Filing # 187648532 E-Filed 12/08/2023 11:48:08 AM

IN THE CIRCUIT COURT OF THE 11TH JUDICIAL CIRCUIT IN AND FOR MIAMI-DADE COUNTY, FLORIDA

COMPLEX BUSINESS LITIGATION DIVISION

In re:

CRYSTAL CRUISES LLC, a California limited liability company,

Case No. 2022-002742-CA-01
Lead Case

CRYSTAL HOLDINGS U.S., LLC, a Delaware limited liability company,

Case No. 2022-002757-CA-01

CRYSTAL AIRCRUISES, LLC, a Florida limited liability company, and

Case No. 2022-002758-CA-01

Assignors,

(Jointly Administered Cases)

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

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

EXHIBIT “A”

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

In Re:

CRYSTAL CRUISES, LLC
a California Limited Liability company.

Assignor, **Case No.: 2022-002742 CA 01**

To:

MARK C. HEALY,

Assignee,

______________________________________/

PROOF OF CLAIM

TO RECEIVE ANY DIVIDEND IN THIS PROCEEDING, YOU MUST COMPLETE THIS PROOF OF CLAIM AND DELIVER IT TO THE ASSIGNEE NO LATER THAN:

JUNE 11, 2022

THE ASSIGNEE'S NAME AND ADDRESS ARE AS FOLLOWS:
Mark C. Healy, Assignee
MICHAEL MOECKER & ASSOCIATES, INC.
1885 Marina Mile Blvd., Suite 106
Fort Lauderdale, FL 33315
(954) 252-1560 · (954) 252-2791 Fax No.
Info@Moecker.com

1. **CREDITOR NAME (Your name):** JACKSON MEMORIAL HOSPITAL
ADDRESS: 1611 NW 12TH AVENUE
MIAMI FL 33136
TELEPHONE NUMBER: +1 305 585 1111
E-MAIL ADDRESS: ____________

Please be sure to notify us if you have a change of address.

2. **BASIS FOR CLAIM:**
[ ] Goods Sold
[✓] Services Performed
[ ] Money Loaned
[ ] Wages, Salaries and Compensations
[ ] Taxes
[ ] Shareholder
[ ] Other: ____________
[ ] Secured Creditor

3. **DATE DEBT WAS INCURRED:** NOV 27 - DEC 30, 2021 & JAN 4, 2022

4. **AMOUNT OF CLAIM:** USD 129,057.96 & USD 231.00 = $129,288.96

5. **SUPPORTING DOCUMENTS:** **Attach copies of supporting documents,** such as promissory notes, purchase order, invoices, itemized statement of running accounts, court judgments, or evidence of security interests. If the documents are not available, explain. If the documents are voluminous, attach a summary.

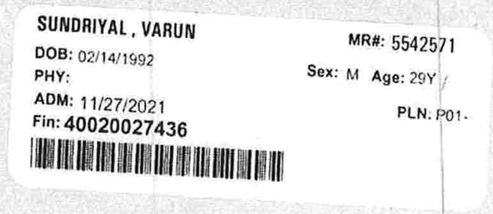
6. **SIGNATURE:** Sign and print name and title, if any, of the creditor or other person authorized to file this claim:

DATED: JUNE 10, 2022

BY: [signature]
Signature of Claimant or Representative

WILSON DANDEY (ACCOUNT MANAGER)
Print Name and Title Here

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



November 26, 2021

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

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; 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

2823 add supp docs

1	2	3a PAT. CNTL # / b. MED. REC. #	4 TYPE OF BILL
PHT JACKSON MEMORIAL HOSP	JACKSON MEMORIAL HOSPITAL	40020027436 Z06	
1611 NW 12TH AVENUE	PO BOX 947728	5542571	0111
MIAMI FL 331361005	ATLANTA GA 30394		
8778816177	XX 1225033020		

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
591713947	112721	123021	

8 PATIENT NAME: SUNDRIYAL, VARUN

9 PATIENT ADDRESS: 137 YAMUNA VIHAR, DELHI, 00009, IN

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02141992	M	112721	22	5	1	12	01	C1	DR											

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
10	112721	11	112721											

38
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	1592 00	80	33 00		
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
121	MED-SUR-GY/2BED	1815.00		32	58080 00		
151	MED-SUR-GY/WARD	1815.00		1	1815 00		
250	PHARMACY	J3490		316	1587 55		
260	IV THERAPY	96374		5	1245 00		
300	LABORATORY	86850		2	297 00		
301	LAB/CHEMISTRY	82150		28	7356 00		
302	LAB/IMMUNOLOGY	86900		15	1428 93		
305	LAB/HEMATOLOGY	85025		20	3283 00		
306	LAB/BACT-MICRO	87635		36	4722 00		
311	PATHOL/CYTOLOGY	88112		1	57 83		
320	DX X-RAY	76080		6	5620 00		
324	DX X-RAY/CHEST	71045		2	782 00		
352	CT SCAN/BODY	74177		4	20238 00		
360	OR SERVICES			6	12848 00		
371	ANESTHE/INCIDENT RA	99152		4	943 00		
434	OCCUP THERP/EVAL	97166		1	446 00		
450	EMERG ROOM	99285		1	1857 00		
483	ECHOCARDIOLOGY	93306		1	2573 00		
636	DRUG/DETAIL CODE	J0692		9	1198 80		
636	DRUG/DETAIL CODE	J0696		52	635 40		
636	DRUG/DETAIL CODE	J1650		136	1069 30		
636	DRUG/DETAIL CODE	J2001		40	33 00		
	PAGE 01 OF 02	CREATION DATE	010522	TOTALS	128115 81		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
Z06 STAR HEALTHCARE		Y	Y		129057 96
P01 SELF PAY		Y	Y		

56 NPI: 1225033020
57 OTHER PRV ID: 591713947 / 591713947

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SUNDRIYAL, VARUN	18	CC109119		
SUNDRIYAL, VARUN	18	02141992		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
0902		UNKNOWN
NOT REQUIRED		UNKNOWN

66 DX: 0
67: K750 Y | U071 Y | J90 Y | E871 Y | D638 Y | E875 Y | N433 Y

69 ADMIT DX: R109 | 70 PATIENT REASON DX: | 71 PPS CODE: 0405 | 72 ECI: | 73:

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
0W993ZZ	120621	0FB03ZZ	120721	0F9030Z	112721

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE
BW21YZZ	112721	B246YZZ	113021	BW25YZZ	120321

76 ATTENDING NPI 1770821993 QUAL
LAST ARAGUEZ-ANCARES FIRST NAYLE

77 OPERATING NPI 1770821993 QUAL
LAST ARAGUEZ-ANCARES FIRST NAYLE

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
Z06 STAR HEALTHCARE
17621 WOODVIEW TERRA
BOCA RATON, FL 33487

81CC a b c d

UB-04 CMS-1450 APPROVED OMB-0938-0997 NUBC National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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 re-certifications 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; 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.

