IN THE CIRCUIT COURT OF THE 11TH JUDICIAL CIRCUIT IN AND FOR MIAMI-DADE COUNTY, FLORIDA In re: COMPLEX BUSINESS LITIGATION **DIVISION** CRYSTAL CRUISES LLC, a California Case No. 2022-002742-CA-01 limited liability company, Lead Case CRYSTAL HOLDINGS U.S., LLC, a Case No. 2022-002757-CA-01 Delaware limited liability company, CRYSTAL AIRCRUISES, LLC, a Florida Case No. 2022-002758-CA-01 limited liability company, and (Jointly Administered Cases) Assignors, To: MARK C. HEALY, Assignee.

ASSIGNEE'S OBJECTION TO CLAIM OF JACKSON MEMORIAL HOSPITAL

NOTICE OF OPPORTUNITY TO OBJECT AND REQUEST FOR HEARING

PLEASE TAKE NOTICE that, Pursuant to section 727.111(4), Florida Statutes, the assignee may disallow improper claims of creditors, and the Court may consider these actions without further notice or hearing unless a party in interest files an objection within 21 days from the date this paper is served. If you object to the relief requested in this paper, you must file your objection with the Clerk of the Court of Miami-Dade County at 73 W. Flagler Street, Room 133, Miami, FL 33130, and serve a copy on the assignee's attorney, Paul N. Mascia, Esq., Nardella & Nardella, PLLC, 135 W. Central Blvd., Ste. 300, Orlando, FL 32801, and any other appropriate person.

If you file and serve an objection within the time permitted, the Court shall schedule a hearing and notify you of the scheduled hearing.

If you do not file an objection within the time permitted, the assignee and the Court will presume that you do not oppose the granting of the relief requested in the paper.

COMES NOW, Mark C. Healy, Assignee in the above-captioned Assignment proceeding (the "Assignee"), pursuant to Section 727.113 and 727.109(4), files this Objection to Claim of Jackson Memorial Hospital ("Jackson" or "Claimant"), and asserts as follows:

BACKGROUND

- 1. On February 10, 2022, the Crystal Cruises, LLC (the "Assignor") executed and delivered, and the Assignee accepted, an irrevocable Assignment for the benefit of creditors to the Assignee (the "Assignment"). On February 11, 2022, a *Petition Commencing Assignment for the Benefit of Creditors* was filed by the Assignee for the Assignor, thereby commencing the following assignment for the benefit of creditors case pursuant to Chapter 727 of the Florida Statutes, in this Court: *In re Crystal Cruises LLC*, Case No. 2022-002742-CA-01 (the "Assignment Case").
- 2. Prior to the Assignment, Assignor engaged in the business of travel and entertainment business, including operating ocean, river, and expedition cruises and conducting related activities around the world (the "Business").
- 3. The Assignee's address and telephone number are c/o Paul N. Mascia, Esq., Nardella & Nardella, PLLC, 135 W. Central Boulevard, Orlando, Florida 32801 and (407) 966-2680.
- 4. Pursuant to § 727.112(2), *Florida Statutes*, all proofs of claims shall be filed by delivering the claims to the Assignee within 120 days from the filing of the Assignment.
 - 5. In this case, all claims were required to be filed by June 11, 2022 (the "Bar Date").
- 6. This Honorable Court has the power to allow or disallow claims against the estate and determine their priority. *See* § 727.109(4), *Florida Statutes*.

OBJECTION TO CLAIM

7. OVAG International AG ("OVAG"), a debt collection agency, delivered Jackson

Claim No. 2823 in the amount of \$129,288.96 (the "Claim") via email to the Assignee on June 10,

2022, a true and correct copy of which Claim is attached hereto as **Exhibit "A"**.

8. In reviewing the Claim, it is apparent that it has been misdirected against Assignor.

The Claim originates from past due medical charges incurred by Varun Sundriyal, presumably a

onetime third-party contractor of Assignor.

9. Nothing in the proof of claim or supporting documents attached to the Claim

indicate that any of Mr. Sundriyal's medical bills were at any time addressed to or provided to

Assignor. Nor is there any evidence that Assignor ever agreed to pay for the medical services

rendered to Mr. Sundriyal.

10. It appears that OVAG was unable to collect from the actual debtor – Mr. Sundriyal

- and is now attempting to collect against Assignor despite Assignor having no obligation to pay

same.

WHEREFORE, the Assignee respectfully requests the Court enter an order sustaining his

Objection to Jackson's Claim, DENYING the Claim in its entirety and granting any such further

relief that this Court may deem just and proper.

DATED this 8th day of December 2023.

NARDELLA & NARDELLA, PLLC

Co-General Counsel for Assignee

135 W. Central Blvd., Ste. 300

Orlando, FL 32801

(407) 966-2680

By: /s/ Paul N. Mascia

Michael A. Nardella, Esq.

Florida Bar No. 051265

Paul N. Mascia, Esq.

Florida Bar No. 0489670

mnardella@nardellalaw.com

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pmascia@nardellalaw.com kcooper@nardellalaw.com

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was served via the

Florida Court's e-Filing Portal on December 8, 2023, which will serve upon all parties and

interested persons of record in this action; on claimant Montecito Village Travel via email at

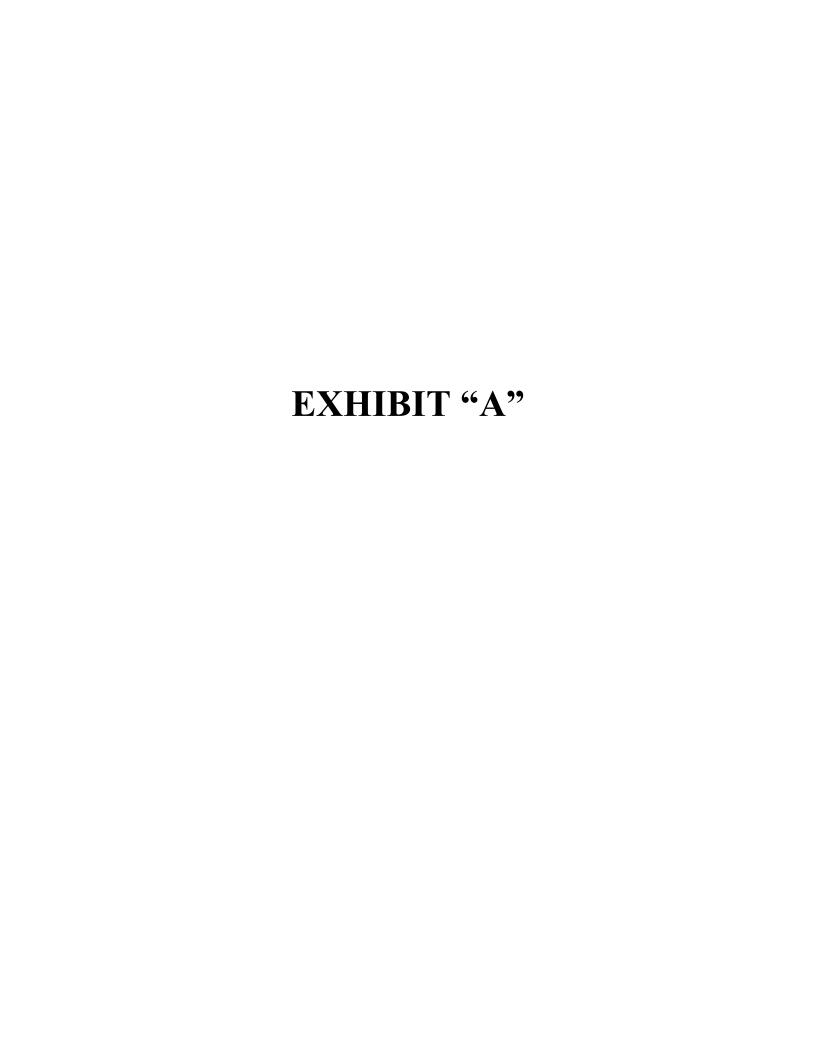
mut@tytc.com and U.S. mail to 3329 State St., Santa Barbara, CA 93105; and via email to

cbl44@jud11.flcourts.org pursuant to CBL Rule 2.2.

By: /s/ Paul N. Mascia

Paul N. Mascia

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IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT, IN AND FOR MIAMI-DADE COUNTY, FLORIDA

			-,
In Re	:		
	CRYSTAL CRUISES, LLC a California Limited Liabili		
	Assignor,		Case No.: 2022-002742 CA 01
To:	MARK C. HEALY,		
	Assignee,	/	
		PROOF OF CLAIM	
ТО	DELIVE THE ASSIGNI	S PROCEEDING, YOU MUST COR IT TO THE ASSIGNEE NO LATE TO THE ASSIGNEE HAEL MOECKER & ASSOCIATION 1885 Marina Mile Blvd., Suite 10 Fort Lauderdale, FL 33315 (4) 252-1560 (954) 252-2791 Info@Moecker.com	E AS FOLLOWS: ES, INC.
1.	CREDITOR NAME (Your name) ADDRESS: TELEPHONE NUMBER: E-MAIL ADDRESS:	1611 NW I	EMORIAL HOSPITAL 2th AVENUE -33136 95 1111
	E-MAIL ADDRESS:	Please be sure to	o notify us if you have a change of address.
2.	BASIS FOR CLAIM: [] Goods Sold [] Services Performed [] Money Loaned	[] Wages, Salaries and Compensa [] Taxes [] Shareholder [] Other:	
3.	DATE DEBT WAS INCURRED:		2021 & JAN 4, 2022
4.	AMOUNT OF CLAIM:	usd 129,057.96	\$129,288.96
		nt of running accounts, court judg	ing documents, such as promissory notes, ments, or evidence of security interests. If the a summary.
6.	SIGNATURE: Sign and print nan	ne and title, if any, of the creditor o	r other person authorized to file this claim:
DATE	D: JUNE 10, 2022	BY: Signature of Claiman	t or Representative
		MISON DAND	EY (ACCOUNT MANAGER)

Print Name and Title Here

INTERNATIONAL AG Zürichstrasse 5 · P.O. Box 6669 6000 Lucerne 6 · Switzerland



November 26, 2021

SUNDRIYAL , VARUN

DOB: 02/14/1992
PHY:

ADM: 11/27/2021
Fin: 40020027436

Sund MR#: 5542571

Sex: M Age: 29Y

PLN: P01.

JACKSON MEMORIAL HOSPITAL 1611 NW 12 AVENUE MIAMI, FL 33136 Tax ID#: 59-1713947

Patient Varun Sundriyal DOB 02/14/1992 ID CC109119

Re: Medical Transfer / Emergency Room Evaluation / Hospital Treatment

In summary of our discussion, Med Solutions International (MSI) and its representatives have been authorized, on behalf of Crystal Cruises, to coordinate the medical transfer / emergency room evaluation / treatment of Mr. Varun Sundriyal. The letter is to serve as authorization for the above noted services. Authorization #0902.

Medical bills should be sent to TPA: Star Healthcare Network 17621 Woodview Terrace Boca Raton, FL 33487 Phone 1914-358-9121 Fax 1914-358-9206

Medical bills will be repriced according to contractual rates with Star Healthcare Network. Patient his \$0 co-pay, \$0 deductible.

We remain available should you have any questions or require further assistance.

Kind regards,

Julie Licari
Managing Director
Med Solutions International
E-mail: ops@medsolutionsint.com

57 West 57 Street, 4th Floor, New York, NY 10019 Phone 1646-404-3314, Fax 1646-514-5147, <u>www.MedSolutionsInt.com</u>

Wilson Dandey

From: Med Solutions International <ops@medsolutionsint.com>

Sent: 13.05.2022 18:29

To: Wilson Dandey; nflores@starhealthcarenet.com; info@starhealthcarenet.com
Cc: Med Solutions International

Subject: RE: STAR HEALTH NY - Claim Nr. CC109119 - Jackson Memorial Hospital USA - Case

12687 006706

Attachments: Crystal Cruises Proof of Claim Form.pdf

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Good afternoon,

As you may have been informed, Crystal Cruises filed for bankruptcy in January 2022, thus suspending all payments due. We recently received the following link with instructions for submitting reimbursement claims: https://crystalcruiseclaims.com/

Kindly submit all documentation for pending claims as outlined in instructions soonest.

We sincerely apologize for this inconvenience and thank you for your understanding.

Regards,

Julie Licari
Managing Director
Med Solutions International
Phone + 1646-404-3314
Fax +1646-514-5147
Ops@MedSolutionsInt.com

From: Wilson Dandey <wdan@ovag.ch>
Sent: Friday, May 13, 2022 12:19 PM

To: nflores@starhealthcarenet.com; info@starhealthcarenet.com; Med Solutions International

<ops@medsolutionsint.com>

Subject: STAR HEALTH NY - Claim Nr. CC109119 - Jackson Memorial Hospital USA - Case 12687 006706

Star Health Claim Nr. CC109119

Patient name: Varun Sundriyal (born 14 February 1992)

Employer: CRYSTAL CRUISES OVAG Ref: 12687 006706

Provider's name: Jackson Memorial Hospital USA Date of Service / Provider's reference / Amount 27 Nov -30 Dec 2021 / 40020027436 / USD 129,057.96

4 Jan 2022 / 40020066477 / USD 231.00

Total charges: USD 129,288.96

Dear Claims,

We represent the above medical provider in relation to the billing and collection of its international patients' accounts.

