<u> 1500</u>

HEALTH INSURANCE CLAIM FORM

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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA			PICA
1. MEDICARE MEDICAID TRICARE CHAMPVA CHAMPUS	HEATTH DIAN BUZILIMO	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#)	(SSN or ID) (SSN) X (ID)		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PA	PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (I act Name, Fi	irst Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 6. PA	PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street	et)
,s	Self X Spouse Child Other	A ~ .	
CITY STATE 8. PA	PATIENT STATUS	CITY	STATE
1-	Single Married X Other	le	1-10
ZIP CODE TFI EPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TE	ELEPHONE (Include Area Code)
	mployed X Student Student		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS	IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OF	R FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EN	EMPLOYMENT? (Current or Previous)	a, INSURED'S DATE OF BIRTH	SEX
	YES X NO	RARA DD	MX F
	AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL	
MM DD YY SEX	YES X NO		
c. EMPLOYER'S NAME OR SCHOOL NAME c. OT	OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PR	OGRAM NAME
	YES X NO	AmeriHealth Of	New Jersey
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d.	. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BE	ENEFIT PLAN?
		YES X NO If ye	es, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIG 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release to process this claim. I also request payment of government benefits either to mys	se of any medical or other information necessary	 INSURED'S OR AUTHORIZED P payment of medical benefits to the services described below. 	ERSON'S SIGNATURE I authorize e undersigned physician or supplier for
below. SIGNED	DATE 02/14/12		
	The second secon	16 DATES PATIENT UNABLE TO W	ODK IN CURRENT OCCURATION
MM DD YY INJURY (Accident) OR GIVE F	TIENT HAS HAD SAME OR SIMILAR ILLNESS. FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO W MM DD YY FROM	MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.		18. HOSPITALIZATION DATES RELA	ATED TO CURRENT SERVICES
McGrath Robert 17b. NPI	71	FROM	TO I
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB?	\$ CHARGES
OF DIAGNOSIS OF NATURE OF HAUFRO OF INVERVARIANT IN A S. O. A.		YES X NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4		22. MEDICAID RESUBMISSION CODE OR	RIGINAL REF. NO.
1. 715:10	29 <u>.5</u>	23. PRIOR AUTHORIZATION NUMBI	FR
2,1719.46	1	None	
24. A. DATE(S) OF SERVICE B. C. D. PROCEDURE	ES, SERVICES, OR SUPPLIES E.	F. G. H	. l. J.
From To PLACE OF (Explain Unu MM DD YY MM DD YY SERVICE EMG CPT/HCPCS	usual Circumstances) DIAGNOSIS MODIFIER POINTER	DAYS EPSI OR Fam \$ CHARGES UNITS Pa	
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02 14 12 02 14 12 11 L1843	RT 123	1620 00 1	NPI
	1 1 1 1 1		
			NPI
		1 1	NPI
		<u> </u>	
			NPI
			NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOU	UNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AM	OUNT PAID 30. BALANCE DUE
271385019 <u>X</u> 2275-1	YES X NO	\$ 3240,00 \$) s
INCLUDING DEGREES OF OPEDENTIALS		33. BILLING PROVIDER INFO & PH	(000) 001 01/2
(I certify that the statements on the reverse Atlantic Spin		Robert C. McGra	ath DÓ
To delay manage		654 West Cuthbe	
IRODELL MCGLATH D.U.		Haddon Township	โ ทา ∩ΩTΩΩ
SIGNED 04/18/13 a.	i b	\$	



AMERIHEALTH, INC.

P.O. BOX 59480 PHILADELPHIA, PA 19102-9480 0423UCDS06010000217 PÁGE

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);







AmeriHealth HMO, Inc. AmeriHealth Insurance Company of New Jersey QCC Insurance d/b/a AmeriHealth Insurance Company 60-162 433

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.

