

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

| 0 | \cap | 0 | 0 | \cap | \cap | \cap | 0 | |
|---|--------|---|---|--------|--------|--------|---|--|
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| PICA 74 226679-0001 | | E 019 | | | 2 | 226679 PICA |
|--|--|-----------------------------|------------------|--|--------------------|-----------------------------|
| PICA A# 226679-0001 MEDICARE MEDICAID TRICARE | CHAMPVA GR | OUP FECA | | 1a INSURED'S I.D NUMBER | (F | or Program in Item 1) |
| (Medicare #) (Medicaid #) (ID#/DoD#) | (Member ID#) HE) | ALTH PLAN BLK LU | X (ID#) | MB03223359 | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initia | | NT'S BIRTH DATE | SEX | 4. INSURED'S NAME (Last Name | | dle Initial) |
| SLUDER CHRISTIE L | 02 | 19 1970 | F X | SLUDER CHRI 7 INSURED'S ADDRESS (No., 5 | | |
| 5. PATIENT'S ADDRESS (No., Street) | | NT RELATIONSHIP TO IN | | | | |
| 233 PALISADE ST | | X Spouse Child | Other | 233 PALISAD | DE DI | STATE |
| CITY | | RVED FOR NUCC USE | | MEMPHIS | | TN 832-6475 SEX F X |
| MEMPHIS | TN | | | ZIP CODE | TELEPHONE (In | clude Area Code) |
| ZIP CODE TELEPHONE (Include | | | | 38111 | (901) | 832-6475 |
| 38111 (901) 832 9 OTHER INSURED'S NAME (Last Name, First Name, M | -6475 | ATIENT'S CONDITION RE | LATED TO: | 11. INSURED'S POLICY GROUP | A | ER |
| 9 OTHER INSURED S NAME (Last Name First Name, W | iodio filmaly | | | 1048800604 | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLO | OYMENT? (Current or Pre | vious) | a. INSURED'S DATE OF BIRTH | | SEX |
| | | YES X | NO | 02 19 19 | | FX |
| b. RESERVED FOR NUCC USE | b. AUTO | ACCIDENT? | PLACE (State) | b. OTHER CLAIM ID (Designated | by NUCC) | |
| | | YES X | NO | | | |
| c. RESERVED FOR NUCC USE | c. OTHE | R ACCIDENT? | | c INSURANCE PLAN NAME OF | R PROGRAM NAM | E |
| | | YES X | | EVOCARE | LI DEMECIT DI AN | 2 |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d, CLA | AIM CODES (Designated I | by NUCC) | d. IS THERE ANOTHER HEALT | | ems 9, 9a and 9d. |
| | | NO THE FORM | | YES XNO 13 INSURED'S OR AUTHORIZE | D PERSON'S SIG | SNATURE Lauthorize |
| | ORE COMPLETING & SIGNING RE I authorize the release of a | | nation necessary | payment of medical benefits services described below | to the undersigned | d physician or supplier for |
| to process this claim. I also request payment of gover | mment benefits either to myser | ii or to the party who doce | pro acongrimen | Market Control | TURE ON | FILE |
| SIGNATURE ON FI | LE | 11/09 | /20 | SIGNED | TOKE ON | 1100 |
| SIGNED PRECNA | ANCY (LMP) 15 OTHER DA | DATE | | 16. DATES PATIENT UNABLE | TO WORK IN CUF | RENT OCCUPATION |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNAMM DD YY | QUAL | MM DD | YY | FROM DD | TO | MM DD YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SO | URCE 17a 1GC | OTHOOO | | 18. HOSPITALIZATION DATES | RELATED TO CU | RRENT SERVICES |
| DN SAMYA CRUZ MD | | L417056409 | | FROM DD | ТО | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by | NUCC) | | | 20. OUTSIDE LAB? | \$ CH/ | ARGES |
| | | | | YES X NO | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Relate A-L to service line be | elow (24E) ICD Ind. | 0 | 22. RESUBMISSION CODE | ORIGINAL REF | NO. |
| M542 | C. L | D. L | | 23 PRIOR AUTHORIZATION N | IUMBER | |
| E. L | G | H. L | | 23. PRIOR AUTHORIZATION I | IOMBETT | |
| I. L. DATE(S) OF SERVICE B. | C. D. PROCEDURES, | , SERVICES, OR SUPPLI | ES E. | F. G. | H. L. | J |
| From To PLACE OF | (Explain Unusi | ual Circumstances) | DIAGNOSIS | S CHARGES DAYS OR UNITS | Family QUAL | RENDERING PROVIDER ID # |
| MM DD YY MM DD YY SERVICE | EMG CPT/HCPCS I | MODIFIER | POINTER | 3 CHANGES ONITS | Fall Gories | |
| 11 09 20 11 | 72040 | | A | 79 00 1 | NPI | 1669553764 |
| 11,00,20 | 97 (CASA) \$10 m. (207 (1955) | | | | | |
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| | 1 | 1 1 1 | | 1 1 | NPI | |
| | | | | | 1,10,1 | |
| | | 1 1 1 | | 1 | NPI | |
| 25 FEDERAL TAX I D. NUMBER SSN EIN | 26. PATIENT'S ACCOUN | IT NO. 27 ACCEP | T ASSIGNMENT? | 28. TOTAL CHARGE | 29 AMOUNT PA | D 30. Rsvd for NUCC use |
| 621116618 X | 10212652 | (For govi | NO NO | s 79 00 | S | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER | 32 SERVICE FACILITY I | | 0.000 | 33. BILLING PROVIDER INFO | | 01 387-2340 |
| INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse | DIPC R&F | | | DIAGNOSTIC | | |
| apply to this bill and are made a part thereof.) | 6401 POPL | AR AVE | | PO BOX 1000 | DEPT | 275 |
| SAMUEL P BILYEU MD | MEMPHIS T | | | MEMPHIS, Th | 38148 | 0275 |
| 11/13/2015 | a | b. | | 1699725812 | b ZZ208 | 5R0202X |