Please provide us with an update on the status of this claim that we have been instructed to collect by our client resulting from the hospitalization of your insured.

Kindly find attached the LOA for review.

Please pay the outstanding balance directly to the provider or by bank transfer into the indicated bank account, mentioning the OVAG reference on the transaction. You may also send a cheque made payable to OVAG International to our address.

Bank transfer details:

Bank – Banesco USA / Beneficiary – OVAG International AG / Bank address – 150 Alhambra Circle suite 100, 33134 Coral Gables, FL, USA / Account N°. – 1000216828 / ABA routing – 067015779 / Swift/BIC Code – BBUBUS33XXX / Reference – 12687 006706

If you have any queries or require any further documentation please contact us, to the contrary we await your confirmation of payment or denial with the EOB.

Yours sincerely,

Wilson Dandey OVAG International AG

Tel: + 41 41 379 03 03 Direct Tel. + 41 41 379 03 31

Facsimile. + 41 41 379 03 74 E-mail. wdan@ovag.ch

http://www.ovag-international.com/

Confidentiality notice: The contents of this electronic transmission are confidential and intended only for the individual or entity named above and not for third party unauthorized distribution or dissemination of whatsoever nature. Any inadvertent or unauthorized disclosure of whatsoever nature shall not compromise or waive the confidentiality of this transmission. It may contain information that is protected by the laws of a number of countries. If you are not the named recipient you should destroy it and are to notify the sender. If you are not the intended recipient and act on or otherwise disclose this information, you may be committing an offence. The contents of an attachment to this e-mail may contain viruses, which could damage your own computer system. While the sender has taken every reasonable precaution to minimize this risk, we cannot accept liability for any damage, which you sustain as a result of viruses. You should carry out your own virus checks before opening any attachments to this e-mail. Opinions, conclusions and other information in this message that do not relate to the official business of OVAG International AG shall be understood as neither given nor endorsed by it.



September 24, 2020

To whom it may concern:

Please be advised that OVAG International is a HIPAA Compliant agency contracted to collect on past due international accounts for Jackson Memorial and with whom we hold a Business Associate Agreement.

Any additional information needed by OVAG International should be released without and additional authorization forms or communication to be completed by OVAG or us.

Should you have any further questions please do not hesitate to contact OVAG International directly, they can provide you with any and all information you may require concerning this case.

We value our relationship with all patients and payers, as well as with OVAG International and request your complete cooperation with OVAG International in issuing, expediting payment and information without delay.

Should you need further information or wish to contact the undersigned please do so at 786-466-8135.

Sincerely yours,

Yorka Faldraga, MHSA

Associate Administrator, CBO Jackson Health System 1500 NW 12Th Ave, West 10Th Floor Miami, Florida 33136

(786) 466-8135

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UB-04 NOTICE:

THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY URON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

- If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
- If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
- Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
- For Religious Non-Medical facilities, verifications and if necessary recertifications of the patient's need for services are on file.
- Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
- 6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
- 7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
- For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
- 9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

- (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
- (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
- (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
- (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0997. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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UB-04 NOTICE:

THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

- 1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
- 2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
- 3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
- 4. For Religious Non-Medical facilities, verifications and if necessary recertifications of the patient's need for services are on file.
- 5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
- 6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
- 7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
- 8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
- 9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

- (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
- (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits:
- (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts;
- (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
- (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0997. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

HCI :	DATE OF DATE BILL PREV.B	1611 N MIAMI, 877 88	ON HEALTH IW 12TH AV FL 31-6177 59171394	ENUE			05 RTH-DATE 2/14/92	PAGE NO.
I SUNDI	S PATIENT NAME RIYAL , VARUN	4 0 0 2			on date dischar 27/21 12/3	ge DATE DAYS 30/21 33		
	UAR PH: (000)00							
GUARANTOR NAME AND ADDRESS	VARUN SUNDR 137 YAMUNA V DELHI 00009 INDIA			2 P	INSURANCE COMPAI 06 INTL M 01 SELF PA	ISC INS	0214	Y NUMBER 19119 1992
						AMOUNT PAYMENT	0F \$	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
L1/27	L OF CURRENT C: 2420950 001		YMENTS AND	ADJUSTME 16.50	NTS			
1/27	IDAZOLE IV 5001 2423432 002		63.85	63.85				
1/27	YCIN HCL, 500 1 2423806 003 /TAZOBA,1G/1.		71.80	71.80				
1/27	2429026 001 YL CITRATE 2ML		16.50	16.50	1			
1/27	2429338 001 SULF 10MG-4MG		16.50	16.50				
NJECT	4074226 001 ION IV, SINGLE/	IN96374	249.00	249.00				
NJECT	4074227 001 ION IV, NEW DR	UG96375	235.00	235.00				
CV HYD	4074228 001 RTN INIT 31-90	MI96360	316.00	316.00				
IV INF	4074230 001 USN INIT 16-90	MI96365	286.00	286.00				
IV INF	4074232 001 ,ADD SEQ,NEW D 0310009 001	RU96367	159.00	159.00 113.00				
ANTIBO	DY SCREEN EACH 0310105 001	T86850	153.00	153.00				
BLOOD	TYPING SEROLOG 0310106 001	IC86900	90.00	90.00				
11/27	PE SERO RH D 1808047 001	86901	26.45	26.45				
11/27	EBA HISTOLYTIC 1823411 001		184.00	184.00				
11/27	E, SERUM 1823417 001 BIN, TOTAL	82150 82247	85.00	85.00			ė.	
11/27	1823476 001 , SERUM	83690	138.00	138.00		₩		
PATIENT	NUMBER PLEASE REFER NUMBER ON ALI AND CORRESPON	INQUIRIES	FOR ANY OMENT WAS	L PATIENT BILLII CHARGES NOT POSTE PREPARED, OR IF AY ANY PART OF TH	D WHEN THIS STATE INSURANCE CARRIER E AMOUNTS SHOWN	:-		

	DATE OF DATE OF PREV.BILL AL 01/05/22 S PATIENT NAME DRIYAL , VARUN UAR PH: (000)000-	1611 NI MIAMI, 877 88 FEI # PATIE 4002	1-6177 59171394 nt number s	7 EX AGE ADMISSI M 29 11/ C.O.B 1 Z 2 P	27/21 12/ INSURANCE COMPA 06 INTL M 01 SELF P.	GE DATE DAYS 30/21 33 NY NAME GROUP	NUMBER POLICE CC10 0214	
DATE OF	DESCRIPTION OF	SERVICE	TOTAL	EST. COVERAGE	EST. COVERAGE	AMOUNT PAYMENT EST. COVERAGE	OF S S EST. COVERAGE	PATIENT
SERVICE	HOSPITAL SERVICES	CODE	CHARGES	INS.CO. NO. 1	INS.CO. NO. 2	INS.CO. NO. 3	INS.CO. NO. 4	AMOUNT
	1825069 001	0.050	454.00	454.00				
	METABOLIC PANEL 8 1832218 001	0053	209.00	209.00				
CBC W	AUTO DIFF 8	5025	120 MI MI M M M M					
	1832263 001 ROMBIN TIME 8	5610	76.00	76.00				
11/27	1832264 001		94.00	94.00				
PTT 11/27	8 1840139 001	5730	145.00	145.00				
COVID	9 PANEL U	0004		54 97 92 92 70 0				
	1844702 001 CULTURE AEROBIC 8	7040	341.00	341.00		1		
11/27	1844702 001		341.00	341.00				
	CULTURE AEROBIC 8 1844711 001	7040	91.00	91.00				
	C CULT ISO & PRE8	7070	91.00	91.00				
	1844711 001	7070	91.00	91.00				
	C CULT ISO & PRE8 1844712 001	7070	112.00	112.00				
ANAERO	BIC CULT ISO & P8	7075						
	1844712 001 BIC CULT ISO & P8	7075	112.00	112.00				
11/27	1844715 001		61.00	61.00				
	FOR BACTERIA 8 1844715 001	7205	61 00	61.00				
		7205	61.00	01.00		*		
	2859764 001		2856.00	2856.00				
	DED ABSC DRAINAG7 2859764 001	5989	2856.00-	2856.00-				
JS GUI	DED ABSC DRAINAG7	5989						
	2871010 001 1 VIEW 7	1045	391.00	391.00				
	2800158 001	1013	5999.00	5999.00				
CT ABI	OMEN+PELVIS W/ C7	4177						

PATIENT

NUMBER

GUARANTOR NAME AND	DATE OF BILL PREV.BI L 01/05/22 S PATIENT NAME RIYAL , VARUN UAR PH: (000)00 VARUN SUNDRI 137 YAMUNA N	1611 MIAMI, 877 88 FEI #	31-6177 59171394 LENT NUMBER S	ENUE 7 EX AGE ADMISSI M 29 11/ C.O.B 1 2	ON DATE DISCHAR 27/21 12/. INSURANCE COMPA 06 INTL M: 01 SELF P:	GE DATE DAYS 30/21 33 NY NAME GROUP ISC INS	RTH-DATE 2/14/92 NUMBER POLICE CC10	
ADDRESS	DELHI 00009 INDIA			A	RAGUEZ-AN	CARES, NAY	'LE	
			1911			AMOUNT PAYMENT	OF S	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
IMAGE	2850365 002 CATH FLUID COLY 4070094 001	KN49405 99285	4452.00	4452.00 1857.00				
11/27	3290007 001 OA12	99263	1815.00	1815.00				
11/28	2420950 001	AC T3 4 0 0	16.50	16.50	,			
11/28	IDAZOLE IV 5001 2420950 001		16.50	16.50				
11/28	IDAZOLE IV 5001 2420950 001		16.50	16.50				
11/28	IDAZOLE IV 5001 2422825 002		38.60	38.60				
11/28	YCIN 750 MG IN 2422825 002		38.60	38.60				
11/28	YCIN 750 MG IN 2422825 002		38.60	38.60				
11/28	YCIN 750 MG IN 2422825 002		38.60	38.60				
11/28	YCIN 750 MG IN 2422825 002		38.60-	38.60-				
11/28	YCIN 750 MG IN 2426359 001		133.20	133.20				
11/28	ME 500MG-2GM I 2426359 001		133.20	133.20				
	ME 500MG-2GM I 2426359 001	NJJ0692	133.20	133.20				
	ME 500MG-2GM I 2426493 004	NJJ0692	31.45	31.45				
	ARIN 10MG- 40M 2429337 001	G J1650	16.50	16.50				
MORPH 11/28	SULF 10MG-2MG 2429337 001 SULF 10MG-2MG		16.50	16.50				
Tr	DIL TOHO PH	0.102270						
PATIENT	NUMBER PLEASE REFER	TO PATIENT	ADDITIONA	L PATIENT BILLI	NO MAY BE WEGEN			
	NUMBER ON ALL AND CORRESPOND	INQUIRIES	FOR ANY MENT WAS	CHARGES NOT POSTE PREPARED, OR IF AY ANY PART OF TH	NHEN THIS STATE	z-		

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILE
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INP.		