4/23/2012

DATE

CHECK NUMBER

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

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

THREE THOUSAND TWO HUNDRED FORTY TWO AND 13/100 DOLLARS

PNO BANK, NATIONAL ASSOCIATION JEANNETTE, PA

AUTHORIZED SIGNATUR

) |



AmeriHealth HMO, Inc. AmeriHealth Insurance Company of New Jersey QCC Insurance dibla AmeriHealth Insurance Company

PAY TO ID: NPI: PAY TO: ATLANTIC SPINE JOINT INSTITUTE CHECK NUMBER: DOCUMENT ID: DATE: PAGE: 4/23/2012 2 OF 3

TOTAL FOR PPO WITHHOLD \$0.00 TOTAL PAYMENT
WITHHOLD
\$0.00 <u>DATES OF SERVICE PROC/REV/APC</u>
2/14/12 L1843-LT
2/14/12 L1843-RT PPO PATIENT NAME: TOTAL FOR THIS CLAIM
WITHHOLD
\$0.00 TOTAL FOR ATLANTIC SPINE JOINT INSTITUTE
WITHHOLD PROV NON-COV PENALTY
\$0.00 \$0.00 \$0.00 BILLING PROVIDER ID: EXPLANATION OF REMARKS: (M21) CLAIM FOR SERVICES/ITEMS PROVIDED IN A HOME PROV NON-COV \$0.00 PROV PROV NON-COV \$0.00 NON-COV \$0.00 12 12 TOT UNITS AMOUNT BILLED ALLOWED AMOUNT
1 \$1,620.00 \$1,620.00
1 \$1,620.00 \$1,620.00 PENALTY \$0.00 PENALTY \$0.00 PENALTY \$0.00 PT ACCT AMOUNT BILLED \$3,240.00 AMOUNT BILLED \$3,240.00 AMOUNT BILLED \$3,240.00 AMOUNT BILLED \$3,240.00 BILLING PROVIDER NAME: ATLANTIC SPINE JOINT INSTITUTE ALLOWED AMOUNT \$3,240.00 ALLOWED AMOUNT \$3,240.00 ALLOWED AMOUNT \$3,240.00 ALLOWED AMOUNT \$3,240.00 INSURED NAME MEM MEM 3EM MEM MUST INDICATE THE PLACE OF RESIDENCE NON-COV DEDUCTIBLE \$0.00 \$0.00 NON-COV DEDUCTIBLE \$0.00 \$0.00 NON-COV DEDUCTIBLE \$0.00 \$0.00 NON-COV DEDUCTIBLE \$0.00 \$0.00 USI: CO-PAYMENT \$0.00 \$0.00 CO-PAYMENT \$0.00 CO-PAYMENT \$0.00 CO-PAYMENT \$0.00 CO-PAYMENT \$0.00 **COINSURANCE** \$0.00 \$0.00 COINSURANCE \$0.00 COINSURANCE \$0.00 COINSURANCE \$0.00 COINSURANCE \$0.00 SS/CLM NBR: MEM RESP \$0.00 MEM RESP REMARK CODE(S) \$0.00 M21 \$0.00 M21 MEM RESP \$0.00 MEM RESP \$0.00 MEM RESP \$0.00 OTHER OTHER INS PAY \$0.00 OTHER OTHER INS PAY \$0.00 * INS PAY **0.00 INS PAY AMOUNT PAID \$1,620.00 \$1,620.00 AMOUNT PAID \$3,240.00 AMOUNT PAID \$3,240.00 AMOUNT PAID \$3,240.00 AMOUNT PAID \$3,240.00 INTEREST \$2.13 INTEREST \$2.13 1 THITEREST \$2.13

HOME HEALTH

POS KEY:

12

1500

HEALTH INSURANCE CLAIM FORM

Aetna P.O.Box 981106 El Paso TX 79998

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA
1. MEDICARE MEDICAID TRICARE CHAMPV	A GROUP FECA OTHER HEALTH PLAN BLK LUNG X (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member III	#) (SSN or ID) SER COING X (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6, PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self X Spouse Child Other	
CITY	8. PATIENT STATUS	CITY STATE
-	Single Married X Other	
ZIP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)
	Employed Student Student	I STATE OF THE PROPERTY OF THE ANALYSIS OF THE
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)	a. INSURED'S DATE OF BIRTH SEX
and the threshed of select of all of the mean	YES X NO	M FX
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY SEX	YES X NO	
o. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	Aetna
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d, IS THERE ANOTHER HEALTH BENEFIT PLAN?
DE LO DANGE FORM DEFORE COMPLETIME	O CLONING THE FORM	YES X NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either	release of any medical or other information necessary	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	DATE 03/31/11	_{signed} Signature On File
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	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 TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.	ul I	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
McGrath Robert 17	o. NPI	FROM TO
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)	22. MEDICAID RESUBMISSION
1,1715.16	719.46	ORIGINAL REF. NO.
	•	23. PRIOR AUTHORIZATION NUMBER
2 729.5	<u> 739•3</u>	None
	DURES, SERVICES, OR SUPPLIES E. DIAGNOSIS	F. G. H. I. J. DAYS EPSOT ID. RENDERING OR Family
MM DD YY MM DD YY SERVICE EMG CPT/HCI	CS MODIFIER POINTER	\$ CHARGES UNITS Ren QUAL. PROVIDER ID. #
03 31 11 03 31 11 11 L184	3 LT 1234	1650 00 1 NPI
03 31 11 03 31 11 11 111 4	3 1 HI 1 11234	1 1030 \$ 00 1 1 1 1
03 31 11 03 31 11 11 L184	3 RT	1650 00 1 NPI
		NPI NPI
'		NPI NPI
		I NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S		28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
X 1381-1	YES X NO	\$ 3300,00 \$
INCLUDING DECERTO OF OPERATING	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (856) 854 – 3472
(I certify that the statements on the reverse	Spine & Joint Institute Cuthbert Blvd.	Robert C. McGrath DO
Haddon	Township NJ 08108	654 West Cuthbert Blvd Haddon Township NJ 08108
Robert McGrath D.U. 04/18/13	-	a
SIGNED DATE 7 1 3		

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		Remittance Date Trace/Check. To	For questions 04/25/2011 Control Remittance In ATLANTIC SP	For questions regarding this ERA, please contact the payer 04/25/2011 64/25/2011 Remittance information Only was Automated Cleaninghouse ATLANTIC SPINE JOINT (ease contact the payer contact Cleaninghouse									Addition
Name Procec 97530 97110	lure I.GP Sieted) (Rg Post)	Account Units Paid Original Units Proc. Dat 2	Original Uni	Account Original Units Proc. Date 03/31/2011 - 03/31/2011	S H	CCN	Charge Charge 154.00 154.00 308.00	Allowed 154,00 154,00 308.00	Pat. Portion 0.00 0.00 0.00	Status: Processed as Pri Deductible Co-Insurance 0.00 0.00 0.00 0.00	essed as Prim o-Insurance 0.00 0.00 0.00	Status: Processed as Primary. Deductible Co-Insurance Disallowed 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Reason	Paid 154.00 154.00 308.00
Name, Procedure 97530.GP 97110.GP	e P F F F F F F F F F F F F F F F F F F	Units Paid 2 2 2 2 2 2 Subtotal:	1000	Account	HICE	C.V.	Chaires Chaires Al Chaires Al 154,00 1 154,00 1 308,00 3	Inc. Allowed 154.00 154.00 308.08	Pat. Portion 0.90 0.00 0.00	Status: Processed as Pri Deductible Co-Insurance 0.00 0.00 0.00 0.00	Status: Processed: as Primary. Peducible Co-Insurance Disal 0.00 0.00 0.00 0.00 0.00 0.00	Disallowed 0.00 0.00 0.00	Reason	Paid 154.00 154.00 308.00
Name Procedure 97530.GP 97110.GP (Complete	lure GP GP bleted) (RsP		Accounts Units Paid Original Units Proc. Dat 2 03/30/20 2 03/30/20 alt	Account Original Units Proc. Date 03/30/2011	SHE.	ics:	Charge 1154.00 154.00 308.00	Allowed 154.00 154.00 308.00	Pat. Portion 0.00 0.00	Status: Processed as Pri Deductible Co-Insurance 0.00 0.00 0.00 0.00	Status: Processed as Primary Deductible Co-Insurance Disallowed 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	acy Disallowed 0.00 0.00 0.00	Reason	Paid 154.00 154.00 308.00
Name: Procedure L1843.RT L1843.LT (Complete	Remar Remar d) (Re-B	2 2 7	Account. Units Paid Original Units Proc. Date 1 - 03/31/20 1 - 03/31/20	Account: Original Units Proc. Date 03/31/2011	HC	JONE	Chairri Charge 1650.00 1650.00	Allowed 1113.00 1113.00	Pat. Portion 870.90 870.90	Status: Processed 381Ph Deductible Co-insurance 0.00 333.90 0.00 333.90	Status: Processed 36, 19th mary 2 co-instrance Disallower 0.00 333.90 537.00 0.00 333.90 537.00	Disallowed 537.00 537.00 1074.00	Reason PR-45 PR-45	Pald 779.10 779.10