SEE http://wwwnubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

1 PHT JACKSON MEMORIAL HOSP
1611 NW 12TH AVENUE
MIAMI FL 331361005
8778816177

2 JACKSON MEMORIAL HOSPITAL
PO BOX 947728
ATLANTA GA 30394
XX 1225033020

3a PAT. CNTL # 40020027436 Z06
b. MED. REC. # 5542571
4 TYPE OF BILL 0111
5 FED. TAX NO. 591713947
6 STATEMENT COVERS PERIOD FROM 112721 THROUGH 123021
7

8 PATIENT NAME a
b SUNDRIYAL, VARUN
9 PATIENT ADDRESS a 137 YAMUNA VIHAR
b DELHI c d 00009 e IN

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02141992	M	112721	22	5	1	12	01	C1	DR											

(18–28: CONDITION CODES)

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
10	112721	11	112721											

38
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	1592 00	80	33 00		
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
636	DRUG/DETAIL CODE	J2250		2	16 50		
636	DRUG/DETAIL CODE	J2270		15	247 50		
636	DRUG/DETAIL CODE	J2543		3	71 80		
636	DRUG/DETAIL CODE	J3010		3	49 50		
636	DRUG/DETAIL CODE	J3370		12	256 85		
730	EKG/ECG	93005		1	300 00		
0001	PAGE 02 OF 02	CREATION DATE	010522	TOTALS	129057 96		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	Z06 STAR HEALTHCARE		Y	Y		129057 96
B	P01 SELF PAY		Y	Y		
C						

56 NPI 1225033020
57 OTHER PRV ID 591713947
591713947

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	SUNDRIYAL, VARUN	18	CC109119		
B	SUNDRIYAL, VARUN	18	02141992		
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	0902		UNKNOWN
B	NOT REQUIRED		UNKNOWN
C			

66 DX: K750 Y | U071 Y | J90 Y | E871 Y | D638 Y | E875 Y | N433 Y
0
67 68

69 ADMIT DX R109 | 70 PATIENT REASON DX | 71 PPS CODE 0405 | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE
0W993ZZ	120621	0FB03ZZ	120721	0F9030Z	112721
c. OTHER PROCEDURE CODE	**DATE**	**d. OTHER PROCEDURE CODE**	**DATE**	**e. OTHER PROCEDURE CODE**	**DATE**
BW21YZZ	112721	B246YZZ	113021	BW25YZZ	120321

75

76 ATTENDING NPI 1770821993 QUAL
LAST ARAGUEZ-ANCARES FIRST NAYLE
77 OPERATING NPI 1770821993 QUAL
LAST ARAGUEZ-ANCARES FIRST NAYLE
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS Z06 STAR HEALTHCARE
17621 WOODVIEW TERRA

BOCA RATON, FL 33487

81CC a b c d

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 re-certifications 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; 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.

SEE http://wwwnubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

PAGE NO. 1

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS

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
11/27	2420950 001 METRONIDAZOLE IV 500MGJ3490		16.50	16.50				
11/27	2423432 002 VANCOMYCIN HCL, 500 MGJ3370		63.85	63.85				
11/27	2423806 003 PIPERA /TAZOBA,1G/1.12J2543		71.80	71.80				
11/27	2429026 001 FENTANYL CITRATE 2ML J3010		16.50	16.50				
11/27	2429338 001 MORPH SULF 10MG-4MG CAJ2270		16.50	16.50				
11/27	4074226 001 INJECTION IV,SINGLE/IN96374		249.00	249.00				
11/27	4074227 001 INJECTION IV, NEW DRUG96375		235.00	235.00				
11/27	4074228 001 IV HYDRTN INIT 31-90MI96360		316.00	316.00				
11/27	4074230 001 IV INFUSN INIT 16-90MI96365		286.00	286.00				
11/27	4074232 001 IV INF,ADD SEQ,NEW DRU96367		159.00	159.00				
11/27	0310009 001 ANTIBODY SCREEN EACH T86850		113.00	113.00				
11/27	0310105 001 BLOOD TYPING SEROLOGIC86900		153.00	153.00				
11/27	0310106 001 BLD TYPE SERO RH D 86901		90.00	90.00				
11/27	1808047 001 ENTAMOEBA HISTOLYTICA 86753		26.45	26.45				
11/27	1823411 001 AMYLASE, SERUM 82150		184.00	184.00				
11/27	1823417 001 BILIRUBIN, TOTAL 82247		85.00	85.00				
11/27	1823476 001 LIPASE, SERUM 83690		138.00	138.00				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

BIRTH-DATE 02/14/92

PAGE NO. 2

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
11/27	1825069 001		454.00	454.00				
COMP	METABOLIC PANEL	80053						
11/27	1832218 001		209.00	209.00				
CBC W	AUTO DIFF	85025						
11/27	1832263 001		76.00	76.00				
PROTH	ROMBIN TIME	85610						
11/27	1832264 001		94.00	94.00				
PTT		85730						
11/27	1840139 001		145.00	145.00				
COVID1	9 PANEL	U0004						
11/27	1844702 001		341.00	341.00				
BLOOD	CULTURE AEROBIC	87040						
11/27	1844702 001		341.00	341.00				
BLOOD	CULTURE AEROBIC	87040						
11/27	1844711 001		91.00	91.00				
AEROBI	C CULT ISO & PRE	87070						
11/27	1844711 001		91.00	91.00				
AEROBI	C CULT ISO & PRE	87070						
11/27	1844712 001		112.00	112.00				
ANAERO	BIC CULT ISO & P	87075						
11/27	1844712 001		112.00	112.00				
ANAERO	BIC CULT ISO & P	87075						
11/27	1844715 001		61.00	61.00				
SMEAR	FOR BACTERIA	87205						
11/27	1844715 001		61.00	61.00				
SMEAR	FOR BACTERIA	87205						
11/27	2859764 001		2856.00	2856.00				
US GUI	DED ABSC DRAINAG	75989						
11/27	2859764 001		2856.00-	2856.00-				
US GUI	DED ABSC DRAINAG	75989						
11/27	2871010 001		391.00	391.00				
CHEST	1 VIEW	71045						
11/27	2800158 001		5999.00	5999.00				
CT ABD	OMEN+PELVIS W/ C	74177						