JACKSON HEALTH SYSTEM 1611 NW 12TH AVENUE MIAMI, FL 877 881-6177 FEI # 591713947

331361005 BIRTH-DATE 02/14/92

AMOUNT OF

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I S PAT	TIENT NAME	PATIENT	NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE	DATE	DAYS	
SUNDRIYAL	,VARUN 40	02002	7436	М	29	11/27/21	12/30	/21	33	

GUAR PH: (000)000-0000

		C.O.B INSURANCE COMPANY NAME GROUP NUMBER POLICY NUMBER	R
GUARANTOR NAME AND ADDRESS	VARUN SUNDRIYAL 137 YAMUNA VIHAR DELHI 00009 INDIA	1 Z06 INTL MISC INS CC109119 2 P01 SELF PAY 02141992	
		ARAGUEZ-ANCARES, NAYLE	

DESCRIPTION SERVICE PATIENT TOTAL EST. COVERAGE INS.CO. NO. 3 EST. COVERAGE EST. COVERAGE HOSPITAL SERVICES CHARGES INS.CO. NO. SERVICE INS.CO. NO. 1 INS.CO. NO. 2 11/28 2429337 001 16.50 16.50 MORPH SULF 10MG-2MG CAJ2270 11/28 1808047 001 26.45 26.45 ENTAMOEBA HISTOLYTICA 86753 11/28 1823480 001 120.00 120.00 MAGNE\$IUM, SERUM 83735 11/28 1823915 001 239.00 239.00 HEP B CORE ANTIBODY IG86705 11/28 1823917 001 239.00 239.00 HEP A ANTIBODY IGM 86709 11/28 1823918 76.00 76.00 HEP C ANTIBODY 86803 11/28 1823919 001 175.00 175.00 HEP B SURFACE ANTIGEN 87340 11/28 1825069 001 454.00 454.00 80053 COMP METABOLIC PANEL 209.00 209.00 11/28 1832218 001 CBC W AUTO DIFF 85025 51.00 11/28 1840135 001 51.00 STAPH AUREUS PCR 87640 11/28 1840136 001 51.00 51.00 MRSA PCR 87641 3.85 11/28 2421586 001 3.85 FOLIC ACID TAB 1MG U/DD00241 11/28 2421728 3.85 3.85 001 MULTIVITAMIN U/D D03140 11/28 2422240 001 8.00 8.00 FAMOTIDINE 20MG TAB U/D00141 8.00 11/28 2422240 8.00 001 FAMOTIDINE 20MG TAB U/D00141 2422240 8.00 8.00 11/28 001 FAMOTIDINE 20MG TAB U/D00141 3.85 3.85 11/28 2426661 001 TRAMADOL 50MG UD TAB D03826 PATIENT NIMBER PATIENT BILLING MAY BE NECESSARY PLEASE REFER TO PATIENT ADDITIONAL

NUMBER ON ALL INQUIRIES AND CORRESPONDENCE. ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

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	S PATIENT NAME RIYAL , VARUN	4 0			on date dischar 27/21 12/3	GE DATE DAYS 30/21 33		
GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA N DELHI 00009 INDIA	IYAL		2 P	INSURANCE COMPAI 0 6 INTL MI 0 1 SELF PI RAGUEZ-ANO	ISC INS	0214	Y NUMBER 19119 11992
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ATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO.	PATIENT A AMOUNT
RAMADO 1/28 .OOM 1 1/29 !ETRON 1/29 !ETRON 1/29 !ETRON 1/29	2426661 001 OL 50MG UD TAB 3280002 001 B605 2420950 001 IDAZOLE IV 5000 2420950 001 IDAZOLE IV 5000 2420950 001 IDAZOLE IV 5000 2422825 002	MGJ3490 MGJ3490 MGJ3490	3.85 1815.00 16.50 16.50 16.50 38.60	3.85 1815.00 16.50 16.50 16.50 38.60				
1/29 ANCOM	YCIN 750 MG IN 2422825 002 YCIN 750 MG IN 2426359 001		38.60 133.20	38.60 133.20				
1/29 EFEPI	ME 500MG-2GM I 2426359 001 ME 500MG-2GM I		133.20	133.20				
NOXAP.	2426493 004 ARIN 10MG- 40M 2429337 001	G J1650	31.45	31.45 16.50				
ORPH 1/29	SULF 10MG-2MG 1823417 001 BIN, TOTAL	CAJ2270 82247	85.00	85.00			-	
L/29	1823504 001 AST)	84450	68.00	68.00				
GPT (1823505 001 ALT)	84460	68.00	68.00		4		
ANCOM	1823550 001 YCIN LEVEL 1823900 001	80202	184.00	184.00 314.00				
ASIC 1/29	METABOLIC PANE 1832218 001 AUTO DIFF	L 80048 85025	209.00	209.00				
PATIENT	NUMBER PLEASE REFER NUMBER ON ALL AND CORRESPON	INQUIRIES	FOR ANY O MENT WAS DO NOT PA	L PATIENT BILLI CHARGES NOT POSTE PREPARED, OR IF AY ANY PART OF TH IMATED INSURANCE	O WHEN THIS STATE INSURANCE CARRIER E AMOUNTS SHOWN			

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I	S PATIENT NAME	PATII	ENT NUMBER S	SEX AGE ADMISS	ION DATE DISCHAR	GE DATE DAYS		
	RIYAL , VARUN		0027436	M 29 11/	27/21 12/3	30/21 33		
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GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA VI DELHI 00009 INDIA			2 P	O6 INTL MI 01 SELF PA	ISC INS AY	NUMBER POLICY CC10 0214	9119
				A	RAGUEZ-AN	CARES, NAY	LiE	1
						AMOUNT OF PAYMENT	of s	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	2421586 001 ACID TAB 1MG U/I	DD00241	3.85	3.85				
11/29 DOCUSA	2421722 001 TE SODIUM 100MG		3.85	3.85				
	2421728 001 ITAMIN U/D	D03140	3.85	3.85				
11/29	2422240 001		8.00	8.00				
11/29	DINE 20MG TAB U, 2422240 001		8.00	8.00				
11/29	DINE 20MG TAB U, 3280002 001 B605	/D00141	1815.00	1815.00			-	
11/30	2420950 001 IDAZOLE IV 500M	5.13490	16.50	16.50				
11/30	2426359 001 ME 500MG-2GM IN		133.20	133.20				
	2426359 001 ME 500MG-2GM IN	JJ0692	133.20	133.20			ı	
11/30	2426493 004 ARIN 10MG- 40MG		31.45	31.45			1	
11/30	2426493 004 ARIN 10MG- 40MG		31.45	31.45				
11/30	2427955 001 IDAZOLE 500MG TA		3.85	3.85				
11/30	1800537 001 ABS+RFLXTITER 1		15.65	15.65				
11/30	1800538 001 ABS+RFLXTITER 2		13.50	13.50				
11/30	1800539 001 ABS+RFLXTITER 3		13.50	13.50				
11/30	1800540 001 ABS+RFLXTITER 4		13.50	13.50				
11/30	1801007 001 COCCUS AB Q	86682	87.88	87.88				

PATIENT NUMBER PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE. ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE—MENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI TYPE O BILL FINA INP.	F DATE OF DATE OF BILL PREV.BII	1611 N MIAMI, 877 88	1-6177 59171394	ENUE	ION DATE DISCHAR		05 RTH-DATE 2/14/92	PAGE NO.
	RIYAL , VARUN		0027436	M 29 11/	27/21 12/	30/21 33		
guarantor name and address	VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA	YAL		2 P	INSURANCE COMPA 06 INTL M 01 SELF P RAGUEZ-AN	ISC INS	0214	• NUMBER 9119 1992
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DATE OF	DESCRIPTION OF	SERVICE	TOTAL	EST. COVERAGE	EST. COVERAGE	EST. COVERAGE	EST. COVERAGE	PATIENT
SERVICE	HOSPITAL SERVICES	CODE	CHARGES	INS.CO. NO. 1	INS.CO. NO. 2	INS.CO. NO. 3	INS.CO. NO. 4	AMOUNT
E. C. S.	1825069 001	0.0053	454.00	454.00				
	ETABOLIC PANEL 1832218 001	80053	209.00	209.00		_		
	AUTO DIFF	85025		20000				
	1844720 001	07177	275.00	275.00				
	ARASITES FECAL 1845087 001	87177	138.00	138.00				
O&P TE	RICHROME STAIN	87209	~ ~ ~ ~ ~ ~ ~ ~					
	1845087 001	07200	138.00	138.00				
	RICHROME STAIN 1850220 001	87209	141.00	141.00				
EIA HI	V-1&HIV-2 AB SN	IG87389	NAME OF THE OWN PARTY.					
- 101 A 4-0 40	2789789 001 TO W/DOPPLER + C	'0C8929	2573.00	2573.00				
	2421586 001	9 2 2 3	3.85	3.85				
	ACID TAB 1MG U/	DD00241						
	2421722 001 TE SODIUM 100MG	F D01021	3.85	3.85				
	2421722 001	. DOIOZI	3.85	3.85				
DOCUSA	TE SODIUM 100MG	G D01021						
	2421722 001 TE SODIUM 100MG	D01021	3.85	3.85				
11/30	2421728 001		3.85	3.85				
	ITAMIN U/D	D03140	0.00	0.00				
	2422240 001 DINE 20MG TAB U	J/D00141	8.00	8.00				
11/30	2422240 001		8.00	8.00			1	
	DINE 20MG TAB (3280002 001	J/D00141	1015 00	1015 00				
ROOM			1815.00	1815.00				
12/01	2426359 001		133.20	133.20				
	ME 500MG-2GM IN 2426359 001	1JJ0692	133.20	133.20				
	ME 500MG-2GM IN	NJJ0692	133.20	133.20				

PATIENT

NUMBER

	F DATE OF DATE OF BILL PREV.BII	1611 N MIAMI, 877 88 FEI #	1-6177 5917139	/ENUE 17 sex age admiss:			BIF)5 RTH-DATE 2/14/92	PAGE NO
GUARANTOR NAME AND ADDRESS		YAL		2 P	INSURANCE COMPA 06 INTL M 01 SELF P RAGUEZ-AN	ISC INS AY		CC10 0214	y NUMBER 9119 91992
ATE OF	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE	EST. COVERAGE	EST. COVER		EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
2/01	2426493 004	CODE	31.45	31.45	INS.CO. NO. 2	INS.CO. NO). 3	INS.CO. NO. 4	AMOUNT
NOXAP 2/01	PARIN 10MG- 40MG 2427955 001 HIDAZOLE 500MG T		3.85	3.85					
2/01	2427955 001 IIDAZOLE 500MG T		3.85	3.85					
2/01	2427955 001 IIDAZOLE 500MG T		3.85	3.85					
2/01	2427955 001		3.85	3.85		1			
2/01	IIDAZOLE 500MG T 1823550 001		184.00	184.00					
	1YCIN LEVEL 1825069 001	80202	454.00	454.00					
	TETABOLIC PANEL 1832218 001	80053	209.00	209.00					,
	AUTO DIFF 1844711 001	85025	91.00	91.00					
2/01	C CULT ISO & PR 2711010 001 1 VIEW	E87070 71045	391.00	391.00					
2/01	2421586 001 ACID TAB 1MG U/		3.85	3.85					
2/01	2421722 001		3.85	3.85					
2/01	ATE SODIUM 100MG 2421722 001		3.85	3.85					
2/01	ATE SODIUM 100MG 2421722 001		3.85	3.85					
2/01	TE SODIUM 100MG 2421728 001		3.85	3.85					
2/01	71TAMIN U/D 2422240 001	D03140	8.00	8.00					
TTOMA	DINE 20MG TAB U	/D00141	[1			1

PATIENT

NUMBER

HCI TYPE 0 BILL FINA INP.	F DATE OF DATE PREV.BI	JACKSO 1611 N MIAMI, 877 88 FEI #	31-6177 59171394	SYSTEM ENUE 7	ON DATE DISCHAR		05 RTH-DATE 2/14/92	PAGE NO. 9 HOSP.NO.
SUND	RIYAL , VARUN	4002	CHECKED STREET CONTROL			30/21 33		
GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA N DELHI 00009 INDIA	[YAL		2 P	INSURANCE COMPAI 06 INTL M 01 SELF PA	ISC INS	NUMBER POLICY CC10 0214	9119
DATE OF	DESCRIPTION OF	SERVICE	TOTAL	EST. COVERAGE	EST. COVERAGE	AMOUNT PAYMENT EST. COVERAGE	OF \$	PATIENT
SERVICE	HOSPITAL SERVICES	CODE	CHARGES	INS.CO. NO. 1	INS.CO. NO. 2	INS.CO. NO. 3	INS.CO. NO. 4	AMOUNT
	0810150 001	TOSOSE	300.00	300.00				
	ROCARDIOGRAM, 12 3070002 001	ТАЗООЗ	1815.00	1815.00				
ROOM	1047		100 15	100 15				
	2423206 008 AXONE SOD 250M	G-J0696	103.15	103.15				
12/02	2426493 004		31.45	31.45				
Second Second	PARIN 10MG- 40M0 2426493 004	G J1650	31.45	31.45				
ENOXA	ARIN 10MG- 40MG	G J1650	31.10	31.13	1			
	2427955 001 IIDAZOLE 500MG '	TAD00108	3.85	3.85				
	2427955 001	IADUUIUU	3.85	3.85				
	IIDAZOLE 500MG '	TAD00108	2 05	2 25				
	2427955 001 IDAZOLE 500MG '	TAD00108	3.85	3.85				
	1825069 001	111000100	454.00	454.00				
	ETABOLIC PANEL 1832218 001	80053	209.00	209.00				
		85025	209.00	209.00				
12/02	2421586 001		3.85	3.85				
	ACID TAB 1MG U 2421722 001	/DD00241	3.85	3.85				*
	TE SODIUM 100M	G D01021	3.03	٥.٥٥				
	2421722 001	C D01001	3.85	3.85				
	TE SODIUM 100M 2421722 001	G D01021	3.85	3.85				
DOCUSA	TE SODIUM 100M	G D01021		2007 57 100 1007				
	2421722 001 TE SODIUM 100M	G D01021	3.85	3.85				
	2421728 001	O DOTOST	3.85	3.85				
	VITAMIN U/D	D03140	0.00	0.00				
	2422240 001 DINE 20MG TAB	U/D00141	8.00	8.00				
PATIENT	NUMBER PLEASE REFER			L PATIENT BILLI			l	
	NUMBER ON ALL AND CORRESPON		MENT WAS	CHARGES NOT POSTE PREPARED, OR IF AY ANY PART OF TH	INSURANCE CARRIER			
				AY ANY PART OF TH FIMATED INSURANCE				

