

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

| HEALTH INSURANCE CLAIM FORM | CAR | | | |
|--|--|--|--|--|
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000 | 226303 PICA | | | |
| A# 226303-0001 CNR534 P E 019 | 1a. INSURED'S I D. NUMBER (For Program in Item 1) | | | |
| (Medicare #) (Medicard #) (ID#/DoD#) (Member ID#) (ID#) (ID#) | MB00321416 | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX MM DD YY | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | |
| TALBOT JILLIAN 06 06 1984 X 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED | TALBOT JILLIAN 7. INSURED'S ADDRESS (No., Street) | | | |
| 5. PATIENT'S ADDRESS (No., Street) | 1076 HEATHER LAKE DR | | | |
| 1076 HEATHER LAKE DR Self X Spouse Child Other CITY STATE 8. RESERVED FOR NUCC USE | CTATE | | | |
| COLLIERVILLE TN ZIP CODE TELEPHONE (Include Area Code) | COLLIERVILLE ZIP CODE 38017 11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800303 a. INSURED'S DATE OF BIRTH MM DD YY 06 06 1984 b. OTHER CLAIM ID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | | | |
| () | 38017 (901) 335-9821 | | | |
| 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 | | | |
| | 1048800303 | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) | a. INSURED'S DATE OF BIRTH MM DD YY M F 70 | | | |
| b. RESERVED FOR NUCC USE YES X NO | 06 06 1984 M X S D. OTHER CLAIM ID (Designated by NUCC) | | | |
| YES X NO | ANA | | | |
| c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | |
| YES X NO | EVOCARE d is there another health benefit plan? | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) | YES XNO If yes, complete items 9, 9a and 9d. | | | |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize | | | |
| 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 | payment of medical benefits to the undersigned physician or supplier for services described below. | | | |
| SIGNATURE ON FILE 10/22/20 | SIGNATURE ON FILE | | | |
| SIGNED DATE | SIGNED | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY QUAL MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY | | | |
| QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ZZ207X00000X | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | |
| DN FREDERICK AZAR MD 170 NPI 1821084633 | FROM DD YY MM DD YY | | | |
| 19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | 20. OUTSIDE LAB? \$ CHARGES | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) | YES X NO | | | |
| M25510 | CODE ORIGINAL REF. NO. | | | |
| A M25519 B C C D | 23. PRIOR AUTHORIZATION NUMBER | | | |
| | | | | |
| 24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS DIAGN | CHARGES THE PROVIDER ID # | | | |
| MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER | | | | |
| 10 22 20 11 71550 A | 1046 00 1 1669553764 | | | |
| 2 | NPI NPI | | | |
| | 1046 00 1 NPI 1669553764 NPI | | | |
| 3 | NPI NPI | | | |
| 4 | 2 | | | |
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| 5 | NPI NPI | | | |
| | NPI ST | | | |
| 6 | NPI | | | |
| 25, FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govi claims see back) | 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use | | | |
| 621116618 X 10196293 X YES NO 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION | \$ 1046 00 \$ 33. BILLING PROVIDER INFO & PH. # (901) 387-2340 | | | |
| INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse DIPC MRI SIEMENS | DIAGNOSTIC IMAGING PC | | | |
| apply to this bill and are made a part thereof.) 6401 POPLAR AVE | PO BOX 1000 DEPT 275 | | | |
| SAMUEL P BILYEU MD MEMPHIS TN 38119- | MEMPHIS, TN 381480275 | | | |
| SIGNED 10/28/20ATE a. D. | 1699725812 ZZ2085R0202X | | | |



EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

EALTH INSURANCE CLAIM FORM

| APPROVED BY NATIONAL UNIFORM CLAIM COMM | NITTEE (NUCC) 02/12 00000 | 000 | | | | |
|--|--|--|---|---|--|--|
| A# 226392-000 | PICA A# 226392-0001 CNR534 P E 003 226392 PICA | | | | | |
| 1. MEDICARE MEDICAID TRICARE | CHAMPVA GROUP HEALTH | PLAN FECA OTHER | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | | | |
| (Medicare #) (Medicaid #) (ID#/DoD#, | | (ID#) X (ID#) BIRTH DATE SEX | | | | |
| | MM I DE |) I YY | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | |
| CARVER MARY 5. PATIENT'S ADDRESS (No., Street) | | 5 1983 F X | CARVER MARY 7. INSURED'S ADDRESS (No., Street) | | | |
| 8765 MOUNT CARMEL I | Self x Sp | oouse Child Other | | CARMEL ROAD | | |
| CITY CARMEL I | 10111 | FOR NUCC USE | CITY | STATE STATE | | |
| BRIGHTON | TN | | BRIGHTON | TN | | |
| ZIP CODE TELEPHONE (Inc | lude Area Code) | | ZIP CODE | TELEPHONE (Include Area Code) | | |
| | L0-8803 | | 38011 | (901) 610-8803 | | |
| OTHER INSURED'S NAME (Last Name, First Name) | e, Middle Initial) 10. IS PATIEN | T'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP | OR FECA NUMBER | | |
| OTUES MAUSER'S SOLICY OF CROUP MUNICIPALITY | THE COURT | NTO 10 | MSSC | 057 | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBE | a. EMPLOYME | NT? (Current or Previous) YES VNO | a. INSURED'S DATE OF BIRTH SEX | | | |
| b. RESERVED FOR NUCC USE | b. AUTO ACCII | Δ | 12 05 198 b. OTHER CLAIM ID (Designated | 3 X | | |
| | | YES X NO | | 5, 11000, | | |
| c. RESERVED FOR NUCC USE | c. OTHER ACC | | c. INSURANCE PLAN NAME OF | PROGRAM NAME | | |
| | | YES X NO | EVOCARE | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CO | DDES (Designated by NUCC) | d. IS THERE ANOTHER HEALT! | BENEFIT PLAN? | | |
| | | | YES X NO | If yes, complete items 9, 9a and 9d. | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNA | BEFORE COMPLETING & SIGNING TH ATURE I authorize the release of any me | dical or other information necessary | INSURED'S OR AUTHORIZE payment of medical benefits to | D PERSON'S SIGNATURE I authorize to the undersigned physician or supplier for | | |
| to process this claim. I also request payment of g below. | E STORY CONTRACTOR OF CONTRACT | | services described below. | | | |
| SIGNATURE ON I | | 10/27/20 | | URE ON FILE | | |
| SIGNED | DATE GNANCY (LMP) 15. OTHER DATE | | SIGNED |) WORK IN CLIBRENT OCCUPATION | | |
| MM DD YY QUAL | QUAL | MM DD YY | FROM DD Y | O WORK IN CURRENT OCCUPATION MM DD YY TO | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER | SOURCE 17a 1GOTH | 000 | | ELATED TO CURRENT SERVICES | | |
| DN SAMYA CRUZ MD | 17b. NPI 141' | | FROM DD Y | Y MM DD YY | | |
| 19 ADDITIONAL CLAIM INFORMATION (Designated | by NUCC) | | 20 OUTSIDE LAB? | \$ CHARGES | | |
| | | | YES X NO | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJU | RY Relate A-L to service line below (24 | ICD Ind. 0 | 22. RESUBMISSION CODE | ORIGINAL REF. NO. | | |
| A. R7611 B. Z111 | C. L | D | | | | |
| E.L. F.L. | G | н. | 23. PRIOR AUTHORIZATION NU | MBER | | |
| 24. A. DATE(S) OF SERVICE B. | C. D. PROCEDURES, SERVI | ICES, OR SUPPLIES E. | F. G. | H. I. J. | | |
| From To PLACE MM DD YY MM DD YY SERVIC | OF (Explain Unusual Circ | umstances) DIAGNOSIS | DAYS | EPSDT ID. RENDERING | | |
| MM DD YY MM DD YY SERVIO | E EMG CPT/HCPCS | MODIFIER POINTER | \$ CHARGES UNITS | Plan QUAL PROVIDER ID. # | | |
| 10 27 20 13 | 71046 | AB | 81 00 1 | NPI 1649220120 | | |
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| | | | | 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 | 10199438 | X YES NO | \$ 81 00 s | | | |
| INCLUDING DEGREES OR CREDENTIALS | | | 33. BILLING PROVIDER INFO & | JUL 307-2340 | | |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | DIAGNOSTIC IMAGING PC | | | | |
| 6401 POPLAR AVE | | PO BOX 1000 DEPT 275 | | | | |
| SIGNED 10/30/20 TE | ROBERT A DUKE MD MEMPHIS TN 38119- | | | MEMPHIS, TN 381480275 | | |
| JUNE TO JUNE | 1900 | 1699725812 ZZ2085R0202X | | | | |



EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

| PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 | 0000000 | | | | |
|--|--|--|--|--|--|
| PICA A# 226422-0001 CNR534 | 1 1934 (1936) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 226422 PICA | | | |
| MEDICARE MEDICAID TRICARE CHAMPV | A GROUP FECA OTHER | ta. INSURED'S I.D. NUMBER (For Program in Item 1) | | | |
| (Medicare #) (Medicaid #) (ID#/DoD#) (Member I | (D#) HEALTH PLAN BLK LUNG (ID#) X(ID#) | MB03464678 | | | |
| . PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE SEX | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | |
| MUMMERT VALLI | 09 08 1961 | | | | |
| 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED | | 7. INSURED'S ADDRESS (No., Street) | | | |
| 3120 MARR CV Self X Spouse Child Other STATE 8. RESERVED FOR NUCC USE | | 3120 MARR CV | | | |
| 9 | | 50000 | | | |
| BARTLETT The Proof of Telephone (Include Area Code) | J. | BARTLETT TI ZIP CODE TELEPHONE (Include Area Code) | | | |
| 38134 (901) 388-6712 | | 38134 (901) 388-6712 | | | |
| 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 | | | |
| | | 1048800213 | | | |
| OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) | a. INSURED'S DATE OF BIRTH SEX | | | |
| | YES XNO | 09 08 1961 M | | | |
| RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) | b. OTHER CLAIM ID (Designated by NUCC) | | | |
| | YES XNO | | | | |
| RESERVED FOR NUCC USE | c. OTHER ACCIDENT? | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | |
| INSURANCE PLAN NAME OR PROGRAM NAME | YES XNO 10d. CLAIM CODES (Designated by NUCC) | EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | | | |
| INSURANCE PEAN NAME OF PROGRAM NAME | Tod. CEATW CODES (Designated by NOCC) | | | | |
| READ BACK OF FORM BEFORE COMPLETIN | G & SIGNING THIS FORM. | YES XNO If yes, complete items 9, 9a and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize | | | |
| PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eith | release of any medical or other information necessary ier to myself or to the party who accepts assignment | payment of medical benefits to the undersigned physician or supplier for services described below. | | | |
| SIGNATURE ON FILE | 10/28/20 | SIGNATURE ON FILE | | | |
| SIGNED | DATE | SIGNED | | | |
| DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. | OTHER DATE MM , DD , YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | | | |
| QUAL. QU | AL | FROM TO | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 1GOTH000 DN SAMYA CRUZ MD 17b NPI 1417056409 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | | | |
| | | | | | |
| DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to sen | vice line below (24E) | 22. PRIOR AUTHORIZATION NUMBER 23. PRIOR AUTHORIZATION NUMBER | | | |
| N200 R K429 | K5730 R310 | | | | |
| E G L | b | | | | |
| J.L. K.L | | | | | |
| | CEDURES, SERVICES, OR SUPPLIES E. | F. G. H. I. J. | | | |
| From To | PCS I MODIFIER POINTER | \$ CHARGES UNITS Plan QUAL PROVIDER ID # | | | |
| 0 28 20 11 7417 | A D CD | 604 00 1 1740047404 | | | |
| 0 28 20 11 7417 | 76 ABCD | 604 00 1 NPI 174024748 | | | |
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| | The state of the s | | | | |
| | | NPI | | | |
| | | | | | |
| FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S | ACCOUNT NO. 27, ACCEPT ASSIGNMENT? | NPI NPI 30. Rsvd for NUCC | | | |
| 621116618 X 10200 | (For govt_claims, see back) | s 604 00 s | | | |
| SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE F. | ACILITY LOCATION INFORMATION | 33 BILLING PROVIDER INFO & PH. # (901) 387-2340 | | | |
| INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse DIPC C | | DIAGNOSTIC IMAGING PC | | | |
| apply to this bill and are made a part thereof.) 6401 POPLAR AVE | | PO BOX 1000 DEPT 275 | | | |