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

TH INSURANCE CLAIM FORM

| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000 | |
|--|--|
| A# 226723-0001 CNR534 P E 020 | 226723 PICA |
| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER BLK LUNG (ID#) (Medicare #) (Medicare #) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) MB 0 2 7 9 3 1 7 8 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| HENDERSON TIFFANY 5. PATIENT'S ADDRESS (No., Street) MM DD YY YY TY TY TY TY TY | HENDERSON TIFFANY 7. INSURED'S ADDRESS (No., Street) |
| 2249 CYPRESS CIR Self X Spouse Child Other | 2249 CYPRESS CIR |
| CITY STATE 8. RESERVED FOR NUCC USE | CITY |
| MEMPHIS TN | MEMPHIS TN |
| ZIP CODE TELEPHONE (Include Area Code) | ZIP CODE TELEPHONE (Include Area Code) |
| 38112 901 299-5635 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO | 38112 901 299-5635 |
| | 1048800103 |
| a OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) | a. INSURED'S DATE OF BIRTH SEX |
| YES X NO | 07 25 1984 M |
| b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) | MEMPHIS ZIP CODE 38112 (901) 299-5635 11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800103 a INSURED'S DATE OF BIRTH MM DD YY 07 25 1984 b. OTHER CLAIM ID (Designated by NUCC) |
| c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| YES X NO | c. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? |
| d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? |
| | YES XNO 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. | INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for |
| below. | services described below. |
| SIGNATURE ON FILE 11/11/20 | SIGNATURE ON FILE |
| 14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION |
| QUAL. QUAL. | FROM TO |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ZZ363L00000X | 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY |
| DN LAURA ERICKSON-BLY NP 17b NPI 1659674208 | FROM TO 20. OUTSIDE LAB? \$ CHARGES |
| and the state of t | YES X NO |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) | 22. RESUBMISSION CODE ORIGINAL REF. NO. |
| A. M25572 B. S93402A C. D. | ONIGINAL REP NO. |
| E. L G. L H. L L | 23. PRIOR AUTHORIZATION NUMBER |
| 1. L J K L L L L 24. A. DATE(S) OF SERVICE B. C D. PROCEDURES. SERVICES, OR SUPPLIES E. | F. G. H. I J. |
| From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS | DAYS EPSDT ID RENDERING |
| MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER POINTER | |
| 11 11 20 11 73610 AB | 71 00 1 NPI 1043258247 |
| | 71 00 1 NPI 1043258247 |
| | NPI NPI |
| | NPI |
| | |
| | NPI |
| | |
| | NPI NPI |
| | 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 10215184 X YES NO | \$ 71 00 \$ |
| 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse | 33. BILLING PROVIDER INFO & PH # (901) 387-2340 |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.) DIPC R&F 6401 POPLAR AVE | DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 |
| LOI T VU MD MEMPHIS TN 38119- | MEMPHIS, TN 381480275 |
| SIGNED 11/16/2 ₁ Q _{,TE} a. b. | a1699725812 ZZ2085R0202X |

