HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

RECEIVED
MAR 18 2024

FIVE POINTS BENEFIT PLANS
6006 N MESA ST STE 108
EL PASO TX 79912-4611

PICA XXX

GOE Industrial

RBP-EE

PICA XXX

CARRIER

1. MEDICARE [X] (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE MM DD YY 11 15 1960 SEX M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]
CITY EL PASO STATE TX	8. RESERVED FOR NUCC USE
ZIP CODE 79925-3404 TELEPHONE (Include Area Code) (915) 252-1560	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]	
7. INSURED'S ADDRESS (No., Street) [redacted]	
CITY EL PASO STATE TX	
ZIP CODE 79925-3404 TELEPHONE (Include Area Code) (915) 252-1560	
11. INSURED'S POLICY GROUP OR FECA NUMBER NONE	
a. INSURED'S DATE OF BIRTH MM DD YY 11 15 1960 SEX M [X] F [ ]	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 02/14/2024

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. R768 B. M2550 C. R5383 D. E. F. G. H. I. J. K. L.	

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0 00	
22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 02 14 2024	02 14 2024	11		99204		A B C	415 00	1		ZZ	207RR0500X
										NPI	1316916125
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 831712398 SSN EIN [X]	26. PATIENT'S ACCOUNT NO. 050239459360-1	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 415 00	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) R8538 03/07/24 SANJAY CHABRA D.O. SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION NEW WESTSIDE LOC 2600 N OREGON STREET EL PASO, TX 79902-3170 a. b.		33. BILLING PROVIDER INFO & PH. # (915) 317-1660 AARA TEXAS ARTHRITIS CENTER 2600 N OREGON ST EL PASO, TX 79902-3170 a. 1548742349 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHICH MAY ALSO BE ENVELOPE WINDOW

FIVEPOINTS
BENEFIT PLANS, LLC
6006 N Mesa Street - Suite 108
El Paso, TX 79912

Explanation of Benefits (EOB)
This statement shows how we applied your coverage to claim(s) submitted to us.
This is **NOT** a Bill

[redacted]
El Paso, TX 79925

G & E Industrial Supplies Inc	RBP-EE	
Effective From: 1/1/2023	**To:**	CURRENT

Explanation of Benefits (EOB)

Patient Name: [redacted]
Issue Date: 4/14/2024

Member I.D.# [redacted]

Date of Service	Service Code	Total Charges	Allowed Charges	Savings to Member	Deductible/ Other Ins.	*Co-Pay	Payment Responsibility	
							Plan	Member
2/14/2024	1	$415.00	$159.93	$255.07	$0.00	$35.00	$124.93	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
						Five Points Plan Responsibility		**$124.93**
						Member Responsibilty		**$35.00**

Provider Billing Address:	**AARA TEXAS ARTHRITIS CENTER** **2600 N OREGON ST** **EL PASO, TX 79902-3170**

Service Codes	Description:
1 - MEDICAL	CLAIM PAID IN FULL: The client is responsible for Co-Payment at the time of service. After repricing through the First Health Network, the client is responsible for 0% of the allowed amount and Five Points Benefit Plan is responsible for the remaining 100%.
2 - HOSPITAL	
3 - ER	
4 - LABS	
5 - IMAGING	

Please see attached repricing sheet for specific CPT Codes in Service

Member I.D. Number - your account # with our health plan
Total Charges - The total amount charged by a healthcare provider for services you received, whether or not the services are covered under your health plan.
First Health Network Allowed Charges - The amount receiving services from First Health Network provider within the network provider PPO.
Amount by Member & Five Points Health Plans, LLC - The amount paid to your health care provider.
Co-Insurance- The amount calculated using a fixed percentage you pay.
Amount not covered- The portion of the charges not covered under your health plan. Examples of Amount Not Covered include any of the following:
* Amount for services that are not medically necessary.
* Amount for services that are not covered by your health plan.
Member Responsibility - Your share for the services shown on this Explanation of Health Care Benefits (EOB). You may have already paid this amount to your health care provider.

Thank you for choosing Five Points Health Benefit Plans, LLC

Have questions?

Please email norman@fivepointsmecplan.com or iris@fivepointsmecplan.com. To find a participating provider call our customer service department at **915-803-4198** or visit our website www.fivepointshealthbenefits.com

Mail all inquiries or claims to Five Points Health Benefit Plans, LLC 6006 N Mesa Street - Suite 108 El Paso, TX 79912

If you need assistance in Spanish to understand this document, you may request it for free by calling customer service.

FIVE POINTS BENEFIT PLANS, LLC
6006 NORTH MESA STREET SUITE 108
EL PASO TX 79912
(915) 803-4198

Group:THE COMPANY STORE
Rcpt Dt:04-14-2024

PATIENT INFORMATION
FH INFORMATION

LAST : [redacted]
FIRST : [redacted] MI:
DOB : 11-15-1960 SEX:M RL:
INSD ID: [redacted]
PT SSN :

TYPE: Outpatient
FROM: 02-14-2024
THRU: 02-14-2024
CLAIM #: 224-105-R-000005-001
PT CTRL:

CLIENT # :997667466
CLIENT ID:KZU
CONTROL #:4-105-R-00005-01

PROVIDER INFORMATION NPI:
FTIN:831712398
FACILITY/OFFICE:
PROVIDER NAME : SANJAY CHABRA
2600 N OREGON ST
EL PASO TX 79902-

