 28 13	12		L1843	RT KX	123	1620 00	1		NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO. 3486 1	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 3240 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.) ROBERT MCGRATH D O SIGNED 04 18 13 DATE	32. SERVICE FACILITY LOCATION INFORMATION ATLANTIC SPINE JOINT INSTITUTE 654 WEST CUTHBERT BLVD HADDON TOWNSHIP NJ 08108 a. b.		33. BILLING PROVIDER INFO & PH # (856) 854 3472 ROBERT C MCGRATH DO 654 WEST CUTHBERT BLVD HADDON TOWNSHIP NJ 08108 a. b.		

Name: GOLDMAN, WILLIAM Account: HIC: ICN: Claim: Status: Processed as Primary

Procedure	Units Paid	Original Units	Proc. Date	Charge	Allowed	Pat. Portion	Deductible	Co-Insurance	Disallowed	Reason	Paid
L1843.LT.KX	1	-	03/28/2013	1620.00	817.67	163.53	0.00	163.53	802.33	CO-45	654.14
L1843.RT.KX	1	-	03/28/2013	1620.00	817.67	163.54	0.00	163.54	802.33	CO-45	654.13
(Completed) (Re-Post) + Subtotal:				3240.00	1635.34	327.07	0.00	327.07	1604.66		1308.27

Remarks: MA01

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Horizon Blue Cross Blue Shield Of New Jers
P.O. Box 820
Newark NJ 07101-1609

PICA | PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single [ ] Married [X] Other [ ]	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	Employed [X] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE / 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 SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH SEX M [X] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME: JDJ CONSTRUCTION MGT INC
c. EMPLOYER'S NAME OR SCHOOL NAME: 1811 Spring Garden St. PA 191	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: Horizon Blue Cross Blue Shield
d. INSURANCE PLAN NAME OR PROGRAM NAME: Carpenters Health And Welfare	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes,* return to and complete item 9 a-d.

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 02/22/13

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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: McGrath Robert	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 715.16 3. 729.5 2. 719.46 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: None

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	22	13	02	22	13	11		L1843	RT	123	1620.00	1		NPI	
02	22	13	02	22	13	11		L1843	LT	123	1620.00	1		NPI	
														NPI	
														NPI	
														NPI	
														NPI	

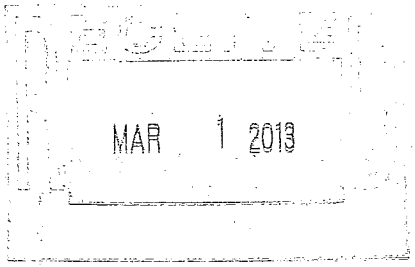
25. FEDERAL TAX I.D. NUMBER SSN EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	3383-1		$ 3240.00	$	$

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 # (856) 854-3472
Robert McGrath D.O. SIGNED 04/18/13 DATE	Atlantic Spine & Joint Institute 654 West Cuthbert Blvd. Haddon Township NJ 08108 a.	Robert C. McGrath DO 654 West Cuthbert Blvd Haddon Township NJ 08108 a. b.

CARPENTERS' HEALTH AND WELFARE FUND
1811 SPRING GARDEN STREET
PHILADELPHIA, PA 19130-3916
215-568-0430

2/28/2013 NO. 00000841232

CLAIM NUMBER	SERVICE DATE	SOC SEC NBR	MEMBER NAME	PATIENT	PROCEDURE CODE	AMOUNT CHARGED	TOTAL PAID
1228988	2/22/2013	U54248881			KNEE ORTHOSIS	1620.00	1200.00
1228988	2/22/2013	U54248881			KNEE ORTHOSIS	1620.00	1200.00



** CLAIMS PAID: 2 TOTAL ** 2,400.00

DOCUMENT IS PRINTED ON CHEMICALLY REACTIVE PAPER - THE BACK OF THIS DOCUMENT INCLUDES A TAMPER EVIDENT CHEMICAL WASH WARNING BOX

CARPENTERS' HEALTH AND WELFARE FUND
1811 SPRING GARDEN STREET
PHILADELPHIA, PA 19130-3916
This payment made possible by
Union Labor

BNY MELLON, N.A
PHILADELPHIA, PA

62-4
311

2/28/2013 NO.

PAY

TWO THOUSAND FOUR HUNDRED DOLLARS AND 00 CENTS

$ *****2400.00

VOID AFTER 60 DAYS ISSUE

PAY
TO THE
ORDER OF

ATLANTIC SPINE + JOINT INSTITU
654 WEST CUTHBERT BLVD
HADDON TOWNSHIP NJ 08108

Edward Coryell
Jane R. Doe

HEAT SENSITIVE
COLOR FADES WITH HEAT

DECW 400

⑈084123 2⑈ ⑆031100047⑆ 2 944 247⑈