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

| HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000 | | | | | |
|--|----------------------|---|--------------------------------------|----------------|----------------------------------|
| PICA A# 18001-0001 CNR534 P E 001 | | | | | 18001 PICA |
| 1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA (Medicare #) (Medicard #) (ID#/DoD#) (Member ID#) (ID#) (ID#) | VG.— | 1a. INSURED'S LD. N | | | (For Program in Item 1) |
| PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE | X (ID#) | MB01359 4 INSURED'S NAME | | st Name, | Middle Initial) |
| ROBINSON APRIL M 04 11 1963 | FX | ROBINSO | | | |
| 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INS 6. PATIENT RELATIONSHIP TO INS Self X Spouse Child | Other | 7. INSURED'S ADDRI | | | |
| CITY STATE 8. RESERVED FOR NUCC USE | | CITY | | | STATE |
| COLLIERVILLE TN ZIP CODE TELEPHONE (Include Area Code) | - | COLLIER | | EPHONE | TN E (Include Area Code) |
| 38017 (901) 230-5762 | | 38017 | | | 1) 230-5762 |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELA | ATED TO: | 11 INSURED'S POLICE 1048800 | | FECA NU | JMBER |
| a OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Current or Previo | ous) | a INSURED'S DATE | OF BIRTH | 720 | SEX |
| b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? | | 04 11 | 1963 | M | FX |
| YES XNC | LITOL (Otate) | b. OTHER CLAIM ID (| Designated by N | 1000) | |
| c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? | | c. INSURANCE PLAN | NAME OR PRO | GRAM N | IAME |
| d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by | | EVOCARE | | NEFIT PL | AN? |
| | | | | | re 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 informati to process this claim. I also request payment of government benefits either to myself or to the party who accepts | ion necessary | INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for | | | |
| SIGNATURE ON FILE 11/05/2 | | services described below. SIGNATURE ON FILE | | | |
| SIGNED DATE | | SIGNED | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY QUAL QUAL | YY | 16. DATES PATIENT MM D | JNABLE TO WO | RK IN C | URRENT OCCUPATION MM DD YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a ZZ2084N0400X | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO 20. OUTSIDE LAB? \$ CHARGES | | | |
| DN LEE STEIN MD 17b NPI 1558392233 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | |
| ACTUAL INVOICE COST | | | NO | 90 | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) | | 22. RESUBMISSION CODE | ORI | GINAL RI | EF. NO. |
| A. G35 B. J321 C. J322 D. L | | 23. PRIOR AUTHORIZ | ATION NUMBER | R | |
| ı.L. J.L. K.L. L.L. | | | | | |
| From To PLACE OF (Explain Unusual Circumstances) | E. DIAGNOSIS POINTER | \$ CHARGES | G. H. DAYS EPSD OR Family UNITS Plan | ID. | J RENDERING PROVIDER ID. # |
| | | | | QUAL | |
| 11 05 20 11 70553 | ABC | 1455 00 | 1 | NPI | 1740247485 |
| 11 05 20 11 A9575 | ABC | 26 25 | 15 | NPI | 1740247485 |
| 3 | | | | NO | |
| | | 10 | | NPI | |
| | | | | NPI | |
| | | | | NPI | |
| | | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT AS | SIGNMENT? | 28. TOTAL CHARGE | 29. AM | NPI OUNT PA | AID 30. Rsvd for NUCC use |
| 621116618 X 10209195 X YES | NO | 1481 | 25 s | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse | | 33 BILLING PROVIDE DIAGNOST | | 1 | 01) 387-2340 |
| apply to this bill and are made a part thereof.) 6401 POPLAR AVE | | PO BOX 1 | | | |
| LOUIS S PARVEY MD MEMPHIS TN 38119- | | MEMPHIS, | TN 38 | 148 | 0275 |
| SIGNED 11/11/2 ₁ Q _{TE} a. b. | | 1699725812 ZZ2085R0202X | | | |

