Statement of Account

MITCHELL A KLINE, MD PC
700 PARK AVENUE
NEW YORK, NY 10021
[redacted]

[redacted]		
02/05/2015	0000008048	1

JEFFREY EPSTEIN
9 EAST 71ST STREET
NEW YORK, NY 10021

[redacted]	
02/05/2015	1275.00

Date	Procedure	Description	Charges	Paid by Insurance	Paid By Patient	Adj.	Balance
01/22/2015	99205	New Pt High Complexity	500.00		500.00		
01/22/2015	11100	Biopsy/Skin, 1st	250.00		250.00		
01/22/2015	17000	Dest Ben/Premalig 1st	175.00		175.00		
01/22/2015	17003	Dest Ben/Premal 2-14	350.00		350.00		

MITCHELL A KLINE MD PC
700 PARK AVENUE
NEW YORK, NY 10021
[redacted]

Merchant ID: 000051302443
Term ID: 51302443 Ref #: 0001

Phone Order

[redacted]3001
AMEX Entry Method: Manual

Total: $ 1,275.00

02/05/15 11:13:18
Inv #: 000001 Appr Code: 288078
Approvd: Online Batch#: 000272
Order #:

Customer Copy

THANK YOU!

Days	61 - 90 Days Past Due	[redacted]	[redacted]
	$0.00	$0.00	$0.00

[redacted]
$0.00

CUT ON DOTTED LINE AND SEND WITH PAYMENT

ONTACT melissa@[redacted]

EPSTEIN, JEFFREY
ACCOUNT NO.
0000008048
Statement Date: 02/05/2015

Please remit payment of **$0.00** payable to: MITCHELL A KLINE, MD PC

1500

HEALTH INSURANCE CLAIM FORM

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

UNITEDHEALTHCARE
P O BOX 740800
ATLANTA GA 30374

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (Member ID#) ☒ (SSN or ID) ☐ (SSN) ☐ (ID)	854905597
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) EPSTEIN, JEFFREY	3. PATIENT'S BIRTH DATE MM DD YY: 01 20 1953 SEX M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial) EPSTEIN, JEFFREY	
5. PATIENT'S ADDRESS (No., Street) 9 EAST 71ST STREET	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street) 9 EAST 71ST STREET	
CITY: NEW YORK — STATE: NY	8. RESERVED FOR NUCC USE
CITY: NEW YORK — STATE: NY	
ZIP CODE: 10021 — TELEPHONE (Include Area Code)	
ZIP CODE: 10021 — 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 272605	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO
a. INSURED'S DATE OF BIRTH MM DD YY: 01 20 1953 SEX M ☒ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME UNITEDHEALTHCARE	
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 2015

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
QUAL.	QUAL.	
17. NAME OF REFERRING PHYSICIAN 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 $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L, to service line below (24E) ICD Ind. 9		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. 2382 B. 7020 C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		
I. J. K. L.		

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 22 15	01 22 15	11	N	99205	25	A	500 00	1		NPI	1932136231
01 22 15	01 22 15	11	N	11100	59	A	250 00	1		NPI	1932136231
01 22 15	01 22 15	11	N	17000	59	B	175 00	1		NPI	1932136231
01 22 15	01 22 15	11	N	17003		B	350 00	7		NPI	1932136231
										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. Rsvd for NUCC Use
133843772 ☐ ☒	0000008048	☐ YES ☒ NO	$ 1275 00	$ 1275 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 # 212 517 6555
MITCHELL A KLINE MD PC 02 05 2015 SIGNED DATE	Mitchell A Kline MD 700 Park Ave New York NY 10021 a. 1154489318 b.	MITCHELL A KLINE MD PC 700 PARK AVENUE NEW YORK NY 10021 a. 1154489318 b.

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

EFTA00282965