EVOCARE
C/O ACCOUNTS PAYABLE
4735 MELISSA WAY
BIRMINGHAM AL 35243

5689

HEALTH INSURANCE CLAIM FORM

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

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PICA A# 209520-0001 CNR534 P E 019 209520 PICA

CARRIER

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#) X (ID#)	MB02022588
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BLANK HOLLY	3. PATIENT'S BIRTH DATE MM DD YY 05 12 1968 SEX M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial) BLANK HOLLY	
5. PATIENT'S ADDRESS (No., Street) 6587 YALE RD	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) 6587 YALE RD	
CITY BARTLETT STATE TN	8. RESERVED FOR NUCC USE
CITY BARTLETT STATE TN	
ZIP CODE 38134 TELEPHONE (Include Area Code) (901) 326-2500	
ZIP CODE 38134 TELEPHONE (Include Area Code) (901) 326-2500	
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 10488009604	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH MM DD YY 05 12 1968 SEX M F X	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X 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.
SIGNATURE ON FILE 11/25/20
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 DN DAVID PRITCHARD MD	17a. 1GOTH000 17b. NPI 1871713537	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 X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind 0 A. J322 B. J321 C. H9319 D. E. 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 11 25 20	11		70551		ABC	1033 00	1		NPI	1669553764
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
621116618 X	10227387	X YES NO	$ 1033 00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (901) 387-2340
SAMUEL P BILYEU MD SIGNED 12/02/20 DATE	DIPC MRI SIEMENS 6401 POPLAR AVE MEMPHIS TN 38119- a. NPI b.	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 a. 1699725812 b. ZZ2085R0202X

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

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BIRMINGHAM AL 35243

HEALTH INSURANCE CLAIM FORM

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227073 PICA

CARRIER

PICA A# 227073-0001 CNR534 P E 003

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): MB00924685

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEADOWS AARON

3. PATIENT'S BIRTH DATE MM DD YY: 02 15 1992 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MEADOWS AARON

5. PATIENT'S ADDRESS (No., Street): 5167 CREEK CV

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

7. INSURED'S ADDRESS (No., Street): 5167 CREEK CV

CITY: ARLINGTON STATE: TN

8. RESERVED FOR NUCC USE

CITY: ARLINGTON STATE: TN

ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 503-5281

ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 503-5281

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: 1048800604

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: 02 15 1992 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: EVOCARE

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.

SIGNED: SIGNATURE ON FILE DATE: 12/01/20

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

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: DN SAMYA CRUZ MD

17a. 1GOTH000

17b. NPI 1417056409

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. J181 B. R062 C. D. E. 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 12 01 20		11		71046		AB	81 00	1		NPI	1649220120
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 621116618 X

26. PATIENT'S ACCOUNT NO.: 10232239

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

28. TOTAL CHARGE: $ 81 00

29. AMOUNT PAID: $

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.)

ROBERT A DUKE MD
SIGNED 12/04/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DIPC R&F
6401 POPLAR AVE
MEMPHIS TN 38119-

a. NPI b.

33. BILLING PROVIDER INFO & PH. # (901) 387-2340

DIAGNOSTIC IMAGING PC
PO BOX 1000 DEPT 275
MEMPHIS, TN 381480275

a. 1699725812 b. ZZ2085R0202X

PATIENT AND INSURED INFORMATION

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