	S PATIENT NAME ORIYAL , VARUN GUAR PH: (000)00	1611 N MIAMI, 877 88 FEI # 4002 0-0000		7		GGE DATE DAYS 30/21 33 NY NAME GROUP ISC INS	NUMBER POLICY	NUMBER 9119
				A	RAGUEZ-AN	CARES, NAY		
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	AMOUNT PAYMENT EST. COVERAGE INS.CO. NO. 3	OF S EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	2422240 001	50,5000	8.00	8.00		1101001		
	DINE 20MG TAB U 3070002 001	/D00141	1815.00	1815.00		<u> </u>		
	1047 2423206 008		103.15	103.15				
	AXONE SOD 250MG 2426493 004	-J0696	31.45	31.45				
2/03	ARIN 10MG- 40MG 2427955 001		3.85	3.85				
2/03	IIDAZOLE 500MG T 2427955 001		3.85	3.85				
2/03	IIDAZOLE 500MG T 2427955 001		3.85	3.85				
2/03	JIDAZOLE 500MG T 1825069 001		454.00	454.00				
2/03	1832218 001	80053	209.00	209.00				
2/03	AUTO DIFF 2800158 001	85025	5999.00	5999.00				
2/03	OOMEN+PELVIS W/ 2806810 001		2241.00	2241.00				
2/03	ST DGNSTIC W/ C 2421586 001		3.85	3.85				
2/03	ACID TAB 1MG U/ 2421722 001		3.85	3.85				
2/03	TE SODIUM 100MG 2421722 001		3.85	3.85		,		
2/03	TE SODIUM 100MG 2421722 001 TE SODIUM 100MG		3.85	3.85				
2/03	2421728 001		3.85	3.85				
L2/03	'ITAMIN U/D 2422240 001 DINE 20MG TAB U	D03140	8.00	8.00				
	DIAL ZUNG TAD U	, 500111						

HCI TYPE 01 BILL FINA INP.	F DATE OF BILL L 01/05/2	DATE O PREV.BIL	JACKS 1611 MIAMI 877 8 FEI #	81-6177 59171394	SYSTEM ENUE 7		С	05 RTH-DATE 2/14/92	PAGE NO. II			
	S PATIENT RIYAL , VA UAR PH: (ARUN	400			and the second second	30/21 33					
GUARANTOR NAME AND ADDRESS	NAME AND 137 YAMUNA VIHAR 2 PO1 SELF PAY 02141992											
DATE OF	DESCRIPTION	OF	SERVICE	TOTAL	EST. COVERAGE	EST. COVERAGE		OF \$	PATIENT			
SERVICE	HOSPITAL SE	ERVICES	CODE	CHARGES	INS.CO. NO. 1	INS.CO. NO. 2	INS.CO. NO. 3	INS.CO. NO. 4	AMOUNT			
TAMOT	2422240 DINE 20MC		/D00141	8.00	8.00							
ROOM	3070002 1047 2423206	001		1815.00	1815.00							
CEFTRI	AXONE SOI		-J0696	103.15	103.15							
ENOXA	PARIN 10MC		J1650	31.45	31.45							
METRON	NIDAZOLE 5		AD00108	3.85	3.85							
METRON	IDAZOLE 5		AD00108	3.85	3.85							
METRON	IIDAZOLE 5 1825069	500MG T	AD00108	454.00	3.85							
COMP N	ETABOLIC 1832218		80053	209.00	209.00							
CBC W	AUTO DIFI 1832263	F	85025	76.00	76.00							
PROTHE	ROMBIN TIN 2421586		85610	3.85								
FOLIC	ACID TAB		DD00241		3.85							
DOCUSA	TE SODIU	M 100MG	D01021	3.85	3.85							
DOCUSA	TE SODIU		D01021	3.85	3.85		1					
DOCUSA	2421722 TE SODIUM 2421722	M 100MG	D01021	3.85	3.85							
DOCUSA	TE SODIU	M 100MG	D01021	3.85	3.85							
MULTIV	2421728 /ITAMIN U	/ D	D03140	3.85	3.85							
	2422240 DINE 20M		/D00141	8.00	8.00							
PATIENT	NU	EASE REFER T MBER ON ALL D CORRESPONDE	INQUIRIES	FOR ANY (MENT WAS DO NOT PA	CHARGES NOT POSTE		-					

HCI TYPE 0 BILL FINA INP.	F DATE OF DATE OF BILL PREV.BIL	JACKSO 1611 N MIAMI, 877 88 FEI #	N HEALTH IW 12TH AV FL 31-6177 59171394	SYSTEM 'ENUE		(005 ERTH-DATE 02/14/92	PAGE NO. 12 HOSP.NO.
I	S PATIENT NAME	PATI	ENT NUMBER \$			30/21 33		
	RIYAL ,VARUN JUAR PH: (000)00				21/21 12/	30/21 33		
				C.O.B	INSURANCE COMPA	NY NAME GROUP	NUMBER POLIC	Y NUMBER
GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA			1 Z	06 INTL M 01 SELF P.	ISC INS	CC10	9119
				А	RAGUEZ-AN	CARES, NAY	LE	
						AMOUNT PAYMENT	OF Ş	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO.	PATIENT AMOUNT
12/04 FAMOTI	2422240 001 DINE 20MG TAB U	/D00141	8.00	8.00				
12/04 ROOM	3070002 001 1047		1815.00	1815.00				
12/05	2423206 008 AXONE SOD 250MG	- 10696	103.15	103.15				
12/05	2426493 004 PARIN 10MG- 40MG		31.45	31.45				
12/05	2427955 001		3.85	3.85				
12/05	IIDAZOLE 500MG TI 2427955 001		3.85	3.85				
12/05	IIDAZOLE 500MG TA 2427955 001		3.85	3.85				
12/05	IIDAZOLE 500MG TI 1821659 001		147.00	147.00				
	TIVE PROTEIN 1823480 001	86140	120.00	120.00				
	SIUM, SERUM 1825069 001	83735	454.00	454.00				
12/05	IETABOLIC PANEL 1832218 001	80053	209.00	209.00				
	AUTO DIFF 1832272 001	85025	75.00	75.00				

SEDIMENTATION RATE AUT85652 12/05 2421586 001 3.85 3.85 FOLIC ACID TAB 1MG U/DD00241 12/05 2421722 001 3.85 3.85 DOCUSATE SODIUM 100MG D01021 12/05 2421722 001 3.85 3.85 DOCUSATE SODIUM 100MG D01021 12/05 2421722 001 3.85 3.85 DOCUSATE SODIUM 100MG D01021 12/05 2421728 001 3.85 3.85 MULTIVITAMIN U/D D03140

PATIENT NUMBER PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE. ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

SUNDRIYAL GUAR PI GUARANTOR VAI NAME AND 13 ADDRESS DEI INI	H: (000)000 RUN SUNDRIY 7 YAMUNA VI LHI 00009 DIA	4002)-0000 (AL IHAR	0027436	M 29 11/.	ON DATE DISCHARGE 27/21 12/3 INSURANCE COMPAN 06 INTL MI 01 SELF PA	NY NAME GROUP ISC INS	NUMBER POLICY CC10 0214	9119
GUARANTOR VAINAME 137 AND ADDRESS DETINATION OF THE PROPERTY O	RUN SUNDRIY 7 YAMUNA VI LHI 00009 DIA	(AL IHAR		1 Z 2 P	06 INTL MI 01 SELF PA	ISC INS	CC10	9119
DATE OF DESCRIPTIONS DATE OF SERVICE 12/05 24222 FAMOTI DINE	7 YAMUNA VI LHI 00009 DIA	IHAR		1 Z 2 P	06 INTL MI 01 SELF PA	ISC INS	CC10	9119
DATE OF DESCRIPTION OF THE PROPERTY OF THE PRO	IPTION OF					CARES, NAY	LE	
SERVICE HOSPI 12/05 24222 FAMOTIDINE						AMOUNT (OF \$	
12/05 24222 FAMOTIDINE		SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
FAMOTIDINE :	40 001		0 00		244	TOWNS OF STREET		-
2/05 24222		/D00141	8.00	8.00				
			8.00	8.00				
AMOTIDINE . 2/05 30700	20MG TAB U/ 02 001	/D00141	1815.00	1815.00				
OOM 1047	02 001		1013.00	1613.00				
2/06 24232	06 008		103.15	103.15				
Section and and inches and an inches	SOD 250MG-	-J0696	27.45	54 45				
2/06 24264	93 004 10MG- 40MG	.T1.650	31.45	31.45				
2/06 24279		01030	3.85	3.85				
ETRONIDAZO	LE 500MG TA	AD00108		78. T 30.				
2/06 24279			3.85	3.85				
ETRONIDAZO		AD00108	2 05	2 0 5				
.2/06 24279 METRONIDAZO		AD00108	3.85	3.85				
2/06 18035			150.00	150.00				
ADENOSINE D	EAMINASE FI	L84311						
18200	77 001	03000	6.00	6.00				
FLUID PH 12/06 18216	59 001	83986	147.00	147.00				
-REACTIVE		86140	147.00	147.00				
2/06 18234			102.00	102.00				
SLUCOSE FLU		82945						
2/06 18234		02725	120.00	120.00				
MAGNE\$IUM, L2/06 18250		83735	454.00	454.00				
COMP METABO		80053	104.00	104.00				
12/06 18322	18 001		209.00	209.00				
CBC W AUTO		85025		m = -=				
12/06 18322 PROTHROMBIN		85610	76.00	76.00				
12/06 18322		85610	94.00	94.00				
PTT		85730						
								I
			1	1			Ti control of the con	1

PATIENT

NUMBER

HCI: TYPE OF BILL FINAL INP.	DATE OF DATE OF BILL PREV.BILL	JACKSON 1611 NW MIAMI, 877 881	12TH A FL	SYS VENU	STEM			331		05 RTH-DATE 2/14/92	PAGE N
I	S PATIENT NAME	PATIENT	F. A. P. S. C.	_		SSION DATE		GE DATE	DAYS		
	RIYAL , VARUN UAR PH: (000)000		027436	M 2	29 11	/27/21	12/3	30/21	33		
l I	UAK PH: (000)000	-0000			С.О.В	Insuranc	E COMPAI	TY NAME	GROUP	NUMBER POLIC	Y NUMBER
GUARANTOR NAME AND ADDRESS	VARUN SUNDRIY. 137 YAMUNA VI DELHI 00009 INDIA				2	Z06 IN P01 SE	LF PA	ΑY		CC10	09119 41992
						ARAGUE	Z-ANO	CARES,	. NAY	LE	
									AMOUNT (of s	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES		. COVERAGE			EST. CO		EST. COVERAGE INS.CO. NO.	PATIENT 4 AMOUNT
						İ	NO. 2	ING.CO.	но. з	2327377	
	1832272 001 NTATION RATE AUT	85652	75.00		75.00						
	1832656 001	03032	184.00	1	184.00						
		89051									
	1844704 001	07116	154.00	1	L54.00						
	LTURE ISO & PRES 1844705 001	8/116	98.00		98.00						
	AST STAIN FOR BA	87206	30.00		20.00						
2/06	1844707 001		107.00	1	107.00						
	TRATION OF SAMPL	87015	101 00		01 00						
	1844709 001 CULT ISO & PRSM	87102	101.00	L .1	101.00						
	1844710 001	07102	82.00		82.00						
ет мф		87210									
	1844711 001	07070	91.00		91.00						
	C CULT ISO & PRE 1844712 001	0/0/0	112.00	1	112.00						
	BIC CULT ISO & P	87075	00	1 "							
	1844715 001		61.00		61.00						
		87205	275.00		75 00						
		87177	213.00	2	275.00						
	1845087 001	cone so estate al Si	138.00	1	L38.00						
		87209	100								
	1845087 001 ICHROME STAIN	87209	138.00		138.00						
	1870001 001	01209	57.83		57.83						
YTOPA	TH CELL ENHANCE	88112									
	2421586 001	D00047	3.85	0	3.85						
	ACID TAB 1MG U/D 2421722 001	000241	3.85		3.85						
	TE SODIUM 100MG	D01021	٥.00		3.03						
2/06	2421722 001		3.85		3.85	,					
OCUSA	TE SODIUM 100MG	D01021									1

PATIENT NUMBER PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE. ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