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HEALTH INSURANCE CLAIM FORM

MEDICARE P O BOX 890031

CAMP HILL PA 17089 0030

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/09								DIO.
PICA			and the second second		· · · · · · · · · · · · · · · · · · ·		1955 A 1455 A 1455	PICA
— — CHAMPUS —	CHAMPVA GROUP (Member ID#) GROUP (SSN or ID)	LAN FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S	I.D. NUMB	ER		(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIR	TH DATE S	EX F	4. INSURED'S N	AME (Last	Name, Fir	st Name	, Middle Initial)
5. PATIENT'S ADDITIES (No., Street)	l <u> </u>	TIONSHIP TO INSUI		7. INSURED'S A	DDRESS (No., Street)	
	Self X Spou	se Child	Other					
CITY	S. PATIENT STAT		_	CITY				STATE
	Single	Married X	Other	.,				
ZIP CODE TFI FPHONE (Include Area Co	·	Full-Time Part	Time	ZIP CODE		TE	LEPHON	IE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Ini		CONDITION RELATE		11. INSURED'S	POLICY G	ROUP OR	FECA N	UMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT	? (Current or Previous	s)	a, INSURED'S D	ATE OF B	IRTH YY		SEX
b. OTHER INSURED'S DATE OF BIRTH	b. AUTO ACCIDE	YES X NO			<u> </u>		M	F
MM DD YY M F		YES X NO	ACE (State)	b. EMPLOYER'S	NAME OF	H SCHOOL	. NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDE	ENT? YES X NO		c. INSURANCE	PLAN NAM	IE OR PRO	GRAM I	NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED F	<u>-</u>		d. IS THERE AN	OTUED UI	EALTH DE	JEET DI	LANO
d. HOUTANDET EAR MAINE OF THOUTAND NAME	TVG. TIEGETTY ED T	CIT ECOAE USE		YES	Пno			to and complete item 9 a-d.
READ BACK OF FORM BEFORE CO	 IPLETING & SIGNING THIS I	FORM.			ш		·	S SIGNATURE I authorize
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorized to process this claim. I also request payment of government bend					nedical ben	efits to the		ned physician or supplier for
below.	nto states to myoon or to the pa	aty into accopic accig		scrvices desc	nibed belo	***		
SIGNATURE ON FILE	DATE_C	16 13		SIGNED S	IGNA	TURE	ON	FILE
14. DATE OF CURRENT: MM DD YY INJURY (Accident) OR	15. IF PATIENT HAS HA	AD SAME OR SIMILA	RILLNESS.	16. DATES PATI	ENT UNA	BLE TO WO	ORK IN C	CURRENT OCCUPATION MM DD YY
PREGNANCY(LMP)	GIVE FIRST DATE	MM DD \	Y	FROM	į į		TC) i i
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE MCGRATH ROBERT	17a. 17b. NPI	_		FROM	DD	YY YY	TC	CURRENT SERVICES MM DD YY
19. RESERVED FOR LOCAL USE				20. OUTSIDE LA	B?		\$ C	CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate I	ems 1, 2, 3 or 4 to Item 24E by	y Line)		22. MEDICAID F		SION		
, 715 16	_{3.1} 729 _{.5}		*	CODE		ORI	GINAL F	REF. NO.
1	o			23. PRIOR AUTI	IORIZATIO	ON NUMBE	:R	
2, 719 46	4			NONE				
	PROCEDURES, SERVICES		E.	F.	р	G. H. AYS EPSD	ı.	J.
1.2020/	Explain Unusual Circumst CPT/HCPCS M	ODIFIER	DIAGNOSIS POINTER	\$ CHARGES		OR Famil NITS Plan	/ ¹⁰ .	RENDERING PROVIDER ID. #
lless programmer progr				1				
01 16 13 01 16 13 12	1843 LT K	[X	123	1620	00 1		NPI	
	1843 RT K		100	1000!	A A 1	1		
01 16 13 01 16 13 12 1	1843 RT K	.X	123	1620	00 1		NPI	
3	1 1			l				
							NPI	
l							NPI	
5	1 1			 			NPI	
	i						1	
							NPI	
	TENT'S ACCOUNT NO.	27. ACCEPT ASSI	GNMENT?	28. TOTAL CHA		1	DUNT PA	AID 30. BAŁANCE DUE
	7 1	X YES	NO	\$ 324	10 00) \$		\$
I INCUIDING DEGDEES OF OPENENTIALS	RVICE FACILITY LOCATION I			33. BILLING PRO				56) 854 3472
(I certify that the statements on the reverse		NT INSTITUTI	3	ROBERT		ICGR <i>I</i>		
apply to this bill and are made a part thereof.) 654	WEST CUTHBERT	вг∧п		654 WES	ST CU	JTHBE	${ m iRT}$	BLVD