LINE	DATES OF SERVICE	PROCEDURE CODE	MOD	UNIT	BILLED CHARGES	NEGOTIATED RATE	SAVINGS
001	02-14-2024 02-14-2024	99204		001	415.00	159.93	255.07
TOTALS:					415.00	159.93	255.07

BILLED CHARGES	415.00
EXCLUDED AMOUNT	0.00
NEGOTIATED RATE	159.93
TOTAL SAVINGS	255.07

RECEIVED
MAY 06 2024

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

XXX ZBP-EE Dynamic Tool

PICA

CARRIER
FIVE POINTS BENEFIT PLAN
6006 N MESA ST
STE 108
EL PASO TX 799124611

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) X

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: 06 25 1962 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY: EL PASO STATE: TX

8. RESERVED FOR NUCC USE

CITY: EL PASO STATE: TX

ZIP CODE: 79936 TELEPHONE (Include Area Code): ( )

ZIP CODE: 79936 TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 06 25 1962 SEX: M X F

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature On File
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
Signature On File
SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO X $ CHARGES

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

A. R9431 B. 110 C. E088 D. E785
E. E669 F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 02 24	05 02 24	11		99214		ABCD	190 00	1		NPI	1679576565
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 842759856 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 1090

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

28. TOTAL CHARGE $ 190 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use 915 5004420

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ENOCH AGUNAINE MD, F
05 03 24
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
CARE CARDIOVASCULAR CENT
1351 N ZARAGOZA ROAD BUILDIN
EL PASO TX 799365909
1790333516
a. b.

33. BILLING PROVIDER INFO & PH # (
CARE CARDIOVASCULAR CENTER
1351 N ZARAGOZA ROAD BUILDING I
EL PASO TX 799365909
1790333516
a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

FIVEPOINTS
BENEFIT PLANS, LLC
6006 N Mesa Street - Suite 108
El Paso, TX 79912

Explanation of Benefits (EOB)
This statement shows how we applied your coverage to claim(s) submitted to us.
This is **NOT** a Bill

[redacted]
El Paso, TX 79936

Dynamic Tool Company Inc	RBP-EE	
Effective From: 6/1/2023	**To:**	CURRENT

Explanation of Benefits (EOB)

Patient Name: [redacted]
Issue Date: 7/9/2024

Member I.D.# [redacted]

Date of Service	Service Code	Total Charges	Allowed Charges	Savings to Member	Deductible/ Other Ins.	*Co-Pay	Payment Responsibility	
							Plan	Member
5/2/2024	1	$190.00	$114.00	$76.00	$0.00	$35.00	$79.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
						Five Points Plan Responsibility		**$79.00**
						Member Responsibilty		**$35.00**

Provider Billing Address:	C CARE CARDIOVASCULAR CENTER 1351 N ZARAGOZA ROAD BLDG L EL PASO, TX 79936-5909

Service Codes	Description:
1 - MEDICAL	CLAIM PAID IN FULL: *The client is responsible for Co-Payment at the time of service. After repricing through the First Health Network, the client is responsible for 0% of the allowed amount and Five Points Benefit Plan is responsible for the remaining 100%.
2 - HOSPITAL	
3 - ER	
4 - LABS	
5 - IMAGING	

Please see attached repricing sheet for specific CPT Codes in Service

Member I.D. Number - your account # with our health plan
Total Charges - The total amount charged by a healthcare provider for services you received, whether or not the services are covered under your health plan.
First Health Network Allowed Charges - The amount receiving services from First Health Network provider within the network provider PPO.
Amount by Member & Five Points Health Plans, LLC - The amount paid to your health care provider.
Co-Insurance- The amount calculated using a fixed percentage you pay.
Amount not covered- The portion of the charges not covered under your health plan. Examples of Amount Not Covered include any of the following:
* Amount for services that are not medically necessary.
* Amount for services that are not covered by your health plan.
Member Responsibility - Your share for the services shown on this Explanation of Health Care Benefits (EOB). You may have already paid this amount to your health care provider.

Thank you for choosing Five Points Health Benefit Plans, LLC

Have questions?

Please email norman@fivepointsmecplan.com or iris@fivepointsmecplan.com. To find a participating provider call our customer service department at **915-803-4198** or visit our website www.fivepointshealthbenefits.com

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FIVE POINTS BENEFIT PLANS, LLC
6006 NORTH MESA STREET SUITE 108
EL PASO TX 79912
(915) 803-4198

Group:THE COMPANY STORE Rcpt Dt:07-08-2024

PATIENT INFORMATION FH INFORMATION

LAST : [redacted]
FIRST : [redacted] MI:
DOB : 06-25-1962 SEX:M RL:
INSD ID: [redacted]
PT SSN :

TYPE: Outpatient
FROM: 05-02-2024
THRU: 05-02-2024
CLAIM #: 224-190-R-000163-001
PT CTRL:

CLIENT # :997667466
CLIENT ID:KZU
CONTROL #:4-190-R-00163-01

PROVIDER INFORMATION NPI: FTIN:842759856
FACILITY/OFFICE:
PROVIDER NAME : ENOCH AGUNANNE
1351 NORTH ZARAGOZA ROAD
EL PASO TX 79936-

LINE	DATES OF SERVICE	PROCEDURE CODE	MOD	UNIT	BILLED CHARGES	NEGOTIATED RATE	SAVINGS
001	05-02-2024 05-02-2024	99214		001	190.00	114.00	76.00
TOTALS:					190.00	114.00	76.00

BILLED CHARGES	190.00
EXCLUDED AMOUNT	0.00
NEGOTIATED RATE	114.00
TOTAL SAVINGS	76.00