36 0							
HCI TYPE OF BILL FINA INP.	DATE OF DATE OF MILL D1/05/22 87	CKSON HEALTH 11 NW 12TH AV AMI, FL 7 881-6177 I # 59171394	ENUE			005 RTH-DATE 02/14/92	PAGE NO 15
I	S PATIENT NAME				GE DATE DAYS		
	RIYAL , VARUN UAR PH: (000)000-0000		M 29 11/	27/21 12/3	30/21 33		
9	T TOUCHURG COOK		с.о.в	INSURANCE COMPA	w www Tanaun		
GUARANTOR NAME AND ADDRESS	VARUN SUNDRIYAL 137 YAMUNA VIHAR DELHI 00009 INDIA		1 Z 2 P	06 INTL M: 01 SELF P?	ISC INS	0214	9119 1992
					AMOUNT PAYMENT	of ş	
DATE OF SERVICE	DESCRIPTION OF SERVICE HOSPITAL SERVICES CODE		EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
2/06	2421722 001	3.85	3.85				
OCUSA	TE SODIUM 100MG D0102 2421728 001		3.85				
ULTIV	TITAMIN U/D D0314 2422240 001	0 8.00	8.00				
2/06	DINE 20MG TAB U/D0014 2422240 001	8.00	8.00				
2/06	DINE 20MG TAB U/D0014 3070002 001	1815.00	1815.00				
2/07	1047 2420855 020 AINE HCL 10MG-1%2J2001	16.50	16.50				
2/07	2423205 004 AXONE SOD 250MG-J0696	16.50	16.50				
2/07		103.15	103.15				
ENOXA	2426493 004 ARIN 10MG- 40MG J1650	31.45	31.45				
1ETRON	2427955 001 IDAZOLE 500MG TAD0010	200	3.85				
METRON	2427955 001 IIDAZOLE 500MG TAD0010		3.85				
ENTAN	2429026 001 YYL CITRATE 2ML J3010 2429282 002		16.50				
MIDAZO	2429282	16.50	16.50 16.50				_
MORPH	SULF 10MG-2MG CAJ2270 2429337 001		16.50				
MORPH	SULF 10MG-2MG CAJ2270 2429337 001		16.50				
12/07	SULF 10MG-2MG CAJ2270 2429337 001 SULF 10MG-2MG CAJ2270	16.50	16.50				
JONEU	SOLI TONG-ZNG CAUZZ/C						

PATIENT

NUMBER

	F DATE OF DATE PREV.BI	MIAMI, 877 88 FEI #	31-6177 59171394 LENT NUMBER S	PENUE 7 SEX AGE ADMISS M 29 11/		GE DATE DAYS 30/21 33	IRTH-DATE	
GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA			2 P	O6 INTL MO1 SELF PROPERTY OF THE PROPERTY OF T	ISC INS AY	0214	99119 11992
DATE OF	DESCRIPTION OF HOSPITAL SERVICES	SERVICE	TOTAL CHARGES	EST. COVERAGE	EST. COVERAGE	AMOUNT PAYMENT EST. COVERAGE	EST. COVERAGE	PATIENT 4 AMOUNT
SERVICE	2845630 002	CODE	1846.00	1846.00	INS.CO. NO. 2	INS.CO. NO. 3	INS.CO. NO.	i www.i
FISTUI L2/07	A/SINUS TRACT 2847415 002	76080	1928.00	1928.00				
12/07	OF CATHETER/DR 2847425 001 AGRAM/ABSCESSOG		923.00	923.00	li .			
12/07	2847425 001 AGRAM/ABSCESSOG		923.00-	923.00-				
2/07	2849087 002 EXCH OF ABSC CA		6520.00	6520.00				
SED >5	2839891 001 YRS 1ST 15MIN S	A99152	397.00	397.00				
SED EA	2839893 003 ADD 15 MIN;SAM	IE99153	546.00	546.00				
	2421586 001 ACID TAB 1MG U/	DD00241	3.85	3.85				
	2421722 001 TE SODIUM 100MG	G D01021	3.85	3.85				
12/07	2421722 001 TE SODIUM 100MG		3.85	3.85				
12/07	2421728 001 'ITAMIN U/D	D03140	3.85	3.85				
12/07	2422240 001 DINE 20MG TAB U		8.00	8.00				
12/07	2422240 001		8.00	8.00				
12/07	DINE 20MG TAB U 2426661 001 OOL 50MG UD TAB		3.85	3.85				
12/07	3070002 001	DUSOZO	1815.00	1815.00				
L2/08	1047 2426493 004	71.650	31.45	31.45				
IAXON	ARIN 10MG- 40MG 2427955 001	J1650		3.85				1

PATIENT

NUMBER

HCI YPE OF BILL FINA INP.	F DATE OF DATE OF BILL PREV.BIL	1611 I MIAMI 877 88	ON HEALTH NW 12TH AV , FL 31-6177 59171394	ENUE			005 ERTH-DATI 02/14/92	PAGE NO.
	S PATIENT NAME RIYAL , VARUN	400			on date dischar 27/21 12/			
G	UAR PH: (000)00	0-0000		C.O.B	INSURANCE COMPA	NY NAME GROUP	NUMBER POLIC	CY NUMBER
ARANTOR NAME AND DDRESS	VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA			2 P	06 INTL M 01 SELF P	AY	021	09119 41992
				A	RAGUEZ-AN	CARES, NAY	LE	
						AMOUNT PAYMENT	of §	
E OF	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO.	E PATIENT 4 AMOUNT
	2427955 001		3.85	3.85				
/08	IIDAZOLE 500MG T 2429337 001		16.50	16.50				
/08	SULF 10MG-2MG C 2429337 001		16.50	16.50	1			
/08	SULF 10MG-2MG C 2429337 001		16.50	16.50				
/08	SULF 10MG-2MG C 2421586 001		3.85	3.85				
/08	ACID TAB 1MG U/ 2421722 001		3.85	3.85				
/08	TE SODIUM 100MG 2421722 001		3.85	3.85				
/08	ATE SODIUM 100MG 2421722 001		3.85	3.85				
/08	ATE SODIUM 100MG 2421728 001		3.85	3.85				
/08	/ITAMIN U/D 2422240 001	D03140	8.00	8.00				
/08	DINE 20MG TAB U 2422240 001	W 084 30 W 877 W 17	8.00	8.00				
/08	DINE 20MG TAB U 2426661 001		3.85	3.85				
/08	OL 50MG UD TAB 3070002 001 1047	D03826	1815.00	1815.00				
/09	2426493 004 PARIN 10MG- 40MG	11.650	31.45	31.45				
/09	7ARIN 10MG- 40MG 2427955 001 IIDAZOLE 500MG 1		3.85	3.85				
/09	2427955 001 IDAZOLE 500MG T		3.85	3.85				
/09	11DAZOLE 500MG 1 2427955 001 IIDAZOLE 500MG 1		3.85	3.85				
ATIENT	NUMBER PLEASE REFER T NUMBER ON ALL			L PATIENT BILLI CHARGES NOT POSTE				

HCI TYPE 0 BILL FINA INP. I	F DATE OF DATE BILL PREV.B	0F 1611 N MIAMI, 877 88 FEI #	1-6177 59171394 ent number s	ENUE 7 EX AGE ADMISSI	ON DATE DISCHAR 27/21 12/	C	005 RTH-DATE 02/14/92	PAGE NO. 18 HOSP.NO.
	UAR PH: (000)00	00-0000		с.о.н 1 Z 2 P	INSURANCE COMPA 06 INTL M 01 SELF PA	NY NAME GROUP	NUMBER POLICY CC10 0214	9119
DATE OF	DESCRIPTION OF	SERVICE	TOTAL	EST. COVERAGE	EST. COVERAGE	AMOUNT PAYMENT EST. COVERAGE	OF \$	PATIENT
METRON 12/09 MORPH 12/09 MORPH 12/09 MORPH 12/09 MORPH 12/09 MORPH 12/09 TR 12/09	## HOSPITAL SERVICES 2427955 001 IDAZOLE 500MG 1 2429337 001 SULF 10MG-2MG 0 2429337 001 SULF 10MG-2MG 0 1825069 001 ETABOLIC PANEL 1832218 001 AUTO DIFF 1844720 001 RASITES FECAL 1845087 001 ICHROME STAIN 1845087 001 ICHROME STAIN 2421586 001 ACID TAB 1MG U/ 2421722 001 TE SODIUM 100MG 2421728 001 ITAMIN U/D 2422240 001 DINE 20MG TAB G 2422240 001 DINE 20MG TAB G 3070002 001 1047 2426493 004 PARIN 10MG- 40MG	CAJ2270 CAJ2270 80053 85025 87177 87209 87209 /DD00241 GD01021 GD01021 D03140 U/D00141 U/D00141	3.85 16.50 16.50 454.00 209.00 275.00 138.00 3.85 3.85 3.85 3.85 3.85 8.00 8.00 1815.00 31.45	3.85 16.50 16.50 454.00 209.00 275.00 138.00 138.00 3.85 3.85 3.85 3.85 3.85 3.85 3.85 3.85	TNS.CO. NO. 2	TNS.CO. NO. 3	INS.CO. NO. 4	AMOUNT
PATIENT	NUMBER PLEASE REFER NUMBER ON ALL AND CORRESPOND	INQUIRIES	FOR ANY C MENT WAS DO NOT PA	. PATIENT BILLIN HARGES NOT POSTEI PREPARED, OR IF Y ANY PART OF TH IMATED INSURANCE	WHEN THIS STATE INSURANCE CARRIER E AMOUNTS SHOWN			

HCI TYPE OF BILL FINA INP.	DATE OF DATE OF BILL PREV.BIL	1611 N MIAMI, 877 88	N HEALTH W 12TH AV FL 1-6177 59171394	ENUE			05 RTH-DATE 2/14/92	PAGE NO. 19 HOSP.NO.
	S PATIENT NAME RIYAL , VARUN				on date dischar			
GUARANTOR NAME AND ADDRESS	UAR PH: (000)00 VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA	YAL		2 P	INSURANCE COMPA 06 INTL M 01 SELF P RAGUEZ-AN	ISC INS	0214	Y NUMBER 09119 11992
						AMOUNT PAYMENT	of s	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO.	PATIENT AMOUNT
METRON L2/10	2427955 001 IDAZOLE 500MG T 2427955 001		3.85	3.85 3.85				
2/10	IDAZOLE 500MG T 2427955 001 IDAZOLE 500MG T		3.85	3.85				
2/10 IORPH	2429337 001 SULF 10MG-2MG C		16.50	16.50				
T EVA	4810362 001 L INTERMEDIATE 2421586 001	97166	446.00 3.85	446.00				
OLIC 2/10	ACID TAB 1MG U/ 2421722 001		3.85	3.85				
2/10	TE SODIUM 100MG 2421722 001		3.85	3.85				
2/10	TE SODIUM 100MG 2421722 001 TE SODIUM 100MG		3.85	3.85				
2/10 ULTIV	2421728 001 ITAMIN U/D	D03140	3.85	3.85				
TAMOT	2422240 001 DINE 20MG TAB U	J/D00141	8.00	8.00				
TAMOT	2422240 001 DINE 20MG TAB U 3070002 001	J/D00141	8.00	8.00 1815.00				
2/11	1047 2426493 004		31.45	31.45				
2/11	ARIN 10MG- 40MG 2427955 001 IDAZOLE 500MG T		3.85	3.85				
2/11	2427955 001 IDAZOLE 500MG 1		3.85	3.85				
	2427955 001 IDAZOLE 500MG 1	FAD00108	3.85	3.85				
PATIENT	NUMBER PLEASE REFER TO NUMBER ON ALL AND CORRESPONDE	INQUIRIES	FOR ANY (MENT WAS DO NOT PA	L PATIENT BILLI CHARGES NOT POSTE PREPARED, OR IF AY ANY PART OF TH CIMATED INSURANCE	D WHEN THIS STATE INSURANCE CARRIES E AMOUNTS SHOWN	E-		

ndriyal, N	Varun Enc# 40020027436				5/2022 1pg				
HCI TYPE OF BILL FINA INP.	F DATE OF DATE OF BILL PREV.BIL	JACKSC 1611 N MIAMI, 877 88	N HEALTH SYSTEM W 12TH AVENUE FL 1-6177 591713947			331361005 BIRTH-DATE HOSP.NO. 02/14/92			
I	S PATIENT NAME	PATI	ENT NUMBER S	SEX AGE ADMISS	ION DATE DISCHAR	GE DATE DAYS			
	RIYAL , VARUN		0027436	M 29 11/	27/21 12/	30/21 33			
G	UAR PH: (000)00	0-0000							
GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA			2 P	O6 INTL M O1 SELF P.	ISC INS AY	CC109119 02141992		
				A	RAGUEZ-AN	CARES, NAI	; P.B.		
						AMOUNT PAYMENT	OF \$		
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE PATIENT INS.CO. NO. 4 AMOUNT		
12/11	2427955 001		3.85	3.85					
	IDAZOLE 500MG T	AD00108							
STATE OF THE PART	2421586 001	3.85	3.85						
	ACID TAB 1MG U/ 2421722 001	3.85	3.85						
Source (C) NO Section (C)	TE SODIUM 100MG	3.03	3.03						
	2421722 001	3.85	3.85						
DOCUSA	TE SODIUM 100MG								
	2421722 001	3.85	3.85						
	TE SODIUM 100MG								
	2421728 001	3.85	3.85						
	ITAMIN U/D 2422240 001	0 00	0 00						
	DINE 20MG TAB U	/0001/1	8.00	8.00					
	2422240 001	8.00	8.00						
	AMOTIDINE 20MG TAB U/D00141								
12/11	3070002 001	1815.00	1815.00						
ROOM				Tara Pine Control					
	2426493 004	71.650	31.45	31.45					
	ARIN 10MG- 40MG 2427955 001	J1650	2 05	3.85					
1127	2427955 001 IDAZOLE 500MG T.	3.85	3.83						
	2427955 001	3.85	3.85						
102	IDAZOLE 500MG T.	AD00108							
12/12	2427955 001		3.85	3.85					
	IDAZOLE 500MG T	AD00108	30 30 300	7620 KG NOT					
	2421586 001	5500011	3.85	3.85					
	ACID TAB 1MG U/	0000241	2 05	2 0 5					
	2421722 001 TE SODIUM 100MG	3.85	3.85						
	2421722 001	3.85	3.85		i				
	TE SODIUM 100MG		0.00						
	2421722 001	3.85	3.85						