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

PAGE NO. 3

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
11/27	2850365 002		4452.00	4452.00				
IMAGE	CATH FLUID COLXN49405							
11/27	4070094 001		1857.00	1857.00				
ER LEVEL V		99285						
11/27	3290007 001		1815.00	1815.00				
ROOM	OA12							
11/28	2420950 001		16.50	16.50				
METRONIDAZOLE IV 500MGJ3490								
11/28	2420950 001		16.50	16.50				
METRONIDAZOLE IV 500MGJ3490								
11/28	2420950 001		16.50	16.50				
METRONIDAZOLE IV 500MGJ3490								
11/28	2422825 002		38.60	38.60				
VANCOMYCIN 750 MG INJ J3370								
11/28	2422825 002		38.60	38.60				
VANCOMYCIN 750 MG INJ J3370								
11/28	2422825 002		38.60	38.60				
VANCOMYCIN 750 MG INJ J3370								
11/28	2422825 002		38.60	38.60				
VANCOMYCIN 750 MG INJ J3370								
11/28	2422825 002		38.60-	38.60-				
VANCOMYCIN 750 MG INJ J3370								
11/28	2426359 001		133.20	133.20				
CEFEPIME 500MG-2GM INJJ0692								
11/28	2426359 001		133.20	133.20				
CEFEPIME 500MG-2GM INJJ0692								
11/28	2426359 001		133.20	133.20				
CEFEPIME 500MG-2GM INJJ0692								
11/28	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
11/28	2429337 001		16.50	16.50				
MORPH	SULF 10MG-2MG CAJ2270							
11/28	2429337 001		16.50	16.50				
MORPH	SULF 10MG-2MG CAJ2270							

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

PAGE NO. 4

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
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				
MAGNESIUM, 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 001		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				
COMP METABOLIC PANEL 80053								
11/28	1832218 001		209.00	209.00				
CBC W AUTO DIFF 85025								
11/28	1840135 001		51.00	51.00				
STAPH AUREUS PCR 87640								
11/28	1840136 001		51.00	51.00				
MRSA PCR 87641								
11/28	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
11/28	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
11/28	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
11/28	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
11/28	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
11/28	2426661 001		3.85	3.85				
TRAMADOL 50MG UD TAB D03826								

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

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

331361005

BIRTH-DATE 02/14/92

PAGE NO. 5

HOSP.NO.

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
11/28	2426661 001		3.85	3.85				
TRAMADOL 50MG UD TAB		D03826						
11/28	3280002 001		1815.00	1815.00				
ROOM	B605							
11/29	2420950 001		16.50	16.50				
METRONIDAZOLE IV 500MG		J3490						
11/29	2420950 001		16.50	16.50				
METRONIDAZOLE IV 500MG		J3490						
11/29	2420950 001		16.50	16.50				
METRONIDAZOLE IV 500MG		J3490						
11/29	2422825 002		38.60	38.60				
VANCOMYCIN 750 MG INJ		J3370						
11/29	2422825 002		38.60	38.60				
VANCOMYCIN 750 MG INJ		J3370						
11/29	2426359 001		133.20	133.20				
CEFEPIME 500MG-2GM INJ		J0692						
11/29	2426359 001		133.20	133.20				
CEFEPIME 500MG-2GM INJ		J0692						
11/29	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG		J1650						
11/29	2429337 001		16.50	16.50				
MORPH SULF 10MG-2MG CA		J2270						
11/29	1823417 001		85.00	85.00				
BILIRUBIN, TOTAL		82247						
11/29	1823504 001		68.00	68.00				
SGOT (AST)		84450						
11/29	1823505 001		68.00	68.00				
SGPT (ALT)		84460						
11/29	1823550 001		184.00	184.00				
VANCOMYCIN LEVEL		80202						
11/29	1823900 001		314.00	314.00				
BASIC METABOLIC PANEL		80048						
11/29	1832218 001		209.00	209.00				
CBC W AUTO DIFF		85025						

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

PAGE NO. 6

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
11/29	2421586 001		3.85	3.85				
FOLIC	ACID TAB 1MG U/DD00241							
11/29	2421722 001		3.85	3.85				
DOCUSATE	SODIUM 100MG D01021							
11/29	2421728 001		3.85	3.85				
MULTIVITAMIN	U/D D03140							
11/29	2422240 001		8.00	8.00				
FAMOTIDINE	20MG TAB U/D00141							
11/29	2422240 001		8.00	8.00				
FAMOTIDINE	20MG TAB U/D00141							
11/29	3280002 001		1815.00	1815.00				
ROOM	B605							
11/30	2420950 001		16.50	16.50				
METRONIDAZOLE	IV 500MGJ3490							
11/30	2426359 001		133.20	133.20				
CEFEPIME	500MG-2GM INJJ0692							
11/30	2426359 001		133.20	133.20				
CEFEPIME	500MG-2GM INJJ0692							
11/30	2426493 004		31.45	31.45				
ENOXAPARIN	10MG- 40MG J1650							
11/30	2426493 004		31.45	31.45				
ENOXAPARIN	10MG- 40MG J1650							
11/30	2427955 001		3.85	3.85				
METRONIDAZOLE	500MG TAD00108							
11/30	1800537 001		15.65	15.65				
QFEVERABS+RFLXTITER	1 86638							
11/30	1800538 001		13.50	13.50				
QFEVERABS+RFLXTITER	2 86638							
11/30	1800539 001		13.50	13.50				
QFEVERABS+RFLXTITER	3 86638							
11/30	1800540 001		13.50	13.50				
QFEVERABS+RFLXTITER	4 86638							
11/30	1801007 001		87.88	87.88				
ECHINOCOCCUS	AB Q 86682							