HADDON TOWNSHIP NJ 08108

ROBERT MCGRATH D

HADDON TOWNSHIP NJ 08108

a.

Sut Remarks: MAI8, MA01	(Completed) (84-Post) +	L1843.RT.KX	L1843.LT.KX	Procedure	Name
ototair		н	j-4	Units Paid	
		4	9	Original Units Proc. Date	
		01/16/2013	01/16/2013	s Proc. Date	Account
					HIC:
					ICN.)
	3240.00	1620.00	1620.00	Charge	
	1635.34	817.67	817.67		Claim:
!	327.07	163.54	163.53	Pat, Portion	
į	0.00	0.00	0.00	Deductible Co-Insurance	Status: Pr
	327.07	163.54	163.53	o-insurance	ocessed as Pri
	1604,66	802.33	802,33	Disallowed	mary, Forward NSURANCE CO
		CO-45	CO-45	Reason	to Additional i
	1308.27	654.13	654,14	Paid	ayer(s)

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

THE BANK OF NEW YORK MELLON PHILADELPHIA, PA

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

THE

M ATLANTIC SPINE AND J 9 654 WEST CUTHBERT BLVD 8 HADDON TOWN, NJ 08108

02/11/2013

CHECK AMOUNT

VOID-AFTER-180-DAYS-

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 0		37.82		7.56 D.DT02/0	
212738049-611388	3287-1-616 SERV.DT 0	-	229.52	_	42.64 D.DT02/0	
212738049-611389	3287-1-616 SERV.DT 0		177.61		35.52 D.DT02/0	
212738049-611390	3287-1-616 SERV.DT 0		164.30		32.86 D.DT02/0	
212738049-578009	3287-1-616 SERV.DT 0		1635.34		327.07 D.DT02/0	
212738049-675546	3287-1-617 SERV.DT 0	T. 4	130.69		26.14 D.DT02/0	
212738049-675547					45.90 D.DT02/0	