PATIENT PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE. NUMBER

DOCUSATE SODIUM 100MG D01021

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI # TYPE OF BILL FINAL INP.	DATE OF DATE BILL PREV.BI	JACKSO 1611 I MIAMI 877 8	ON HEALTH NW 12TH AV , FL 81-6177 59171394	ENUE			05 RTH-DATE [2/14/92	PAGE NO. 21
	S PATIENT NAME RIYAL , VARUN	400.	M 10 12 10 10 10 10 10 10 10 10 10 10 10 10 10		on date dischar 27/21 12/3	AND DESCRIPTION OF THE PARTY OF		
GUAR PH: (000)000-0000 COLUMN SUNDRIYAL 1 206 INTL MISC INS 1 1 206 INTL MISC INS 206 INT								
						AMOUNT PAYMENT	DF S	
ATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3		TIENT OUNT
	2421728 001		3.85	3.85				
2/12 2	ITAMIN U/D 2422240 001	D03140	8.00	8.00				
~ 1	DINE 20MG TAB (2422240 001	J/D00141	8.00	8.00				
	DINE 20MG TAB (3070002 001	J/D00141	1815.00	1815.00				
	1047 2426493 004		31.45	31.45				
OXAP	ARIN 10MG- 40M0 2427955 001	J1650	3.85	3.85				
ETRON	IDAZOLE 500MG	TAD00108						
ETRON:	2427955 001 IDAZOLE 500MG :	TAD00108	3.85	3.85				
ETRON	2427955 001 IDAZOLE 500MG :	TAD00108	3.85	3.85				
	2427955 001 IDAZOLE 500MG 1	TAD00108	3.85-	3.85-				
2/13	2427955 001 IDAZOLE 500MG 1		3.85-	3.85-				
2/13	2800158 001 OMEN+PELVIS W/		5999.00	5999.00				
2/13	2421586 001 ACID TAB 1MG U		3.85	3.85				
2/13	2421722 001		3.85	3.85				
2/13	TE SODIUM 100M0 2421722 001		3.85	3.85				
2/13	TE SODIUM 100M 2421722 001		3.85	3.85				
	TE SODIUM 100M0 2421728 001	G D01021	3.85	3.85				
2/13	ITAMIN U/D 2422240 001 DINE 20MG TAB	D03140 U/D00141	8.00	8.00				
PATIENT	NUMBER PLEASE REFER NUMBER ON ALL AND CORRESPOND	INQUIRIES	FOR ANY O	L PATIENT BILLIO CHARGES NOT POSTE PREPARED, OR IF NY ANY PART OF TH	D WHEN THIS STATE INSURANCE CARRIES			

	DE DATE OF BILL PREV.BILL AL 01/05/22 S PATIENT NAME DRIYAL , VARUN GUAR PH: (000)000-0	1611 NI MIAMI, 877 88 FEI # PATIE 4002	1—6177 59171394 мт мимвек s	7 ENUE 7 AGE ADMISS M 29 11/ C:0.8 1 Z 2 P	ION DATE DISCHAR 27/21 12/ INSURANCE COMPA 06 INTL M 01 SELF P.	IGE DATE DAY 30/21 3 NY NAME GI ISC INS AY CARES, N	BIRTH-DATE 02/14/92 SS S3 ROUP NUMBER POLICE 0214	
DATE OF	DESCRIPTION OF S HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE	EST. COVERAGE	PAYM EST. COVERAG	ENT BE EST. COVERAGE	PATIENT AMOUNT
service		5555	8.00	INS.CO. NO. 1	INS.CO. NO. 2	INS.CO. NO.	J 243.00. 20. 4	
FAMOTI	DINE 20MG TAB U/DC 3070002 001	00141	1815.00	1815.00				
	1047 2426493 004		31.45	31.45				,
12/14	PARIN 10MG- 40MG J1 2427955 001		3.85	3,85				
12/14	VIDAZOLE 500MG TADO 2427955 001 VIDAZOLE 500MG TADO		3.85	3.85				
12/14	11DAZOLE 500MG TADO 2427955 001 NIDAZOLE 500MG TADO		3.85	3.85				
12/14	2421586 001 ACID TAB 1MG U/DD0		3.85	3.85				
12/14	2421722 001 ATE SODIUM 100MG DO		3.85	3.85	*			
12/14	2421728 001 VITAMIN U/D DO		3.85	3.85				
12/14	2422240 001 DINE 20MG TAB U/DO		8.00	8.00				
12/14	2422240 001 DINE 20MG TAB U/DO		8.00	8.00				
12/14	3070002 001 1047	a LV sees is state	1815.00	1815.00				
12/15	2426493 004 PARIN 10MG- 40MG J1	L650	31.45	31.45			AT .	
12/15	2427955 001 IDAZOLE 500MG TADO		3.85	3.85				
12/15	2427955 001 IDAZOLE 500MG TADO		3.85	3.85				
12/15	2427955 001 IDAZOLE 500MG TADO		3.85	3.85				
	2421586 001 ACID TAB 1MG U/DD0	00241	3.85	3.85				

PATIENT

NUMBER

HCI TYPE 01 BILL FINA INP.	DATE BILL D1/05 S PATIL	PREV.BI	JACKSO 1611 MIAMI 877 8 FEI #	81-6177 59171394 TENT NUMBER SI	SYSTEM ENUE 7 EX AGE ADMISSI		GE DATE DAYS	05 RTH-DATE 2/14/92	PAGE NO. 23
	RIYAL , UAR PH:	(000)00		20027436			30/21 33		
GUARANTOR NAME AND ADDRESS	137	N SUNDRI YAMUNA V I 00009 A			2 P	INSURANCE COMPAI 06 INTL M 01 SELF PA	ISC INS	0214	9119 1992
							AMOUNT PAYMENT	0F \$	
DATE OF SERVICE	DESCRIPT HOSPITAL	ION OF SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
12/15	2421722	001		3.85	3.85				
	TE SODI 2421728	UM 100MC	G D01021	3.85	3.85				
ULTIV	ITAMIN	U/D	D03140	3.03	3.03				
	2422240 DINE 20) 001)MG TAB (J/D00141	8.00	8.00				
12/15	2422240	001		8.00	8.00				
	3070002	MG TAB (001	J/D00141	1815.00	1815.00				
	1047 2420855	020		16.50	16.50				
LIDOCA	INE HCI	10MG-19	2J2001	322 : 93					
	2426493 ARIN 10	3 004)MG-40M0	J1650	31.45	31.45				
12/16	2427955	001		3.85	3.85				
	2427955	500MG 5 001	LAD00108	3.85	3.85				
		500MG	FAD00108	2 05	2 05				
	2427955 IIDAZOLE	001 500MG :	FAD00108	3.85	3.85				
	2429026		T2010	16.50	16.50				
	2845630	RATE 2ML	J3010	1846.00	1846.00				
	A/SINUS 2847425		76080	923.00	923.00				
FISTUI	LAGRAM/A	ABSCESSO	GR76080				ě:		
	2847425 AGRAM/ <i>I</i>	5 001 ABSCESSO	GR76080	923.00-	923.00-				
12/16	2849086	002		1876.00	1876.00				
	2421586	SCESS CA' 5 001	1149424	3.85	3.85				
FOLIC	ACID TA	AB 1MG U	/DD00241						,
	2421722 ATE SOD	2 001 IUM 100M	G D01021	3.85	3.85				
						2			
PATIENT	NUMBER	PLEASE REFER NUMBER ON ALL	INQUIRIES		L PATIENT BILLI CHARGES NOT POSTE				
		AND CORRESPOND	DENCE.	MENT WAS DO NOT PA	PREPARED, OR IF AY ANY PART OF TH TIMATED INSURANCE	INSURANCE CARRIES E AMOUNTS SHOWN			

GUARANTOR	DF DATE OF BILL PREV.BIL AL 01/05/22 S PATIENT NAME DRIYAL , VARUN GUAR PH: (000)00	1611 N MIAMI, 877 88 FEI # 4002		7 ENUE 7 AGE ADMISS M 29 11/	137	RGE DATE DAYS 30/21 33	NUMBER POLICE	
NAME AND ADDRESS	137 YAMUNA V DELHI 00009 INDIA	IHAR			01 SELF P	CARES, NAY	/LE	1992
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
12/16 MULTIV 12/16 FAMOTI 12/16 FAMOTI 12/16 ROOM 12/17 ENOXAF 12/17 METRON 12/17 METRON 12/17 COVIDI 12/17 CETIRI 12/17 CETIRI 12/17 FOLIC 12/17 MULTIV 12/17 FAMOTI	2426493 004 PARIN 10MG- 40MG 2427955 001 IIDAZOLE 500MG T 2427955 001 IIDAZOLE 500MG T 2427955 001 IIDAZOLE 500MG T 110AZOLE 500MG T	/D00141 J1650 AD00108 AD00108 U0004 DD00241 D01021 D03140	3.85 8.00 8.00 1815.00 31.45 3.85 3.85 145.00 3.85 3.85 3.85 3.85	3.85 8.00 8.00 1815.00 31.45 3.85 3.85 3.85 145.00 3.85 3.85 3.85 3.85 3.85 3.85				
ROOM 12/18	3070002 001 1047 2426493 004 PARIN 10MG- 40MG	J1650	1815.00	1815.00 31.45				,

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

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PATIENT

NUMBER

HCI TYPE OF BILL FINA INP.	DATE	/22 PREV.BI	JACKSO 1611 N MIAMI,	1-6177 59171394	SYSTEM ENUE 7	ON DATE DISCHAR		05 RTH-DATE 2/14/92	PAGE NO. 25
	RIYAL ,	VARUN (000)00		0027436	M 29 11/	27/21 12/3	30/21 33		
GUARANTOR NAME AND ADDRESS	137 YAMUNA VIHAR 2 P01 SELF PAY 021419								
								OF §	
DATE OF SERVICE	DESCRIPT HOSPITAL	ION OF SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
12/18	2427955 IDAZOLE	5 001 5 500MG 1	AD00108	3.85	3.85		9		
METRON	2427955 IDAZOLE 2427955	500MG 1	TAD00108	3.85	3.85 3.85				
METRON 2/18	IDAZOLE 1823480	500MG 7	TAD00108	120.00	120.00				
2/18	IUM, SE 1823900		83735	314.00	314.00				
12/18	1832218 AUTO DI	3 001	85025	209.00	209.00				
CETIR		MG TAB		3.85	3.85		1		
FOLIC	2421586 ACID TA 2421722	AB 1MG U,	/DD00241	3.85	3.85				
OCUSA		UM 100M	G D01021	3.85	3.85				
12/18	2421728			3.85	3.85				
12/18	ITAMIN 242224 DINE 20		D03140 J/D00141	8.00	8.00				
FAMOTI		OMG TAB (J/D00141	8.00	8.00				
ROOM	3010002 0707 242649			1815.00 31.45	1815.00 31.45				
ENOXA		OMG- 40MG	J1650	3.85	3.85				
METRON 12/19	IDAZOLI 242795	E 500MG '		3.85	3.85				
PATIENT	NUMBER	PLEASE REFER NUMBER ON ALL AND CORRESPOND	INQUIRIES	FOR ANY O MENT WAS DO NOT PA	L PATIENT BILLII CHARGES NOT POSTE PREPARED, OR IF AY ANY PART OF TH	WHEN THIS STATE INSURANCE CARRIER E AMOUNTS SHOWN	:-		

	S PATIENT NAME DRIYAL , VARUN SUAR PH: (000)00	1611 MIAMI, 877 88 FEI # 4002 0-0000		/ENUE 17 SEX AGE ADMISS M 29 11/ C.O.B		RGE DATE I 30/21	DAYS 33	RTH-DATE 2/14/92 NUMBER POLIC CC10	
				A	RAGUEZ-AN		NAY.		
DATE OF	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2		RAGE	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	2427955 001	•	3.85	3.85					
	IIDAZOLE 500MG T 2421167 001	AD00108	3.85	3.85					
	ZINE 10MG TAB 2421586 001		3.85	3.85					
	ACID TAB 1MG U/ 2421722 001	DD00241	3.85	3.85					
	TE SODIUM 100MG 2421728 001	D01021	3.85	3.85					
	/ITAMIN U/D 2422240 001	D03140	8.00	8.00	_				
	DINE 20MG TAB U 2422240 001	/D00141	8.00	8.00					
	DINE 20MG TAB U 3010002 001	/D00141	1815.00	1815.00					
100000000000000000000000000000000000000	0707 2426493 004		31.45	31.45					
	ARIN 10MG- 40MG 2427955 001	J1650	3.85	3.85					
IETRON	IIDAZOLE 500MG T 2427955 001	AD00108	3.85	3.85					
	IIDAZOLE 500MG T 2427955 001	AD00108	3.85	3.85					
ETRON	IIDAZOLE 500MG T 2427955 001	AD00108	3.85	3.85					
ETRON	IIDAZOLE 500MG T 1825069 001	AD00108	454.00	454.00					
OMP N	METABOLIC PANEL 1832218 001	80053	209.00	209.00			-		
BC W	AUTO DIFF 2421167 001	85025	3.85	3.85					
ETIRI 2/20	ZINE 10MG TAB 2421586 001 ACID TAB 1MG U/	DD00241	3.85	3.85					