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

BIRTH-DATE 02/14/92

PAGE NO. 7

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
11/30	1825069 001		454.00	454.00				
COMP	METABOLIC PANEL	80053						
11/30	1832218 001		209.00	209.00				
CBC W	AUTO DIFF	85025						
11/30	1844720 001		275.00	275.00				
OVA-PA	RASITES FECAL	87177						
11/30	1845087 001		138.00	138.00				
O&P TR	ICHROME STAIN	87209						
11/30	1845087 001		138.00	138.00				
O&P TR	ICHROME STAIN	87209						
11/30	1850220 001		141.00	141.00				
EIA HI	V-1&HIV-2 AB SNG	87389						
11/30	2789789 001		2573.00	2573.00				
2D ECH	O W/DOPPLER + CO	C8929						
11/30	2421586 001		3.85	3.85				
FOLIC	ACID TAB 1MG U/D	D00241						
11/30	2421722 001		3.85	3.85				
DOCUSA	TE SODIUM 100MG	D01021						
11/30	2421722 001		3.85	3.85				
DOCUSA	TE SODIUM 100MG	D01021						
11/30	2421722 001		3.85	3.85				
DOCUSA	TE SODIUM 100MG	D01021						
11/30	2421728 001		3.85	3.85				
MULTIV	ITAMIN U/D	D03140						
11/30	2422240 001		8.00	8.00				
FAMOTI	DINE 20MG TAB U/	D00141						
11/30	2422240 001		8.00	8.00				
FAMOTI	DINE 20MG TAB U/	D00141						
11/30	3280002 001		1815.00	1815.00				
ROOM	B605							
12/01	2426359 001		133.20	133.20				
CEFEPI	ME 500MG-2GM INJ	J0692						
12/01	2426359 001		133.20	133.20				
CEFEPI	ME 500MG-2GM INJ	J0692						

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 8

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/01	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				
12/01	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/01	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/01	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/01	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/01	1823550 001 VANCOMYCIN LEVEL	80202	184.00	184.00				
12/01	1825069 001 COMP METABOLIC PANEL	80053	454.00	454.00				
12/01	1832218 001 CBC W AUTO DIFF	85025	209.00	209.00				
12/01	1844711 001 AEROBIC CULT ISO & PRE	87070	91.00	91.00				
12/01	2711010 001 CHEST 1 VIEW	71045	391.00	391.00				
12/01	2421586 001 FOLIC ACID TAB 1MG U/D	D00241	3.85	3.85				
12/01	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/01	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/01	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/01	2421728 001 MULTIVITAMIN U/D	D03140	3.85	3.85				
12/01	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/01	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 9

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/01	0810150 001 ELECTROCARDIOGRAM,12	L93005	300.00	300.00				
12/01	3070002 001 ROOM	1047	1815.00	1815.00				
12/02	2423206 008 CEFTRIAXONE SOD 250MG-	J0696	103.15	103.15				
12/02	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				
12/02	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				
12/02	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/02	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/02	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/02	1825069 001 COMP METABOLIC PANEL	80053	454.00	454.00				
12/02	1832218 001 CBC W AUTO DIFF	85025	209.00	209.00				
12/02	2421586 001 FOLIC ACID TAB 1MG U/D	D00241	3.85	3.85				
12/02	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/02	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/02	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/02	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/02	2421728 001 MULTIVITAMIN U/D	D03140	3.85	3.85				
12/02	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005
BIRTH-DATE
02/14/92

PAGE NO. 10

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

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

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/02	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/02	3070002 001 ROOM 1047		1815.00	1815.00				
12/03	2423206 008 CEFTRIAXONE SOD 250MG-J0696		103.15	103.15				
12/03	2426493 004 ENOXAPARIN 10MG- 40MG J1650		31.45	31.45				
12/03	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/03	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/03	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/03	1825069 001 COMP METABOLIC PANEL 80053		454.00	454.00				
12/03	1832218 001 CBC W AUTO DIFF 85025		209.00	209.00				
12/03	2800158 001 CT ABDOMEN+PELVIS W/ C74177		5999.00	5999.00				
12/03	2806810 001 CT CHEST DGNSTIC W/ CT71260		2241.00	2241.00				
12/03	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				
12/03	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/03	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/03	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/03	2421728 001 MULTIVITAMIN U/D D03140		3.85	3.85				
12/03	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

BIRTH-DATE 02/14/92

PAGE NO. 11

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/03	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/03	3070002 001 ROOM 1047		1815.00	1815.00				
12/04	2423206 008 CEFTRIAXONE SOD 250MG-J0696		103.15	103.15				
12/04	2426493 004 ENOXAPARIN 10MG- 40MG J1650		31.45	31.45				
12/04	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/04	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/04	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/04	1825069 001 COMP METABOLIC PANEL 80053		454.00	454.00				
12/04	1832218 001 CBC W AUTO DIFF 85025		209.00	209.00				
12/04	1832263 001 PROTHROMBIN TIME 85610		76.00	76.00				
12/04	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				
12/04	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/04	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/04	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/04	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/04	2421728 001 MULTIVITAMIN U/D D03140		3.85	3.85				
12/04	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 12

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/04	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/04	3070002 001		1815.00	1815.00				
ROOM	1047							
12/05	2423206 008		103.15	103.15				
CEFTRIAXONE SOD 250MG-J0696								
12/05	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/05	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/05	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/05	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/05	1821659 001		147.00	147.00				
C-REACTIVE PROTEIN 86140								
12/05	1823480 001		120.00	120.00				
MAGNESIUM, SERUM 83735								
12/05	1825069 001		454.00	454.00				
COMP METABOLIC PANEL 80053								
12/05	1832218 001		209.00	209.00				
CBC W AUTO DIFF 85025								
12/05	1832272 001		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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 13

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/05	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/05	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/05	3070002 001 ROOM 1047		1815.00	1815.00				
12/06	2423206 008 CEFTRIAXONE SOD 250MG-J0696		103.15	103.15				
12/06	2426493 004 ENOXAPARIN 10MG- 40MG J1650		31.45	31.45				
12/06	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/06	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/06	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/06	1803598 001 ADENOSINE DEAMINASE FL84311		150.00	150.00				
12/06	1820077 001 FLUID PH	83986	6.00	6.00				
12/06	1821659 001 C-REACTIVE PROTEIN	86140	147.00	147.00				
12/06	1823425 001 GLUCOSE FLUID	82945	102.00	102.00				
12/06	1823480 001 MAGNESIUM, SERUM	83735	120.00	120.00				
12/06	1825069 001 COMP METABOLIC PANEL	80053	454.00	454.00				
12/06	1832218 001 CBC W AUTO DIFF	85025	209.00	209.00				
12/06	1832263 001 PROTHROMBIN TIME	85610	76.00	76.00				
12/06	1832264 001 PTT	85730	94.00	94.00				

