

East Side Medical Radiology PLLC

170 East 77th Street - Lower Level

New York, NY 10075

Phone [REDACTED]

Date JAN. 18, 2018

Patient Last Name EPSTEIN First JEFFREY

Home Address 9 EAST 71ST ST. Apt # _____

City NEW YORK State NY Zip 10021

Country USA

Home Phone [REDACTED]

Date of Birth 01-20-53 SS# [REDACTED] Sex Male Female

Emergency Contact Name KARYNA SHUWAK Relationship FRIEND Phone [REDACTED]

Name of Employer SOUTHERN TRUST COMP. (STC)

Employers Address 6100 RED HOOK QUARTER, SUITE B-3, ST. THOMAS, VI
00802

Primary Insurance Name UNITED HEALTHCARE

Policy Holder Name JEFFREY EPSTEIN Policy Holder Date of Birth JAN 20, 1953

Policy # [REDACTED] Group # 272605

Phone Number of Insurance Company [REDACTED]

Secondary Insurance Name _____

Policy # _____ Group # _____

Phone # of Secondary Insurance Company _____

Policy Holder Name _____ Policy Holder Date of Birth _____

I authorized the release of any medical or other information necessary to process the claim for services rendered to me. I also request payment of government benefits or commercial insurance benefits to myself or the party who accepts the assignment below.

Name JEFFREY EPSTEIN Signature _____ Date JAN. 18, 2018

I authorize payment of medical benefits to the physician or medical practice for the services rendered.

Name JEFFREY EPSTEIN Signature  Date JAN. 18, 2018