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PATIENT

NUMBER

HCI TYPE OF BILL FINA INP.	DATE BIL	5/22 PREV.BI	JACKSO 1611 N MIAMI, 877 88	DN HEALTH NW 12TH AV FL 31-6177 59171394	SYSTEM ENUE			05 RTH-DATE 2/14/92	PAGE NO. 27	
SUND	S PATI		4 0 0 2				GE DATE DAYS 30/21 33			
G	UAR PH	: (000)00	0-0000		C.O.B	INSURANCE COMPA		NUMBER POLICE		
GUARANTOR NAME AND ADDRESS DELHI 00009 INDIA VARUN SUNDRIYAL 1 Z06 INTL MISC INS CC109119 2 P01 SELF PAY ARAGUEZ-ANCARES, NAYLE										
							AMOUNT PAYMENT	OF S		
DATE OF SERVICE		CION OF L SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT	
	242172	2 001	Ja Carlon	3.85	3.85	185.00. 80. 2	183.CO. NO. 3	1101001 101		
ocusa	TE SOD	IUM 100MC	D01021							
	242172; TE SOD	2 001 IUM 100MC	G D01021	3.85	3.85					
	242172	2 001 IUM 100MG	D01021	3.85	3.85					
	242172		5 001021	3.85	3.85					
COURT WEST SECTION OF	ITAMIN 242224	200 W 1000	D03140	8.00	8.00					
TAMOT	DINE 2	OMG TAB (J/D00141							
	242224 DINE 2	0 001 0MG TAB (J/D00141	8.00	8.00					
	301000. 0707	2 001		1815.00	1815.00					
12/21	242649			31.45	31.45					
	242795	0MG- 40M0 5 001	J1650	3.85	3.85					
1ETRON	IDAZOL	E 500MG 7	TAD00108							
		5 001 E 500MG 1	FAD00108	3.85	3.85					
	242795	5 001 E 500MG 5	מתוחת מיד	3.85	3.85		-			
12/21	184014	0 001		75.00	75.00					
	9 JMH 242116		U0002	3.85	3.85				=	
CETIR	ZINE 1	OMG TAB								
FOLIC		AB 1MG U,	/DD00241	3.85	3.85					
	242172 TE SOD	2 001 IUM 100M0	G D01021	3.85	3.85					
12/21	242172	2 001		3.85	3.85					
	TE SOD 242172	IUM 100MC 2 001	3 D01021	3.85	3.85					
		IUM 100M	G D01021							
PATIENT	NUMBER	PLEASE REFER			L PATIENT BILLI			l		
		NUMBER ON ALL AND CORRESPOND		FOR ANY (MENT WAS DO NOT PA	CHARGES NOT POSTE PREPARED, OR IF AY ANY PART OF TH TIMATED INSURANCE	D WHEN THIS STATE INSURANCE CARRIES E AMOUNTS SHOWN	I- 0110 11100 11100 11100			

	DATE OF DATE PREV.BI	1611 N MIAMI, 877 88 FEI #	1-6177 59171394	ZENUE			005 IRTH-DATE 02/14/92	PAGE NO. 28
GUARANTOF NAME AND ADDRESS	137 YAMUNA V DELHI 00009 INDIA	'IHAR		2 1	INSURANCE COMPA ZO6 INTL M PO1 SELF P ARAGUEZ-AN	ISC INS AY	0214	y NUMBER 9119 1992
DATE OF	DESCRIPTION OF	SERVICE	TOTAL	EST. COVERAGE	EST. COVERAGE	AMOUNT PAYMENT EST. COVERAGE	EST. COVERAGE	PATIENT
SERVICE	HOSPITAL SERVICES	CODE	CHARGES	INS.CO. NO. 1	INS.CO. NO. 2	INS.CO. NO. 3	INS.CO. NO.	AMOUNT
12/21 MULTIV	2421728 001 /ITAMIN U/D	D03140	3.85	3.85				
12/21 FAMOTI	2422240 001 DINE 20MG TAB U	I/D00141	8.00	8.00				
12/21	2422240 001	,	8.00	8.00				
	DINE 20MG TAB U 3010002 001	7000141	1815.00	1815.00				
ROOM 12/22	0707 2426493 004		31.45	31.45				
ENOXAE	PARIN 10MG- 40MG 2427955 001	J1650	3.85	3.85				
METRON	IDAZOLE 500MG T	'AD00108						
	2427955 001 IIDAZOLE 500MG T	'AD00108	3.85	3.85				
12/22	2421167 001		3.85	3.85				
12/22	ZINE 10MG TAB 2421586 001		3.85	3.85				
	ACID TAB 1MG U/ 2421722 001	DD00241	3.85	3.85				
OOCUS	TE SODIUM 100MG 2421722 001	G D01021	3.85	3.85				
DOCUSA	TE SODIUM 100MG	G D01021						
	2421728 001 /ITAMIN U/D	D03140	3.85	3.85				
12/22	2422240 001 DINE 20MG TAB U		8.00	8.00				
12/22	2422240 001		8.00	8.00				
	DINE 20MG TAB U 3010002 001	J/D00141	1815.00	1815.00				
ROOM	0707 2426493 004		31.45	31.45				
ENOXAL	ARIN 10MG- 40MG	J1650						
	2427955 001 IDAZOLE 500MG T	AD00108	3.85	3.85				

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PATIENT

NUMBER

DATE OF DESCRIPTION OF SERVICE CODE CHARGES EST. COVERAGE EST. COVERAGE IBS.CO. 100. 2 IBS.CO. 100. 2 IBS.CO. 100. 3 IBS.CO. 100. 2 IBS.CO. 100. 3 IBS.CO. 100. 2 IBS.CO. 100. 3 I	HCI TYPE O BILL FINA INP. I SUND	F DATE OF BILL PREV.BII AL 01/05/22 S PATIENT NAME DRIYAL , VARUN GUAR PH: (000)00	JACKSON 1611 NV MIAMI, 877 88: FEI # PATIE 40020 0-0000		ENUE 7 EX AGE ADMISSI M 29 11/2 C.O.B 1 Z 2 P	INSURANCE COMPAN 06 INTL MI 01 SELF PA	3313610 BI 0 GE DATE DAYS 30/21 33 FY NAME GROUP	RTH-DATE 2/14/92 NUMBER POLICY CC10 0214	PAGE NO. 29 HOSP.NO. NUMBER
SERVICE MOSPUTAL SERVICES CODE CHARGES 188.00. 10. 1 188.00. 100. 2 188.00. 100. 3 188.00. 3					FCT COVEDAGE	EST COVEDAGE	PAYMENT	illundarini alla mana	PATIENT
METRONIDAZOLE 500MG TAD00108 12/23 2427955 001									
12/23 2421167 001 3.85 3.85	METRON 12/23	IDAZOLE 500MG T 2427955 001							
12/23 2421586 001	12/23	2421167 001	3.85	3.85					
DOCUSATE SODIUM 100MG D01021 12/23 2421722 001	12/23	2421586 001	'DD00241	3.85	3.85				
DOCUSATE SODIUM 100MG D01021 12/23 2421722 001 DOCUSATE SODIUM 100MG D01021 12/23 2421728 001 MULTIVITAMIN U/D	12/23	2421722 001	oe w ve se.	3.85	3.85				
DOCUSATE SODIUM 100MG D01021 12/23 2421728 001 MULTIVITAMIN U/D D03140 12/23 2422240 001 FAMOTIDINE 20MG TAB U/D00141 12/23 2422240 001 FAMOTIDINE 20MG TAB U/D00141 12/23 3010002 001 ROOM 0708 12/24 2426493 004 ENOXAPARIN 10MG- 40MG J1650 12/24 2427955 001 METRONIDAZOLE 500MG TAD00108 12/24 2421167 001 3.85 3.85	DOCUS	TE SODIUM 100MG	G D01021						
MULTIVITAMIN U/D D03140 12/23 2422240 001 8.00 8.00 FAMOTIDINE 20MG TAB U/D00141 12/23 2422240 001 8.00 FAMOTIDINE 20MG TAB U/D00141 12/23 3010002 001 1815.00 ROOM 0708 12/24 2426493 004 31.45 31.45 ENOXAPARIN 10MG- 40MG J1650 12/24 2427955 001 3.85 3.85 METRONIDAZOLE 500MG TAD00108 12/24 242167 001 3.85 3.85	DOCUSA	TE SODIUM 100MG	G D01021						
FAMOTIDINE 20MG TAB U/D00141 12/23 2422240 001 8.00 8.00 FAMOTIDINE 20MG TAB U/D00141 12/23 3010002 001 1815.00 ROOM 0708 12/24 2426493 004 31.45 31.45 ENOXAPARIN 10MG- 40MG J1650 12/24 2427955 001 3.85 3.85 METRONIDAZOLE 500MG TAD00108 12/24 2427955 001 3.85 3.85	MULTIV	/ITAMIN U/D	D03140	A . KH					
FAMOT DINE 20MG TAB U/D00141 12/23 3010002 001	FAMOT:	DINE 20MG TAB U	J/D00141						
ROOM 0708 12/24 2426493 004 31.45 ENOXAPARIN 10MG- 40MG J1650 12/24 2427955 001 3.85 METRONIDAZOLE 500MG TAD00108 12/24 242167 001 3.85 3.85	FAMOT:	DINE 20MG TAB U	J/D00141						
ENOXAPARIN 10MG- 40MG J1650 12/24 2427955 001 3.85 METRONIDAZOLE 500MG TAD00108 12/24 242167 001 3.85 3.85	ROOM	0708							
METRONIDAZOLE 500MG TAD00108 12/24 2427955 001 3.85 METRONIDAZOLE 500MG TAD00108 12/24 2427955 001 3.85 METRONIDAZOLE 500MG TAD00108 12/24 2427955 001 3.85 METRONIDAZOLE 500MG TAD00108 12/24 2421167 001 3.85 3.85	ENOXA	ARIN 10MG- 40MG	J1650						
METRONIDAZOLE 500MG TAD00108 12/24 2427955 001 3.85 3.85 METRONIDAZOLE 500MG TAD00108 12/24 2427955 001 3.85 3.85 METRONIDAZOLE 500MG TAD00108 12/24 2421167 001 3.85 3.85	METRO	IDAZOLE 500MG 7	TAD00108						
METRONIDAZOLE 500MG TAD00108 12/24 2427955 001 3.85 3.85 METRONIDAZOLE 500MG TAD00108 12/24 2421167 001 3.85 3.85	METRO	IIDAZOLE 500MG 1	FAD00108						
METRONIDAZOLE 500MG TAD00108 12/24 2421167 001 3.85 3.85	METRO	VIDAZOLE 500MG 7	FAD00108						
	METRO 12/24	IDAZOLE 500MG 1 2421167 001	FAD00108						
						,			

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PATIENT

NUMBER

HCI TYPE OF BILL FINA INP. I SUNI GUARANTOR NAME AND ADDRESS	DE DATE OF BILL PREV.BIL AL 01/05/22 S PATIENT NAME DRIYAL , VARUN GUAR PH: (000)00	1611 N MIAMI, 877 88 FEI # PATI 4002 0-0000	0027436	VENUE 17 SEX AGE ADMISS M 29 11/ C.O.B 1 Z 2 P	ION DATE DISCHAE 27/21 12/ INSURANCE COMPA 06 INTL M 01 SELF P.	RGE DATE DAYS 30/21 33 NY NAME GROUE ISC INS	RTH-DATE 02/14/92 NUMBER POLICY CC10 0214	NUMBER 9119
						AMOUNT PAYMENT	OF ş	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
12/24	2421722 001		3.85	3.85				
	TE SODIUM 100MG 2421722 001	D01021	3.85	3.85				
and the same of the same of	TE SODIUM 100MG 2421722 001	3.85	3.85					
DOCUSA	TE SODIUM 100MG 2421728 001	D01021	3.85	3.85				
MULTIV	VITAMIN U/D	D03140						
	2422240 001 DINE 20MG TAB U,	/D00141	8.00	8.00				
	2422240 001 DINE 20MG TAB U	/D00141	8.00	8.00				
	3010002 001 0708	, 200 111	1815.00	1815.00				
12/25	2426493 004		31.45	31.45				
	ARIN 10MG- 40MG 2427955 001	J1650	3.85	3.85				
	IDAZOLE 500MG TX 2427955 001	AD00108	3.85	3.85				
METRON	IDAZOLE 500MG T	AD00108						
METRON	2427955 001 IDAZOLE 500MG TA	AD00108	3.85	3.85				
	1840143 001 OV-2/FLU/RSV C	40241U	143.00	143.00				
12/25	2421167 001 ZINE 10MG TAB		3.85	3.85				
12/25	2421586 001		3.85	3.85				
	ACID TAB 1MG U/1 2421722 001	DD00241	3.85	3.85				
DOCUSA	TE SODIUM 100MG 2421722 001	D01021	3.85	3.85				
DOCUSA	TE SODIUM 100MG 2421722 001	D01021	3.85	3.85				
	TE SODIUM 100MG	D01021			h.			
							1	