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

BIRTH-DATE
02/14/92

PAGE NO.
14

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/06	1832272 001		75.00	75.00				
SEDIMENTATION RATE AUT85652								
12/06	1832656 001		184.00	184.00				
BODY FLUID PROFILE 89051								
12/06	1844704 001		154.00	154.00				
AFB CULTURE ISO & PRES87116								
12/06	1844705 001		98.00	98.00				
ACID FAST STAIN FOR BA87206								
12/06	1844707 001		107.00	107.00				
CONCENTRATION OF SAMPL87015								
12/06	1844709 001		101.00	101.00				
FUNGUS CULT ISO & PRSM87102								
12/06	1844710 001		82.00	82.00				
WET MOUNT 87210								
12/06	1844711 001		91.00	91.00				
AEROBIC CULT ISO & PRE87070								
12/06	1844712 001		112.00	112.00				
ANAEROBIC CULT ISO & P87075								
12/06	1844715 001		61.00	61.00				
SMEAR FOR BACTERIA 87205								
12/06	1844720 001		275.00	275.00				
OVA-PARASITES FECAL 87177								
12/06	1845087 001		138.00	138.00				
O&P TRICHROME STAIN 87209								
12/06	1845087 001		138.00	138.00				
O&P TRICHROME STAIN 87209								
12/06	1870001 001		57.83	57.83				
CYTOPATH CELL ENHANCE 88112								
12/06	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/06	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/06	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 15

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

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

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/06	2421722 001		3.85	3.85				
DOCUSATE	SODIUM 100MG D01021							
12/06	2421728 001		3.85	3.85				
MULTIVITAMIN	U/D D03140							
12/06	2422240 001		8.00	8.00				
FAMOTIDINE	20MG TAB U/D00141							
12/06	2422240 001		8.00	8.00				
FAMOTIDINE	20MG TAB U/D00141							
12/06	3070002 001		1815.00	1815.00				
ROOM	1047							
12/07	2420855 020		16.50	16.50				
LIDOCAINE	HCL 10MG-1%2J2001							
12/07	2423205 004		16.50	16.50				
CEFTRIAXONE	SOD 250MG-J0696							
12/07	2423206 008		103.15	103.15				
CEFTRIAXONE	SOD 250MG-J0696							
12/07	2426493 004		31.45	31.45				
ENOXAPARIN	10MG- 40MG J1650							
12/07	2427955 001		3.85	3.85				
METRONIDAZOLE	500MG TAD00108							
12/07	2427955 001		3.85	3.85				
METRONIDAZOLE	500MG TAD00108							
12/07	2429026 001		16.50	16.50				
FENTANYL	CITRATE 2ML J3010							
12/07	2429282 002		16.50	16.50				
MIDAZOLAM	1MG- MG/ML J2250							
12/07	2429337 001		16.50	16.50				
MORPH	SULF 10MG-2MG CAJ2270							
12/07	2429337 001		16.50	16.50				
MORPH	SULF 10MG-2MG CAJ2270							
12/07	2429337 001		16.50	16.50				
MORPH	SULF 10MG-2MG CAJ2270							
12/07	2429337 001		16.50	16.50				
MORPH	SULF 10MG-2MG CAJ2270							

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 16

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

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

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/07	2845630 002		1846.00	1846.00				
FISTULA/SINUS TRACT		76080						
12/07	2847415 002		1928.00	1928.00				
CHANGE OF CATHETER/DRA75984								
12/07	2847425 001		923.00	923.00				
FISTULAGRAM/ABSCESSOGR76080								
12/07	2847425 001		923.00-	923.00-				
FISTULAGRAM/ABSCESSOGR76080								
12/07	2849087 002		6520.00	6520.00				
LVG & EXCH OF ABSC CAT49423								
12/07	2839891 001		397.00	397.00				
SED >5YRS 1ST 15MIN SA99152								
12/07	2839893 003		546.00	546.00				
SED EA ADD 15 MIN;SAME99153								
12/07	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/07	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/07	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/07	2421728 001		3.85	3.85				
MULTIVITAMIN U/D		D03140						
12/07	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/07	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/07	2426661 001		3.85	3.85				
TRAMADOL 50MG UD TAB		D03826						
12/07	3070002 001		1815.00	1815.00				
ROOM	1047							
12/08	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/08	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

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

331361005

PAGE NO. 17

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/08	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/08	2429337 001		16.50	16.50				
MORPH SULF 10MG-2MG CAJ2270								
12/08	2429337 001		16.50	16.50				
MORPH SULF 10MG-2MG CAJ2270								
12/08	2429337 001		16.50	16.50				
MORPH SULF 10MG-2MG CAJ2270								
12/08	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/08	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/08	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/08	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/08	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
12/08	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/08	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/08	2426661 001		3.85	3.85				
TRAMADOL 50MG UD TAB D03826								
12/08	3070002 001		1815.00	1815.00				
ROOM 1047								
12/09	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/09	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/09	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/09	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 18

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/09	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/09	2429337 001 MORPH SULF 10MG-2MG	CAJ2270	16.50	16.50				
12/09	2429337 001 MORPH SULF 10MG-2MG	CAJ2270	16.50	16.50				
12/09	1825069 001 COMP METABOLIC PANEL	80053	454.00	454.00				
12/09	1832218 001 CBC W AUTO DIFF	85025	209.00	209.00				
12/09	1844720 001 OVA-PARASITES FECAL	87177	275.00	275.00				
12/09	1845087 001 O&P TRICHROME STAIN	87209	138.00	138.00				
12/09	1845087 001 O&P TRICHROME STAIN	87209	138.00	138.00				
12/09	2421586 001 FOLIC ACID TAB 1MG U/	DD00241	3.85	3.85				
12/09	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/09	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/09	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/09	2421728 001 MULTIVITAMIN U/D	D03140	3.85	3.85				
12/09	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/09	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/09	3070002 001 ROOM 1047		1815.00	1815.00				
12/10	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

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

331361005

PAGE NO. 19

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/10	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/10	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/10	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/10	2429337 001 MORPH SULF 10MG-2MG CAJ2270		16.50	16.50				
12/10	4810362 001 OT EVAL INTERMEDIATE 97166		446.00	446.00				
12/10	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				
12/10	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/10	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/10	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/10	2421728 001 MULTIVITAMIN U/D D03140		3.85	3.85				
12/10	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/10	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/10	3070002 001 ROOM 1047		1815.00	1815.00				
12/11	2426493 004 ENOXAPARIN 10MG- 40MG J1650		31.45	31.45				
12/11	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/11	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/11	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 20

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/11	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/11	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/11	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/11	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/11	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/11	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
12/11	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/11	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/11	3070002 001		1815.00	1815.00				
ROOM	1047							
12/12	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/12	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/12	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/12	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/12	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/12	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/12	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/12	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 21

