VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE (Page 2)

	15 P	EPORT OF SERVICES	RENDERED - ATTAC	H ADDIT	IONAL SHEETS IF	NECESSARY		
Date of	15. REPORT OF SERVICES RENDERED - ATTACH Date of Place of Service Description of Treatment or Health				Fee Schedule	The control of the co		
Service Including Zip Code			rvice Rendered		Treatment Code	E	Charges	
*					TOTAL CHARGES			
16. If treating p	rovider is different than	billing provider comple	te the following:					
	ing Provider's	T	License or			Business Relation		
Name		Title Certification No.				Check Applicable Box		
LIRAN I	MANONEL	MD	184765	5	Employee	Independent Contractor	Other (Specify)	
17. If the provi	der of service is a profes	sional service corporati	on or doing business unde		med name (DBA), lis	t the owner and pro	fessional licensing	
	of all owners (Provide a			. //	10 111	1	./	
LE DR	thopedic &	Sport M	ledicine, Y.C.	d/6	Id MEHRA	N MANOUE	EC ND 18476	
18. Is patient st	ill under your care for th	is condition? Ye	s No					
19. Estimated	luration of future treatm	ent	ermined A-	/ 1				
ALSO ENTE	YOU HAVE CHOSE R INTO AN ASSIGNM ATION TO PAY BENE	IENT OF BENEFITS	THE DIRECT PAYM CONTAINED IN ITEM	IENT OF <u>1 #21)</u>	BENEFITS BY C	HECKING THIS	OPTION, <u>YOU MAY N</u>	
I AUTHORI DESCRIBED	ZE PAYMENT OF	HEALTH BENEFITS N ALL RIGHTS, PRI	S TO THE UNDERSI VILEGES AND REMI	IGNED I EDIES TO	HEALTH CARE IN WHICH I AM I	PROVIDER OR SENTITLED UNDE	SUPPLIER OF SERVIOR ARTICLE 51 (THE	
PRINT NAMI	EPATI	ENT	SIGNED		PATIENT		DATE	
				1.1.6		dianethy to seem be	ealth provider (Assignmen	
Benefits). If y equivalent. T other written	you and your health prov he language contained in agreement.	vider agree to an assign in the assignment of be	ment of benefits, you mus nefits is mandatory and r	st both sig may not b	n the agreement cont e altered or avoided	ained in #21 or the p by any other langua	prescribed NF-AOB form of agreement	
21. X (II	F YOU HAVE CHOSE IR INTO AN AUTHO	EN TO ASSIGN YOU RIZATION TO PAY E	R BENEFITS TO THE BENEFITS CONTAINE	HEALT	H PROVIDER BY M #20 ABOVE)	CHECKING THIS	OPTION, YOU MAY	
ASSIGNMEN	NT OF NO-FAULT BE	NEFTTS:						
HEALTH CA INSURANCI ASSIGNOR INJURIES S AGREEMEN	ARE SERVICES PROV E LAW. THE ASSIGN AND SHALL NOT P USTAINED DUE TO T NT MAY BE REVOK	VIDED BY THE ASSIC NEE HEREBY CERTIC PURSUE PAYMENT THE MOTOR VEHICL CED BY THE ASSIG	GNEE TO WHICH I AI IFIES THAT THEY HA DIRECTLY FROM TH LE ACCIDENT, NOTW NEE WHEN BENEFI NDITION DUE TO THE	M ENTITAVE NOT HE ASSICUTED ASSICUTE	LED UNDER ART RECEIVED ANY SNOR FOR SERV NDING ANY OTHE NOT PAYABLE	ICLE 51(THE NO- PAYMENT FROM ICES PROVIDED IR AGREEMENT ' BASED UPON TE	EDIES TO PAYMENT I FAULT STATUTE) OF M OR ON BEHALF OF BY SAID ASSIGNEE TO THE CONTRARY. THE IE ASSIGNOR'S LACK R.	
PRINT NAM	E:	T (ASSIGNOR)	<u>&</u>) SIGNED:_	PATIEN	T	DATE	
PRINT NAM	E: MEHRAN	MANOUE LEALTH CARE SERVICE	MD SIGN	NED:	PROVIDER OF HEA			
		TION OR ASSIGNME	NT PREVIOUSLY BEET		TED?	YES NO		
APPLICAT BENEFITS CONCERN KNOWING THEFT, DE OF MOTO ALSO BE	ION FOR COMMER CONTAINING ANY ING ANY FACT MA LY MAKES OR KNO STRUCTION, DAMA R VEHICLES OR AN	CIAL INSURANCE MATERIALLY FALS ATERIAL THERETO OWINGLY ASSISTS, AGE OR CONVERSIO I INSURANCE COM TIL PENALTY NOT	OR A STATEMENT SE INFORMATION, O D, AND ANY PERSON ABETS, SOLICITS OR ON OF ANY MOTOR ' IPANY, COMMITS A TO EXCEED FIVE T	OF CLA OR CONC N WHO, R CONSP. VEHICL FRAUDI	IM FOR ANY CO EALS FOR THE F IN CONNECTION IRES WITH ANOT E TO A LAW ENF ILENT INSURANO	OMMERCIAL OF PURPOSE OF MIS N WITH SUCH A THER TO MAKE FORCEMENT AG CE ACT, WHICH	THER PERSON FILES R PERSONAL INSURA SLEADING, INFORMAT APPLICATION OR CL A FALSE REPORT OF ENCY, THE DEPARTM IS A CRIME, AND SE OF THE SUBJECT MO	
Date	Provider's Si				Identification No.		WCB Rating Code If None, Specialty	
				- 11	35189	13	020	