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

NUMBER

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PATIENT

TYPE OF DATE OF PREV.BILL MIAMI, FINAL 01/05/22 877 88	N HEALTH W 12TH AV FL 1-6177 59171394	ENUE			005 RTH-DATE 02/14/92	PAGE NO. 31 HOSP.NO.
I S PATIENT NAME PATEL SUNDRIYAL , VARUN 4002			27/21 12/	ge DATE DAYS 30/21 33		
GUAR PH: (000)000-0000	0027436	M 29 11/	21/21 12/	30/21 33		
		C.O.B	INSURANCE COMPA	NY NAME GROUP	NUMBER POLICY	Y NUMBER
VARUN SUNDRIYAL NAME AND ADDRESS VARUN SUNDRIYAL 137 YAMUNA VIHAR DELHI 00009 INDIA		2 P	06 INTL M 01 SELF P. RAGUEZ-AN		0214	9119 1992
	1 4			AMOUNT	of 5	
TE OF DESCRIPTION OF SERVICE	TOTAL	EST. COVERAGE	EST. COVERAGE	PAYMENT EST. COVERAGE	EST. COVERAGE	PATIENT
ERVICE HOSPITAL SERVICES CODE	CHARGES	INS.CO. NO. 1	INS.CO. NO. 2	INS.CO. NO. 3	INS.CO. NO. 4	AMOUNT
/25 2421728 001	3.85	3.85				
ULTIVITAMIN U/D D03140	8.00	8.00				
MOTIDINE 20MG TAB U/D00141	0.00	0.00				
2/25 2422240 001	8.00	8.00				
MOTIDINE 20MG TAB U/D00141 2/25 3010002 001	1815.00	1815.00				
OOM 0708	1010.00	1010.00				
2/26 2426493 004	31.45	31.45				
NOXAPARIN 10MG- 40MG J1650 2/26 2427955 001	3.85	3.85		-	-	
TRONIDAZOLE 500MG TAD00108						
2/26 2427955 001	3.85	3.85				
TRONIDAZOLE 500MG TAD00108	3.85	3.85		-		
ETRONIDAZOLE 500MG TAD00108						
2/26 2421167 001	3.85	3.85				
ETIRİZINE 10MG TAB 2/26 2421586 001	3.85	3.85				
DLIC ACID TAB 1MG U/DD00241		ŭ.				
2/26 2421722 001 DCUSATE SODIUM 100MG D01021	3.85	3.85				
2/26 2421722 001	3.85	3.85				
DCUSATE SODIUM 100MG D01021						
2/26 2421728 001 JLTIVITAMIN U/D D03140	3.85	3.85				
2/26 2422240 001	8.00	8.00				
AMOTIDINE 20MG TAB U/D00141						
2/26 2422240 001 AMOTIDINE 20MG TAB U/D00141	8.00	8.00	,			
2/26 3010002 001	1815.00	1815.00				
OOM 0708						
2/27 2426493 004 NOXAPARIN 10MG- 40MG J1650	31.45	31.45				
TOTAL TOTAL TOTAL	1	II.	1	1	T.	1

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PATIENT

NUMBER

DATE OF DESCRIPTION OF SERVICE CO 1.2/27 2427955 001 METRONIDAZOLE 500MG TAD001 1.2/27 2427955 001 METRONIDAZOLE 500MG TAD001 1.2/27 2421167 001				CARES, NAY	/LE	
HOSPITAL SERVICES CO				AMOUNT PAYMENT		
METRONIDAZOLE 500MG TAD001 12/27 2427955 001 METRONIDAZOLE 500MG TAD001	DE CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO.	PATIENT AMOUNT
ETIRIZINE 10MG TAB 12/27 2421586 001 FOLIC ACID TAB 1MG U/DD002 12/27 2421722 001 DOCUSATE SODIUM 100MG D010 12/27 2421722 001 DOCUSATE SODIUM 100MG D010 12/27 2421728 001 MULTIVITAMIN U/D D031 12/27 2422240 001 FAMOTIDINE 20MG TAB U/D001 12/27 2422240 001 FAMOTIDINE 20MG TAB U/D001 12/27 3010002 001 ROOM 0708 12/28 2426493 004 ENOXAPARIN 10MG- 40MG J165 12/28 1840135 001 STAPH AUREUS PCR 8764 12/28 1840136 001 MRSA PCR 8764 12/28 2421167 001 CETIRIZINE 10MG TAB 12/28 2421586 001 FOLIC ACID TAB 1MG U/DD002	3.85 3.85 3.85 3.85 41 3.85 21 3.85 40 40 41 8.00 41 1815.00 31.45 0 51.00 0 51.00 1 3.85	3.85 3.85 3.85 3.85 3.85 3.85 3.85 8.00 8.00 1815.00 31.45 51.00 51.00 3.85 3.85				

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATE-MENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PATIENT

NUMBER

THE RESERVE OF THE PERSON NAMED IN COLUMN 1	F DATE OF DATE O BILL PREV.BIL	1611 NI MIAMI, 877 88 FEI #	1-6177 59171394 nt number si	ENUE 7 EX AGE ADMISSI	on date dischar 27/21 12/3	0	05 RTH-DATE 2/14/92	PAGE NO. 33
GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA			2 P	INSURANCE COMPAN 06 INTL M: 01 SELF PA RAGUEZ-ANO	ISC INS		
						AMOUNT PAYMENT	OF \$	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
OOCUSA 12/28 MULTIV 12/28 MULTIV	2421722 001 ATE SODIUM 100MG 2421728 001 YITAMIN U/D 2421728 001 YITAMIN U/D 2422240 001	D01021 D03140 D03140	3.85 3.85 3.85 8.00	3.85 3.85 3.85 8.00				
AMOT] 2/28 00M 2/29 NOXAE	/28 2422240 001 40TIDINE 20MG TAB U/D00141 /28 3010002 001		1815.00 31.45 75.00	1815.00 31.45 75.00				
OVID1 2/29 ETIR1	_	U0002	3.85	3.85				
OLIC 2/29 OCUSA 2/29	ACID TAB 1MG U/ 2421722 001 ATE SODIUM 100MG 2421722 001 ATE SODIUM 100MG	D01021	3.85	3.85				
2/29 OCUS 2/29	2421722 001 ATE SODIUM 100MG 2421728 001 VITAMIN U/D		3.85	3.85 3.85				
2/29 TAMOT: 2/29 TAMOT:	2422240 001 IDINE 20MG TAB U 2422240 001 IDINE 20MG TAB U 3010002 001	J/D00141	8.00 8.00 1815.00	8.00 8.00 1815.00				
ROOM 12/30		DD00241	3.85	3.85				

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PATIENT

NUMBER

HCI TYPE OF BILL FINA INP.	BILL PREV.BI	JACKSO 1611 I MIAMI 877 86 FEI #	ON HEALTH NW 12TH AV FL 31-6177 59171394	SYSTEM ENUE 7		B:	005 IRTH-DATE 02/14/92	PAGE NO.		
SUND	RIYAL , VARUN UAR PH: (000)00	4002	e na Tee Waylin or vall se	TAIANNA CONTRACTOR						
GUARANTOR NAME AND ADDRESS	VARUN SUNDRI 137 YAMUNA V DELHI 00009 INDIA	YAL		2 F						
	DESCRIPTION. OF	SERVICE	TOTAL			AMOUNT PAYMENT	OF S	PATIENT		
DOCUSA 12/30 MULTIV 12/30	### HOSPITAL SERVICES 2421722 001 TE SODIUM 100MG 2421728 001	D01021	3.85 3.85 8.00	3.85 3.85 8.00	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	INS.CO. NO. 4	AMOUNT		
T O	T A L S T A L S NUMBER PLEASE REFER TO NUMBER ON ALL AND CORRESPONDE	O PATIENT INQUIRIES	FOR ANY C	HARGES NOT POSTE	NG MAY BE NECESSA D WHEN THIS STATE INSURANCE CARRIER	- PAY THIS	AMOUNT	0.00		

JACKSON HEALTH SYSTEM MIAMI, FL

HCI TYPE 0 BILL FINA INP.	F DATE OF DATE OF BILL PREV.BILL	1611 NW MIAMI, 877 881	L-6177	ENUE			05 RTH-DATE 2/14/92	PAGE NO. 35
I SUND	S PATIENT NAME ORIYAL , VARUN	4 0 0 2 0	NT NUMBER S			GE DATE DAYS 30/21 33		
	UAR PH: (000)000	11 11 12 1 11 12 1						
GUARANTOR NAME AND ADDRESS	VARUN SUNDRIY 137 YAMUNA VI DELHI 00009 INDIA		1 Z 2 P	1 Z06 INTL MISC INS CC109119 2 P01 SELF PAY 02141992 ARAGUEZ-ANCARES, NAYLE				
						AMOUNT PAYMENT	OF \$	
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
R&C W	ARY OF CHARGES JARD 1DAYS@ SEMI-PR 32DAYS@ OTHER SURGERY ANESTHESIA EMERGENCY ROOM LAB IMAGING/X-RAY PHARMACY CARDIOLOGY PT/OT/SPEECH T	1815.00	12848.00 943.00 1857.00 17144.76	58080.00 12848.00 943.00 1857.00 17144.76 26640.00 6411.20				
SUB-1	OTAL OF CHARGES	1	29057.96	129057.96				
ACC- DSCH ADM.	EDURE: OFB03ZZ	R10.9	SEX TIN		GUAR NO: PL	ACE:	EMPL REL	:
T O	A PUBLIC HOSE STATE OF FLOE T A L S T A L S	RIDA	NSED BY '	THE 129057.96				
	NUMBER PLEASE REFER TO NUMBER ON ALL II AND CORRESPONDEN	NQUIRIES CE.	FOR ANY MENT WAS DO NOT P	CHARGES NOT POSTE		- PAV THT	S AMOUNT	0.00

Page 35 of 117

MIAMI, FL

JACKSON HEALTH SYSTEM

HCI TYPE O BILL FINA INP. I	F DATE OF DATE PREV. L 01/05/22	JACKSON 1611 NV MIAMI, 877 883 FEI # PATIEN 40020	1-6177 59171394	/ENUE 17 sex age admiss	ION DATE DISCHAR 27/21 12/:	C	005 RTH-DATE 02/14/92	PAGE NO. 36 HOSP.NO.			
GUARANTOR NAME AND ADDRESS	VARUN SUNDR 137 YAMUNA DELHI 00009 INDIA	VIHAR)		2 P	1 Z06 INTL MISC INS CC109119						
DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE	EST. COVERAGE	AMOUNT PAYMENT EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT			
AI DI	SCHARGE/FINAL K75.0 *A U07.1 *C J90 F E87.1 H D63.8 A E87.5 H N43.3 H RGICAL PROCEDU 0FB03ZZ *E 0W993ZZ C 0F9030Z E	DURES: DSIS: UNSPECIFIED P DIAGNOSIS: BSCESS OF L COVID-19 LEURAL EFFUR EYPO-OSMOLAL ENEMIA IN OTE EYPERKALEMIA	IVER SION, NOT ITY AND H HER CHRON NSPECIFIE LIVER, PE RIGHT PLE LIVER WIT	PAIN ELSEWHER YPONATREM IC DISEAS CRCUTANEOU URAL CAVI	12/07/2 12/06/2	1 584700 1 424180 1 584700 1 89410 1 584700					
OF CO ALTER	NSULTING:	UTHAMER, ANI IZALES ZAMOR IATION:		ME129							
T O	T A L S NUMBER PLEASE REFER NUMBER ON AL AND CORRESPON	L INQUIRIES	FOR ANY MENT WAS	29057, 96 L PATIENT BILLING CHARGES NOT POSTEIN PREPARED, OR IF AY ANY PART OF THE INMATED INSURANCE	WHEN THIS STATE INSURANCE CARRIER: E AMOUNTS SHOWN	-					

PHTJACKSON MEMORIAL HOS 1611 NW 12TH AVENUE	SP PHTJA PO BO		IEMORI 28	IAL HOS	b MED 5	5425	066477 71		Z 0 6		TYPE F BILL 131
MIAMI FL 331361005	ATLAN	NTA GA 3	30394		5 FED. TAX	NO. 00	0 0 6 STA	TEMENT COVE	RS PERIOD THROUGH	7	
8778816177 3053552273						1394			0422		
B PATIENT NAME a		9 PATIENT ADDRESS	S a	137 YAM	UNA VI	HAR	100	[2].			FEL
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JACKSON HEALTH SYSTEM MIAMI, FL

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JACKSON HEALTH SYSTEM MIAMI, FL