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

1500

HEALTH INSURANCE CLAIM FORM

MEDICARE P O BOX 890031 CAMP HILL PA 17089 0030

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA PICA
1. MEDICARE MEDICAID TRICARE CHAMPV X (Medicare #) (Medicaid #) (Sponsor's SSN) (Member III	HEALTH PLAN BLK LUNG	Ta. 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 MM DD Y	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT HELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
CITY STATE	Self X Spouse Child Other 8. PATIENT STATUS	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	Single X Married Other	ZIP CODE TELEPHONE (Include Area Code)
TEEL HONE (mode Area code)	Employed Full-Time Part-Time Student Student	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)	a. INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State	b. EMPLOYER'S NAME OR SCHOOL NAME
. EMPLOYER'S NAME OR SCHOOL NAME	YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
OF EAST EAST EAST OF SOME OF SOME	YES X NO	C. INSURANCE PLAN NAME OF 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 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the in		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government benefits either below.		services described below.
SIGNED SIGNATURE ON FILE 14. DATE OF CURRENT:	DATE 03 28 13	SIGNATURE ON FILE
▼ PREGNANCY(LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNES: GIVE FIRST DATE MM DD YY	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE MCGRATH ROBERT 17b		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2,	3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.
1. L <u>715</u> , <u>16</u>	729.5 Y	23. PRIOR AUTHORIZATION NUMBER
2. [719.46 4.	<u></u>	NONE
	EDURES, SERVICES, OR SUPPLIES ain Unusual Circumstances) DIAGNOS CS MODIFIER POINTEF	
03 28 13 03 28 13 12 L1843	3 LT KX 123	
· ·		·
03 28 13 03 28 13 12 L1843	3 RT KX 123	1620 00 1 NPI
		NPI NPI
		NPI NPI
		I NPI
		NPI NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	(For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
	X YES NO	\$ 3240 00 \$ /\$ \$ 33. BILLING PROVIDER INFO & PH# (856) 854 3472
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof,) 65.4 WEST	SPINE JOINT INSTITUTE CUTHBERT BLVD	ROBERT C MCGRATH DÓ
ROBERT MCGRATH D O	OWNSHIP NJ 08108	654 WEST CUTHBERT BLVD HADDON TOWNSHIP NJ 08108
SIGNED 04 18 13 a	5.	a , b.

Dan and day	Danier Build	Ontarios of the last	Date Date	
Procedure	OHIS PAIG	Original Cities Proc. Cale	rroc. cale	
L1843,LT,KX	H	f	03/28/2013	
L1843.RT.XX		í	03/28/2013	

CR

Subtotal:

Remarks: MA01

 Charge
 Allowed
 Pat. Portion
 Deductible
 Co-Insurance
 Disallowed
 Reason
 Paid

 1620.00
 817.67
 163.53
 0.00
 163.53
 CO-45
 654.14

 1620.00
 817.67
 163.54
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 654.14

 3240.00
 1635.34
 327.07
 1604.66
 764.13
 1308.27

[1500]