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/12	2421728 001		3.85	3.85				
MULTIVITAMIN U/D		D03140						
12/12	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/12	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/12	3070002 001		1815.00	1815.00				
ROOM	1047							
12/13	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/13	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/13	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/13	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/13	2427955 001		3.85-	3.85-				
METRONIDAZOLE 500MG TAD00108								
12/13	2427955 001		3.85-	3.85-				
METRONIDAZOLE 500MG TAD00108								
12/13	2800158 001		5999.00	5999.00				
CT ABDOMEN+PELVIS W/ C74177								
12/13	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/13	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/13	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/13	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/13	2421728 001		3.85	3.85				
MULTIVITAMIN U/D		D03140						
12/13	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

PAGE NO. 22

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/13	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/13	3070002 001		1815.00	1815.00				
ROOM 1047								
12/14	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/14	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/14	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/14	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/14	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/14	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/14	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
12/14	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/14	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/14	3070002 001		1815.00	1815.00				
ROOM 1047								
12/15	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/15	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/15	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/15	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/15	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 23

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS: VARUN SUNDRIYAL, 137 YAMUNA VIHAR, DELHI 00009, INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT: $

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
12/15	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/15	2421728 001 MULTIVITAMIN U/D	D03140	3.85	3.85				
12/15	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/15	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/15	3070002 001 ROOM 1047		1815.00	1815.00				
12/16	2420855 020 LIDOCAINE HCL 10MG-1%	2J2001	16.50	16.50				
12/16	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				
12/16	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/16	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/16	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/16	2429026 001 FENTANYL CITRATE 2ML	J3010	16.50	16.50				
12/16	2845630 002 FISTULA/SINUS TRACT	76080	1846.00	1846.00				
12/16	2847425 001 FISTULAGRAM/ABSCESSOGR	76080	923.00	923.00				
12/16	2847425 001 FISTULAGRAM/ABSCESSOGR	76080	923.00-	923.00-				
12/16	2849086 002 INJECTION ABSCESS CATH	49424	1876.00	1876.00				
12/16	2421586 001 FOLIC ACID TAB 1MG U/D	D00241	3.85	3.85				
12/16	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 24

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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	2421728 001		3.85	3.85				
MULTI	VITAMIN U/D	D03140						
12/16	2422240 001		8.00	8.00				
FAMOTI	DINE 20MG TAB U/D00141							
12/16	2422240 001		8.00	8.00				
FAMOTI	DINE 20MG TAB U/D00141							
12/16	3070002 001		1815.00	1815.00				
ROOM	1047							
12/17	2426493 004		31.45	31.45				
ENOXA	PARIN 10MG- 40MG J1650							
12/17	2427955 001		3.85	3.85				
METRO	NIDAZOLE 500MG TAD00108							
12/17	2427955 001		3.85	3.85				
METRO	NIDAZOLE 500MG TAD00108							
12/17	2427955 001		3.85	3.85				
METRO	NIDAZOLE 500MG TAD00108							
12/17	1840139 001		145.00	145.00				
COVID1	9 PANEL	U0004						
12/17	2421167 001		3.85	3.85				
CETIRI	ZINE 10MG TAB							
12/17	2421586 001		3.85	3.85				
FOLIC	ACID TAB 1MG U/DD00241							
12/17	2421722 001		3.85	3.85				
DOCUSA	TE SODIUM 100MG D01021							
12/17	2421728 001		3.85	3.85				
MULTI	VITAMIN U/D	D03140						
12/17	2422240 001		8.00	8.00				
FAMOTI	DINE 20MG TAB U/D00141							
12/17	2422240 001		8.00	8.00				
FAMOTI	DINE 20MG TAB U/D00141							
12/17	3070002 001		1815.00	1815.00				
ROOM	1047							
12/18	2426493 004		31.45	31.45				
ENOXA	PARIN 10MG- 40MG J1650							

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 25

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33	

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/18	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/18	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/18	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/18	1823480 001 MAGNESIUM, SERUM	83735	120.00	120.00				
12/18	1823900 001 BASIC METABOLIC PANEL	80048	314.00	314.00				
12/18	1832218 001 CBC W AUTO DIFF	85025	209.00	209.00				
12/18	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/18	2421586 001 FOLIC ACID TAB 1MG U/D	D00241	3.85	3.85				
12/18	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/18	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/18	2421728 001 MULTIVITAMIN U/D	D03140	3.85	3.85				
12/18	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/18	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/18	3010002 001 ROOM 0707		1815.00	1815.00				
12/19	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				
12/19	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				
12/19	2427955 001 METRONIDAZOLE 500MG	TAD00108	3.85	3.85				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

BIRTH-DATE
02/14/92

PAGE NO. 26

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

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

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/19	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/19	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/19	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				
12/19	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/19	2421728 001 MULTIVITAMIN U/D D03140		3.85	3.85				
12/19	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/19	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/19	3010002 001 ROOM 0707		1815.00	1815.00				
12/20	2426493 004 ENOXAPARIN 10MG- 40MG J1650		31.45	31.45				
12/20	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/20	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/20	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/20	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/20	1825069 001 COMP METABOLIC PANEL 80053		454.00	454.00				
12/20	1832218 001 CBC W AUTO DIFF 85025		209.00	209.00				
12/20	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/20	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 27

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/20	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/20	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/20	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/20	2421728 001 MULTIVITAMIN U/D	D03140	3.85	3.85				
12/20	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/20	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/20	3010002 001 ROOM 0707		1815.00	1815.00				
12/21	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				
12/21	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/21	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/21	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/21	1840140 001 COVID19 JMH STAT	U0002	75.00	75.00				
12/21	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/21	2421586 001 FOLIC ACID TAB 1MG U/D	D00241	3.85	3.85				
12/21	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/21	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/21	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 28

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS: VARUN SUNDRIYAL, 137 YAMUNA VIHAR, DELHI 00009, INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/21	2421728 001		3.85	3.85				
MULTIVITAMIN U/D		D03140						
12/21	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/21	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/21	3010002 001		1815.00	1815.00				
ROOM	0707							
12/22	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/22	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/22	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								
12/22	2421167 001		3.85	3.85				
CETIRIZINE 10MG TAB								
12/22	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/22	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/22	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/22	2421728 001		3.85	3.85				
MULTIVITAMIN U/D		D03140						
12/22	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/22	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/22	3010002 001		1815.00	1815.00				
ROOM	0707							
12/23	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/23	2427955 001		3.85	3.85				
METRONIDAZOLE 500MG TAD00108								

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 STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 29

