

1500

UNITEDHEALTHCARE
P O BOX 740800
ATLANTA GA 30374

HEALTH INSURANCE CLAIM FORM

SUBMIT TO YOUR
INSURANCE COMPANY

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN (DOR or ID) FECA (PL 11793) (2080) OTHER

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

3. PATIENT'S BIRTH DATE (MM, DD, YY)
01 20 1953 M F

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

5. PATIENT'S ADDRESS (No. Street)
9 EAST 71ST STREET
CITY NEW YORK STATE NY ZIP CODE 10021 TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No. Street)
9 EAST 71ST STREET
CITY NEW YORK STATE NY ZIP CODE 10021 TELEPHONE (Include Area Code)

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

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER
272605

12. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX
01 20 1953 M F

13. OTHER CLAIM ID (Designated by NUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME
UNITEDHEALTHCARE

15. IS THERE ANOTHER HEALTH BENEFIT PLAN
YES NO If yes, complete items 2, 3, and 9.

16. 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: 04 08 2015

17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)
SIGNED: DATE: 04 08 2015

18. DATE OF ONSET/INJURY or PREGNANCY (MM, DD, YY) QUAL
19. OTHER DATE (MM, DD, YY) QUAL

20. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (1a) (1b) NPI

21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
PAY DIRECTLY TO MEMBER

22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to I to service the bene (I-4)) ICD-9: 9

23. DATE(S) OF SERVICE (From MM, DD, YY To MM, DD, YY) PLACE OF SERVICE (EMG, OP/HCPCS, MODIFIER) DIAGNOSIS POINTER

24. DATE(S) OF SERVICE (From MM, DD, YY To MM, DD, YY) PLACE OF SERVICE (EMG, OP/HCPCS, MODIFIER) DIAGNOSIS POINTER

25. FEDERAL TAX ID NUMBER (EIN/EIN) 133843772

26. PATIENT'S ACCOUNT NO. 0000008046

27. ACCEPT ASSIGNMENT? (Program Name, see back) YES NO

28. TOTAL CHARGE \$ 675.00

29. AMOUNT PAID \$ 675.00

30. BILLING PROVIDER INFO & PI # 212 517 8555
MITCHELL A KLINE MD PC
700 PARK AVENUE
NEW YORK NY 10021

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (I certify that the statements on this invoice apply to the bill and are made a part thereof.)
MITCHELL A KLINE MD PC
04 08 2015
#1154489318

32. SERVICE FACILITY LOCATION INFORMATION
Mitchell A Kline MD
700 Park Ave
New York NY 10021
#1154489318

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0928-1167 FORM 1500 (02-12)

Statement of Account

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

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

Merchant ID: 000000000000
Term ID: 000000000000
Ref ID: 0000

Date	Account
04/08/2015	00000000

Last Payment	
Date	Amount
04/08/2015	

Sale
*****300
MEX Entry Method: Swiped
Total: 1 675.00
04/08/15 18:23:45
Inv #: 000001 Acq Code: 548534
Approval: Online Batch#: 000546

Date	Procedure	Description	Charges	Paid by Insurance	Paid By Patient
04/08/2015	99214	Est Pt Visit Detailed	500.00		500.00
04/08/2015	17000	Dest Ben/Premalig 1st	175.00		175.00

0 - 30 Days Current	31 - 60 Days Past Due	61 - 90 Days Past Due	91 - 120 Days Past Due	> 120 Days Past Due	Patient Balance Due
\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

CUT ON DOTTED LINE AND SEND WITH PAYMENT

Notes:

FOR BILLING INQUIRIES CONTACT [REDACTED]

FOR YOUR RECORDS

EPSTEIN, JEFFREY
ACCOUNT NO.
0000008048
Statement Date: 04/08/2015

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

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

Merchant ID: 000051193746
Term ID: 51193746

Ref #: 0002

Sale

*****3001

AMEX

Entry Method: Swiped

Total: \$ 850.00

04/08/15

11:07:29

Inv #: 000002

Appr Code: 527907

Apprvd: Online

Batch#: 000946

Customer Copy

THANK YOU!