Statement of Account

MITCHELL A KLINE, MD PC
[redacted]

Date	Account No.	Page #
03/30/2016	0000008048	1

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

Last Payment	
Date	Amount
04/08/2015	675.00

Date	Procedure	Description	Charges	Paid by Insurance	Paid By Patient	Adj.	Balance
03/30/2016	99214	Est Pt Visit Detailed	450.00				450.00
03/30/2016	11100	Biopsy/Skin, 1st	250.00				250.00
03/30/2016	17000	Dest Ben/Premalig 1st	175.00				175.00
03/30/2016	17003	Dest Ben/Premal 2-14	150.00				150.00
03/30/2016	96904	whole body integumentary photograpy	500.00				500.00

0 - 30 Days Current	31 - 60 Days Past Due	61 - 90 Days Past Due	91 - 120 Days Past Due	> 120 Days Past Due
$1525.00	$0.00	$0.00	$0.00	$0.00

Patient Balance Due
$1525.00

CUT ON DOTTED LINE AND SEND WITH PAYMENT

Notes:

FOR BILLING INQUIRIES CONTACT [redacted]

EPSTEIN, JEFFREY
ACCOUNT NO.
0000008048
Statement Date: 03/30/2016

Please remit payment of **$1525.00** payable to: MITCHELL A KLINE, MD PC

From: [redacted]
Subject: Jeffrey and doctors-Wed. March 30th, 2016
Date: March 29, 2016 at 11:39 AM
To: Bella Klein [redacted]

FYI…Jeffrey is going to see Dr. Magnani tomorrow at 9am and Dr. Kline at 10am (Magnani for a cavity and Kline is a dermatologist)

Statement of Account

MITCHELL A KLINE, MD PC
[redacted]

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

04/07/2016	0000008048	1

04/07/2016	1525.00

Date	Procedure	Description	Charges	Paid by Insurance	Paid By Patient	Adj.	Balance
03/30/2016	99214	Est Pt Visit Detailed	450.00		450.00		
03/30/2016	11100	Biopsy/Skin, 1st	250.00		250.00		
03/30/2016	17000	Dest Ben/Premalig 1st	175.00		175.00		
03/30/2016	17003	Dest Ben/Premal 2-14	150.00		150.00		
03/30/2016	96904	whole body integumentary photograpy	500.00		500.00		

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

Patient Balance Due
$0.00

CUT ON DOTTED LINE AND SEND WITH PAYMENT

Notes:

FOR BILLING INQUIRIES CONTACT [redacted]

EPSTEIN, JEFFREY
ACCOUNT NO.
0000008048
Statement Date: 04/07/2016

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

MITCHELL A KLINE MD PC

[redacted]

04/07/2016 02:56:28 PM
Ref #: 098490653785
Authorization Code: 123648

Total: $1,525.00 USD

Card Number: 37XXXXXXXXX3001
Card Holder: JEFFREY EPSTEIN

Question about this receipt? Call us at .

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

1a. INSURED'S I.D. NUMBER: 854905597 (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE: 01 20 1953 SEX: M [X] 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 [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 9 EAST 71ST STREET

CITY: NEW YORK STATE: NY

8. RESERVED FOR NUCC USE

ZIP CODE: 10021 TELEPHONE (Include Area Code):

CITY: NEW YORK STATE: NY

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 [X]

a. INSURED'S DATE OF BIRTH: 01 20 1953 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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

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 [X] 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: 04 07 2016

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: QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. D225 B. D485 C. L570 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 30 16	03 30 16	11	N	99214	25	A	450 00	1		NPI	1932136231
03 30 16	03 30 16	11	N	11100	59	B	250 00	1		NPI	1932136231
03 30 16	03 30 16	11	N	17000	59	C	175 00	1		NPI	1932136231
03 30 16	03 30 16	11	N	17003		C	150 00	3		NPI	1932136231
03 30 16	03 30 16	11	N	96904		B	500 00	1		NPI	1932136231
										NPI	

25. FEDERAL TAX [redacted] NUMBER SSN EIN: 133843772 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 0000008048

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

28. TOTAL CHARGE: $ 1525 00

29. AMOUNT PAID: $ 1525 00

30. Rsvd for NUCC Use

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.)
MITCHELL A KLINE MD PC
04 07 2016
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Mitchell A Kline MD
[redacted]
a. 1154489318 b.

33. BILLING PROVIDER INFO & PH # 212 517 6555
MITCHELL A KLINE MD PC
[redacted]
a. 1154489318 b.

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

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