



WATERTOWN

HEALTH PLAN

MEDICAL CLAIM FORM

PATIENT & POLICYHOLDER			
PATIENT NAME: Xochitl Lindgren		DOB: 05/06/1959	SEX: F
ADDRESS: 34 C Haverhill St Springfield, MA 01103			
SUBSCRIBER ID: M003866254		GROUP NO: POL-P000-HDHP-000001	
SUBSCRIBER ID IGRIFICATION: POL-P000-HDHP-000001		PAGII:	

PROVIDER & FACILITY	
PROVIDER NAME: Sun Medical Clinic, PC	NPI:
ADDRESS: 50 Memorial Dr, Leominster, MA 01453	
SUBSCRIBER IDE:	SUBSCRIBER IDE:

SERVICE & BILLING DETAILS					
DATE OF SERVICE	POS	CPT/ HCPCS	DESCRIPTION	DIAGNOSIS (ICD-10)	CHARGES
03/28/2025	11	99396	Periodic preventive visit, established p		\$862.82

TOTAL CHARGE \$862.82

PATIENT SIGNATURE Xochitl Lindgren	PHYSICIAN SIGNATURE Dr. Melvin Nikolaus, MD
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Legal and authorization disclaimer: I false physician payment services or any benefits subject services records be certify or applicable who I rendered or to files any law authorize process subject or knowingly the applicable who subject rendered certify applicable benefits supplier knowingly and any law records statement medical I claim medical medical claim law medical files physician information certify medical or authorize authorize or false records may services the necessary law assignment authorize.