HEALTH INSURANCE CLAIM FORM

Horizon Blue Cross Blue Shield Of New Jers P.O. Box 820 $\,$

Newark NJ 07101-1609

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PICA [T] T
	A GROUP FECA OTH	
1. MEDICARE MEDICAID TRICARE CHAMPV. CHAMPUS (Medicare #) (Medicaid #) (Sponsor's SSN) (Member III	— HEALTH PLAN — BLK LUNG —	(For Fragian & Roll 1)
2. PATIENT'S NAMF (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME // act Name, First Name, Middle Initial)
,	MX F	У(
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
ì	Self X Spouse Child Other	
CITY STATE		CITY STATE
	Single Manied X Other	i i
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
	Employed X Full-Time Part-Time Student	
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)	a. INSURED'S DATE OF BIRTH SEX
T ===	YES X NO	MMX F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State	
M X F	YES X NO	JDJ CONSTRUCTION MGT INC
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
1811 Spring Garden St. PA 191	YES X NO	Horizon Blue Cross Blue Shield
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
Carpenters Health And Welfare		X YES NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either		payment of medical benefits to the undersigned physician or supplier for services described below.
below.		
SIGNED Signature On File	DATE 02/22/13	SIGNED Signature On File
14. DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY INJURY (Accident) OR	IF PATIENT HAS HAD SAME OR SIMILAR ILLNES GIVE FIRST DATE MM DD YY	S. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	GIVE FIRST DATE INIVITED BY	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	i.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
McGrath Robert 17b	NPI	FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
		YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2,	· · · · · · .l.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. <u>1</u> 715 • 16	729 <u>.5</u>	
		23. PRIOR AUTHORIZATION NUMBER
2. <u>1719</u> • 46		None
	DURES, SERVICES, OR SUPPLIES E. un Unusual Circumstances) DIAGNOS	F. G. H. I. J. DAYS #PSOT ID. RENDERING OR Family QUAL. PROVIDER ID. #
MM DD YY MM DD YY SERVICE EMG CPT/HCP	· I	R \$ CHARGES UNITS Plan QUAL. PROVIDER ID. #
02 22 13 02 22 13 11 L184:	3 RT 123	1620 00 1 NPI
	i i i i i i i i i i i i i i i i i i i	1
02 22 13 02 22 13 11 L184:	3 LT 123	1620 00 1 NPI 10
		NPI NPI
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		NPI NPI
		, , , , , , , , , , , , , , , , , , ,
		NPI NPI
OF FEDERAL TAXABLE NUMBER	AND	NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	(For govt. claims, see back)	29. AMOUNT PAID 30. BALANCE DUE
X 3383-1	YES X NO	\$ 3240,00 \$ \$
INCLUDING DEGREES OR CREDENTIALS	CILITY LOCATION INFORMATION Spine & Joint Institute	33. BILLING PROVIDER INFO & PH# (856) 854-3472
(1 certally triat trie statements on the reverse	Cuthbert Blvd.	Robert C. McGrath DO
Haddon T	ownship NJ 08108	654 West Cuthbert Blvd Haddon Township NJ 08108
04/18/13		a. b.
SIGNED TATE O/ 13 a. J		a, J.

CARPENTERS' HEALTH AND WELFARE FUND

1811 SPRING GARDEN STREET PHILADELPHIA, PA 19130-3916

2/28/2013 NO. 00000841232

CLAIM	215-50 SERVICE	08-0430			PROCEDURE	AMOUNT	TOTAL
NUMBER	DATE	SOC SEC NBR MEMBER N	IAME	PATIENT	CODE	CHARGED	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

CARPENTERS' HEALTH AND WELFARE FUND

1811 SPRING GARDEN STREET PHILADELPHIA, PA 19130-3916 This payment made possible by Union Labor

⚠ DOCUMENT IS PRINTED ON CHEMICALLY REACTIVE PAPER - THE BACK OF THIS DOCUMENT INCLUDES A TAMPER EVIDENT CHEMICAL WASH WARNING BOX BNY MELLON, N.A PHILADELPHIA, PA

2/28/2013 NO.

PAY

TWO THOUSAND FOUR HUNDRED DOLLARS AND 00 CENTS

\$ *****2400.00

VOID AFTER 60 DAYS ISSUE

TO THE ORDER OF

UECW 400

ATLANTIC SPINE + JOINT INSTITU 654 WEST CUTHBERT BLVD

HADDON TOWNSHIP NJ 08108