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT: $

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
12/23	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/23	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/23	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/23	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				
12/23	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/23	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/23	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/23	2421728 001 MULTIVITAMIN U/D D03140		3.85	3.85				
12/23	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/23	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/23	3010002 001 ROOM 0708		1815.00	1815.00				
12/24	2426493 004 ENOXAPARIN 10MG- 40MG J1650		31.45	31.45				
12/24	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/24	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/24	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/24	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/24	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 30

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/24	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/24	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/24	2421728 001 MULTIVITAMIN U/D	D03140	3.85	3.85				
12/24	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/24	2422240 001 FAMOTIDINE 20MG TAB U/	D00141	8.00	8.00				
12/24	3010002 001 ROOM 0708		1815.00	1815.00				
12/25	2426493 004 ENOXAPARIN 10MG- 40MG	J1650	31.45	31.45				
12/25	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/25	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/25	2427955 001 METRONIDAZOLE 500MG TA	D00108	3.85	3.85				
12/25	1840143 001 SARS-COV-2/FLU/RSV C	40241U	143.00	143.00				
12/25	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/25	2421586 001 FOLIC ACID TAB 1MG U/D	D00241	3.85	3.85				
12/25	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/25	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				
12/25	2421722 001 DOCUSATE SODIUM 100MG	D01021	3.85	3.85				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

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

331361005

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 31

BIRTH-DATE 02/14/92

HOSP.NO.

I	S	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/25	2421728 001		3.85	3.85				
MULTI	VITAMIN U/D	D03140						
12/25	2422240 001		8.00	8.00				
FAMOT	IDINE 20MG TAB U/	D00141						
12/25	2422240 001		8.00	8.00				
FAMOT	IDINE 20MG TAB U/	D00141						
12/25	3010002 001		1815.00	1815.00				
ROOM	0708							
12/26	2426493 004		31.45	31.45				
ENOXA	PARIN 10MG- 40MG	J1650						
12/26	2427955 001		3.85	3.85				
METRO	NIDAZOLE 500MG TA	D00108						
12/26	2427955 001		3.85	3.85				
METRO	NIDAZOLE 500MG TA	D00108						
12/26	2427955 001		3.85	3.85				
METRO	NIDAZOLE 500MG TA	D00108						
12/26	2421167 001		3.85	3.85				
CETIR	IZINE 10MG TAB							
12/26	2421586 001		3.85	3.85				
FOLIC	ACID TAB 1MG U/D	D00241						
12/26	2421722 001		3.85	3.85				
DOCUS	ATE SODIUM 100MG	D01021						
12/26	2421722 001		3.85	3.85				
DOCUS	ATE SODIUM 100MG	D01021						
12/26	2421728 001		3.85	3.85				
MULTI	VITAMIN U/D	D03140						
12/26	2422240 001		8.00	8.00				
FAMOT	IDINE 20MG TAB U/	D00141						
12/26	2422240 001		8.00	8.00				
FAMOT	IDINE 20MG TAB U/	D00141						
12/26	3010002 001		1815.00	1815.00				
ROOM	0708							
12/27	2426493 004		31.45	31.45				
ENOXA	PARIN 10MG- 40MG	J1650						

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

PAGE NO. 32

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/27	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/27	2427955 001 METRONIDAZOLE 500MG TAD00108		3.85	3.85				
12/27	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/27	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				
12/27	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/27	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/27	2421728 001 MULTIVITAMIN U/D D03140		3.85	3.85				
12/27	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/27	2422240 001 FAMOTIDINE 20MG TAB U/D00141		8.00	8.00				
12/27	3010002 001 ROOM 0708		1815.00	1815.00				
12/28	2426493 004 ENOXAPARIN 10MG- 40MG J1650		31.45	31.45				
12/28	1840135 001 STAPH AUREUS PCR 87640		51.00	51.00				
12/28	1840136 001 MRSA PCR 87641		51.00	51.00				
12/28	2421167 001 CETIRIZINE 10MG TAB		3.85	3.85				
12/28	2421586 001 FOLIC ACID TAB 1MG U/DD00241		3.85	3.85				
12/28	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				
12/28	2421722 001 DOCUSATE SODIUM 100MG D01021		3.85	3.85				

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

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

331361005

BIRTH-DATE 02/14/92

PAGE NO. 33

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/28	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/28	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
12/28	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
12/28	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/28	3010002 001		1815.00	1815.00				
ROOM	0708							
12/29	2426493 004		31.45	31.45				
ENOXAPARIN 10MG- 40MG J1650								
12/29	1840140 001		75.00	75.00				
COVID19 JMH STAT U0002								
12/29	2421167 001		3.85	3.85				
CETIRIZINE 10MG TAB								
12/29	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								
12/29	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/29	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/29	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/29	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
12/29	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/29	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
12/29	3010002 001		1815.00	1815.00				
ROOM	0708							
12/30	2421586 001		3.85	3.85				
FOLIC ACID TAB 1MG U/DD00241								

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

HCI #

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 34

BIRTH-DATE 02/14/92

HOSP.NO.

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
12/30	2421722 001		3.85	3.85				
DOCUSATE SODIUM 100MG D01021								
12/30	2421728 001		3.85	3.85				
MULTIVITAMIN U/D D03140								
12/30	2422240 001		8.00	8.00				
FAMOTIDINE 20MG TAB U/D00141								
TOTALS			129057.96					
TOTALS				129057.96				

PATIENT NUMBER 40020027436

PLEASE REFER TO PATIENT 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.

PAY THIS AMOUNT 0.00

JACKSON HEALTH SYSTEM
MIAMI, FL

HCI #

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

331361005

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

PAGE NO. 35

BIRTH-DATE 02/14/92

HOSP.NO.

I	S	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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
SUMMARY OF CHARGES								
R&C WARD	1DAYS@	1815.00	1815.00	1815.00				
R&C SEMI-PR	32DAYS@	1815.00	58080.00	58080.00				
	OTHER SURGERY		12848.00	12848.00				
	ANESTHESIA		943.00	943.00				
	EMERGENCY ROOM		1857.00	1857.00				
	LAB		17144.76	17144.76				
	IMAGING/X-RAY		26640.00	26640.00				
	PHARMACY		6411.20	6411.20				
	CARDIOLOGY		2873.00	2873.00				
	PT/OT/SPEECH THRPY		446.00	446.00				
SUB-TOTAL OF CHARGES			129057.96					
				129057.96				

GUAR RELATIONSHIP: SEX: M GUAR NO:
ACC-DATE: TYPE: TIME: PLACE: EMPL REL:
DSCH/FINAL DIAGNOSIS: K75.0
ADM. DIAGNOSIS: R10.9
PROCEDURE: 0FB03ZZ 12/07/21
0W993ZZ 12/06/21

A PUBLIC HOSPITAL LICENSED BY THE
STATE OF FLORIDA

T O T A L S 129057.96
T O T A L S 129057.96

PATIENT NUMBER 40020027436

PLEASE REFER TO PATIENT 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.