LOUIS S PARVEY MD

MEMPHIS TN 38119-

MEMPHIS, TN 381480275

1699725812 | ZZ2085R0202X



EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

| APPROVED BY NATIONAL UNIFORM CLAIM COMM PICA A# 225239-000 | | 000000 | | | | | | | |
|---|-------------------------|--|---|---|---|------------------------------------|---------------|--|--|
| 1 MEDICARE MEDICAID TRICARE | CHAMPVA | | 003 FECA | OTHER | 1a. INSURED | 'S I.D. NUMBER | | 225239 PICA | |
| (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) 2 PATIENT'S NAME (Lock New York) (ID#/DoD#) (Member ID#) (ID#) | | | MB01573350 | | | | | | |
| UNDERWOOD BRYAN | | 3. PATIENT'S BIRTH DATE SEX MM DD YY | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | |
| F DATIENTIC ADDRESS | | 07 02 1997 X F 6 PATIENT RELATIONSHIP TO INSURED | | UNDERWOOD JEAN 7 INSURED'S ADDRESS (No., Street) | | | | | |
| 6680 BOOTH FORREST | 6680 BOOTH FORREST CV | | use Child X | | | | | | |
| DADUT EUR | | 8 RESERVED F | OR NUCC USE | | 6680 BOOTH FORREST | | EST CV STATE | | |
| BARTLETT ZIP CODE TELEPHONE (Inch. | Ide Area Code) | | | | BART | LETT | | TN | |
| 38135 (901) 60 | 5-8640 | | | | ZIP CODE | 24 | , | NE (Include Area Code) | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle India) | | | | 3813 | S POLICY GROU | P OR FECA | 01) 605-8640 | | |
| a OTHER INSURED'S POLICY OR GROUP NUMBER a FMPI DYMENT? (CURRENT OF PROPERTY) | | | 1048800604 | | | | | | |
| 6 Content of Previous) | | ous) | MM | DATE OF BIRTH | | SEX | | | |
| b. RESERVED FOR NUCC USE | | b. AUTO ACCIDE | YES X NO | PLACE (State) | | 26 196 IM ID (Designate | | FX | |
| a DECEDIED FOR INVOCATE | | | YES X NO | | I I | ow to (besignate | a by NUCCI | | |
| c. RESERVED FOR NUCC USE | | OTHER ACCID | | | | PLAN NAME OF | R PROGRAM | NAME | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | YES X NO ES (Designated by N | ILICO | EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | | | | |
| | | | | 1000) | YES | | | | |
| READ BACK OF FORM BE PATIENT'S OR AUTHORIZED PERSON'S SIGNAT to process this claim. I also request payment of government. | FORE COMPLETING A | SIGNING THIS I | FORM. | D DOCOCOUNT | 13 INSURED'S | OR ALITHOPIZE | D DEDCONIC | ete items 9, 9a and 9d. S SIGNATURE I authorize | |
| SIGNATURE ON F | ernment benefits either | to myself or to the | | | payment of t | medical benefits t cribed below | o the undersi | gned physician or supplier for | |
| SIGNED | | DATE | 11/30/2 | 0 | SIGNED | SIGNAT | URE C | ON FILE | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGN | 100 M 100 mm | HER DATE | MM , DD , | YY | 16. DATES PAT | TENT UNABLE TO |) WORK IN C | CURRENT OCCUPATION | |
| 17 NAME OF REFERRING PROVIDED OF CITIES SOURCE | | | | | O MIM DD YY | | | | |
| DN ZIAD YOUNES MD 176 NPI 1285619874 | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | | | | | | |
| 19 ADDITIONAL CLAIM INFORMATION (Designated by AULCO) | | | FROM TO 20. OUTSIDE LAB? \$ CHARGES | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) | | | YES X NO | | | | | | |
| R1013 - R945 | | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | | | | | | |
| E. L F. L | C. L | | D. L. | | 23. PRIOR AUTHORIZATION NUMBER | | | | |
| I. L J L 24. A. DATE(S) OF SERVICE B | K.L | | | | | 11011 1101 | WDEN | | |
| From To PLACE OF | (Explain | URES, SERVICES Unusual Circumst | , OR SUPPLIES ances) | E. DIAGNOSIS | F | G. DAYS | H. I. | J. RENDERING | |
| THE SERVICE | EMG CPT/HCPCS | MC | DDIFIER | POINTER | \$ CHARGES | (3.5) | Family QUAL. | | |
| 11 30 20 11 | 76700 | | | AB | 294 | 00 1 | NPI | 1649220120 | |
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| | | | | 1 | 1 | 1 1 | NPI | CIA | |
| | | | 7 | | | | 7 | PHYSICIAN | |
| 25 FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCO | DUNT NO | 27 ACCEPT ASSIG | NMENT? | 28. TOTAL CHAR | GE Loc | NPI NPI | | |
| 621116618 X | 1023107 | 4 | X YES | ee back) NO | | 4 00 8 | AMOUNT PAI | D 30 Rsvd for NUCC use | |
| 151 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 132 SERVICE FACILITY LOCATION INFORMATION 333 | | 33. BILLING PRO | VIDER INFO & P | | 387-2340 | | | | |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.) DIPC US 6401 POPLAR AVE | | DIAGNOSTIC IMAGING PC | | | | | | | |
| ROBERT A DUKE MD MEMPHIS TN 38119- | | | PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 | | | | | | |
| 12/02/20 | | | | 1699725812 ZZ2085R0202X | | | | | |