		2014 C 12	(Page 2)	· .	· ·		-	
			RENDERED - ATTACH AD		NECESSARY			
Date of Place of Service			f Treatment or Health	Fee Schedule		Charact		
- Service .	Including Zip Code	Serv	ice Rendered	Treatment Code		Charges		
					.			
٠.								
				TOTAL CHARGES TO DATE \$				
16 164	provider is different than bi	lling provider complet	e the following	1				
	ating Provider's	ining provider compres	License or	T	Business' Re	lationship	•	
	Name	Title	Certification No.			heck Applicable Box		
				Employee	Independ		(Specify)	
mehra	an Manauel	MO	184765	1	Contrac	tor /	°C	
17. If the pro	vider of service is a profess	ional service corporati	on or doing business under a	n assumed name (DBA), 1	ist the owner a	nd professional licer	ising	
oredentia	als of all owners (Provide ar	. ``	it necessary).	. Pa D	11 ALA11	de brown	Manouel	
Able	Orthopedi	C & 5 por	rts Medicin	e 1 C. a	10(1)	10/180	1765	
	nt still under your bare for th		cs No					
19. Estimat	ed duration of future treatin	ent indo.	termine	DAL L	me-			
·	17 1 1 1t - maile ma	v agree to accept payor	nent for health services perform	/ / / /		rization to Pay Rev	refits) so that you	
are not rea	nired to make navment to th	e health provider at th	e time of service. Such agree rization language provided be	ment is optional on the p	art of the health	n provider and must	be signed by both	
20. ALSO ET	(IF YOU HAVE CHOS	EN TO AUTHORIZ	E THE DIRECT PAYME S CONTAINED IN ITEM	NT OF BENEFITS BY	CHECKING	THIS OPTION,	YOU MAY NOT	
ATITUO	RIZATION TO PAY BEN	EFITS:	•					
T AUTH	ORIZE PAYMENT OF	HEALTH BENEFI	TS TO THE UNDERSIG	NED HEALTH CAR	E PROVIDE	R OR SUPPLIER	OF SERVICES	
DESCRI	BED BELOW. I RETA	in all rights, P	RIVILEGES AND REMEI	DIES TO WHICH I AI	M ENTITLE	UNDER ARTIC	LE 51 (THE NO-	
FAULT	PROVISION) OF THE IN	POWINCE DE M.						
PRINT		TIENT	SIGNED	PATIEN	T	·	DATE	
Benefit equival	s). If you and your health p	rovider agree to an assi	u assign you right to no-fau gnment of benefits, you must benefits is mandatory and n	both sign the agreement	contained in #	21 or the prescribed	NF-AOB form or its	