PAY THIS AMOUNT 0.00

JACKSON HEALTH SYSTEM
MIAMI, FL

HCI #

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

331361005
BIRTH-DATE 02/14/92

PAGE NO. 36

HOSP.NO.

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
FINAL	01/05/22	
INP.		

I S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020027436	M	29	11/27/21	12/30/21	33

GUAR PH: (000)000-0000

GUARANTOR NAME AND ADDRESS
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119
2	P01 SELF PAY		02141992

ARAGUEZ-ANCARES, NAYLE

AMOUNT OF PAYMENT $

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

BILLING ABSTRACT

DIAGNOSIS AND PROCEDURES:
ADMITTING DIAGNOSIS:
R10.9 UNSPECIFIED ABDOMINAL PAIN
DISCHARGE/FINAL DIAGNOSIS:
K75.0 *ABSCESS OF LIVER
U07.1 *COVID-19
J90 PLEURAL EFFUSION, NOT ELSEWHER
E87.1 HYPO-OSMOLALITY AND HYPONATREM
D63.8 ANEMIA IN OTHER CHRONIC DISEAS
E87.5 HYPERKALEMIA
N43.3 HYDROCELE, UNSPECIFIED
SURGICAL PROCEDURES:

Code	Description	Date	Physician
0FB03ZZ	*EXCISION OF LIVER, PERCUTANEOU	12/07/21	263500
0W993ZZ	DRAINAGE OF RIGHT PLEURAL CAVI	12/06/21	584700
0F9030Z	DRAINAGE OF LIVER WITH DRAINAG	11/27/21	424180
BW21YZZ	CT SCAN OF ABD & PELVIS USING	11/27/21	584700
B246YZZ		11/30/21	89410
BW25YZZ		12/03/21	584700
0FP0X0Z		12/16/21	240020

PHYSICIAN:
OPERATING:
263500 KRAUTHAMER, ANDRES ME129372
CONSULTING:
23825 GONZALES ZAMORA, JOSE ME129216

ALTERNATE CARE:
DISCHARGE DESTINATION:
AHR

TOTALS 129057.96

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 STATEMENT WAS PREPARED. OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

1 PHTJACKSON MEMORIAL HOSP
1611 NW 12TH AVENUE
MIAMI FL 331361005
8778816177 3053552273

2 PHTJACKSON MEMORIAL HOSP
PO BOX 947728
ATLANTA GA 30394

3a PAT. CNTL # 40020066477 Z06
b. MED. REC. # 5542571
4 TYPE OF BILL 0131
5 FED. TAX NO. 0000 591713947
6 STATEMENT COVERS PERIOD FROM 010422 THROUGH 010422
7

8 PATIENT NAME a
b SUNDRIYAL VARUN
9 PATIENT ADDRESS a 137 YAMUNA VIHAR
b DELHI c d 00009 e IN

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02141992	M			3	2		01													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
11	010422													

38
SUNDRIYAL VARUN
137 YAMUNA VIHAR

DELHI 00009

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0510	OFF/OP EST MAY X REQ PHY	99211	010422	1	231 00		
0001	PAGE 1 OF 1	CREATION DATE	010922	TOTALS	231 00	0 00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
Z06 STAR HEALTHCARE	00000	Y	Y	0 00	0 00

56 NPI 1225033020
57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SUNDRIYAL VARUN	18			
	00			
	00			

63 TREATMENT AUTHORIZATION CODES: NOTREQ
64 DOCUMENT CONTROL NUMBER: CC109119
65 EMPLOYER NAME

66 DX: A064
0
67 A B C D E F G H
I J K L M N O P Q
68

69 ADMIT DX
70 PATIENT REASON DX A064
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 1417244542 QUAL
LAST ROSA ESPINOZA FIRST ROSSANA
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
STAR HEALTHCARE
17621 WOODVIEW TERRA
BOCA RATON FL 33487

81 CC a B282N00000
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC™ National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1

JACKSON HEALTH SYSTEM
1611 NW 12TH AVENUE
MIAMI, FL 331361005
877 881-6177
FEI # 591713947

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	01/08/22	
INS.		

PAGE NO. 1

BIRTH-DATE 02/14/92

HOSP.NO. BCPROV

I C PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	OUT PATIENT
SUNDRIYAL ,VARUN	40020066477	M	29	01/04/22			

GUARANTOR NAME AND ADDRESS:
VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119

ROSA ESPINOZA, ROSSANA

AMOUNT OF PAYMENT: $

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
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
01/04	7960419 001		231.00	231.00				
ESTAB	PT LEVEL I	G0463						
SUMMARY OF CURRENT CHARGES								
	CLINIC		231.00	231.00				
SUB-TOTAL OF CURR. CHARGES			231.00	231.00				
DIAGNOSIS:		A06.4						
TOTALS			231.00	231.00				

A PUBLIC HOSPITAL LICENSED BY THE STATE OF FLORIDA

PATIENT NUMBER: 40020066477

PLEASE REFER TO PATIENT 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.

JACKSON HEALTH SYSTEM
MIAMI, FL

1

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

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	01/08/22	
OUTP.		

PAGE NO. 1

331361005

BIRTH-DATE 02/14/92

HOSP.NO. BCPROV

I C PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
SUNDRIYAL ,VARUN	40020066477	M	29	01/04/22		

GUARANTOR NAME AND ADDRESS

VARUN SUNDRIYAL
137 YAMUNA VIHAR
DELHI 00009
INDIA

C.O.B	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	Z06 INTL MISC INS		CC109119

ROSA ESPINOZA, ROSSANA

AMOUNT OF PAYMENT $

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
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
01/04	7960419 001		231.00	231.00				
ESTAB	PT LEVEL I	G0463						
BALANCE FORWARD			0.00					
SUMMARY OF CURRENT CHARGES								
	CLINIC		231.00	231.00				
SUB-TOTAL OF CURR. CHARGES			231.00	231.00				
TOTALS			231.00	231.00				

A PUBLIC HOSPITAL LICENSED BY
THE STATE OF FLORIDA

PATIENT NUMBER 40020066477

PLEASE REFER TO PATIENT 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.

PAY THIS AMOUNT 0.00

JACKSON HEALTH SYSTEM
MIAMI, FL