21 >	,	SÉN TO ASSIGN Y	OUR BENEFITS TO THE	HEATTH PROVIDER	PV CURCE	NC THIS OPTIO	N VOU MAY.NOT	
-	ENTER INTO AN AUTI	IORIZATION TO PA	Y BENEFITS CONTAINE	D IN ITEM #20 ABOV	ET CHECK	ING THIS OF THO	N, TOO MATINOT	
I HEA	LTH CARE SERVICES P TRANCE LAW. THE ASS	HEALTH CARE PRO ROVIDED BY THE A SIGNEE HEREBY CI	OVIDER INDICATED BEI SSIGNEE TO WHICH I A ERTHIES THAT THEY H	M ENTITLED UNDER VE NOT RECEIVED	ARTICLE 51 ANY PAYMI	(THE NO-FAULT INT FROM OR O	STATUTE) OF THE N BEHALF OF THE	
- INJU	RIES SUSTAINED DUE T REFERENT MAY BE RE	OTHE MOTOR VE VOKED BY THE A	NT DIRECTLY FROM TI HICLE ACCIDENT, NOTW SSIGNEE WHEN BENEFI CONDITION DUE TO THE	THSTANDING ANY S TIS ARE NOT PAYAL EACTIONS OR COND	OTHER AGR	EEMENT TO THE UPON THE ASS	E CONTRARY. THIS	
(X) PRI	NT NAME:	TIENT (ASSIGNOR)	<u> </u>	SIGNED:				
1001			rouel Mosic	NED:	ATIENT		DATE	
I Ki	PROVIDER	OF HEALTH CARE SEE	RVICE (ASSIGNEE)		F HEALTH C	ARE SERVICE	DATE	
HA	S AN ORIGINAL AUTHO THE ORIGINAL SIGNATU	RIZATION OR ASSIGNATION OF THE PARTIES	NMENT PREVIOUSLY BE	EN EXECUTED?	E YES	□ NO	•	
A) B C K T	PPLICATION FOR COMENETTS CONTAINING ONCERNING ANY FACTION MAKES OF THEFT, DESTRUCTION, OF MOTOR VEHICLES	IMERCIAL INSURA ANY MATERIALLY T MATERIAL THE R KNOWINGLY ASS DAMAGE OR CONV OR AN INSURANCI A CIVIL PENALTY	ITH INTENT TO DEFR. NCE OR A STATEMEN' FALSE INFORMATION, RETO, AND ANY PERSO ISTS, ABETS, SOLICITS OF PERSON OF ANY MOTO E COMPANY, COMMITS NOT TO EXCEED FIVE OLATION.	OF CLAIM FOR A OR CONCEALS FOR ON WHO, IN CONNI OR CONSPIRES WITH R VEHICLE TO A LA A FRAUDULENT IN	INY COMM. THE PURP(ECTION WI I ANOTHER IW ENFORCE SURANCE A	ERCIAL OR PEI OSE OF MISLEAI IH SUCH APPL TO MAKE A FA EMENT AGENC CT, WHICH IS A	RSONAL INSURANCE DING, INFORMATION ICATION OR CLAIM LSE REPORT OF THE Y, THE DEPARTMENT L CRIME, AND SHALL	

IRS/TIN Identification No.

113518913

Provider's Signature

Date

WCB Rating Code
If None, Specialty
ORO