SIGNED

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

| HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 | | |
|--|---|--|
| PICA A# 178911-0001 CNR534 | 00000000 PE 001 | 178911 PICA |
| MEDICARE MEDICAID TRICARE CHAMPVA (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID 2 PATIENT'S NAME (Last Name, First Name, Middle Initial) | HEALTH PLAN BLK LUNG, | 1a INSURED'S I.D. NUMBER (For Program in Item 1) MB 0 1 4 3 0 6 5 6 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| DONALDSON REBECCA DATIENT'S ADDRESS (No., Street) | MM DD YY 08 06 1963 F X 6. PATIENT RELATIONSHIP TO INSURED | DONALDSON ROGER 7. INSURED'S ADDRESS (No., Street) |
| 338 HARRIS ST | Self Spouse X Child Other 8. RESERVED FOR NUCC USE | 338 HARRIS ST |
| COLLIERVILLE TN IP CODE TELEPHONE (Include Area Code) | | COLLIERVILLE T. ZIP CODE TELEPHONE (Include Area Code) |
| 38017 (901) 471 - 9789 OTHER INSURED'S NAME (Last Name. First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 38017 (901) 471-9789 11 INSURED'S POLICY GROUP OR FECA NUMBER |
| OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (Current or Previous) | 1048800701 a INSURED'S DATE OF BIRTH MM DD YY MM DD YM MM |
| RESERVED FOR NUCC USE | b. AUTO ACCIDENT? PLACE (State) | 10 24 1960 X |
| RESERVED FOR NUCC USE | c. OTHER ACCIDENT? YES X NO | c. INSURANCE PLAN NAME OR PROGRAM NAME |
| INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC) | C IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO # yes, complete items 9, 9a and 9d. |
| READ BACK OF FORM BEFORE COMPLETING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the re to process this claim. I also request payment of government benefits eithe below. | elease of any medical or other information necessary | 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 | 11/05/20 DATE | SIGNATURE ON FILE |
| MM DD YY QUAL QUA | | 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO YY TO YY |
| | 1GOTH000 NPI 1417056409 | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM |
| ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate A-L to service. | ce line below (24E) | 20. OUTSIDE LAB? \$ CHARGES YES X NO 22. RESUBMISSION |
| A J8410 B R05 C L | J40 D R911 | CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER |
| F. | L L EDURES, SERVICES, OR SUPPLIES E. | F. G H I. J. |
| From To PLACE OF (EXplain MM DD YY SERVICE EMG CPT/HCPC | ain Unusual Circumstances) CS MODIFIER POINTER | |
| .1 05 20 11 71250 | ABCD | 652 00 1 NPI 174024748 |
| | | NPI |
| | | NPI NPI |

31. SIGNATURE OF PHYSICIAN OF SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOUIS S PARVEY MD

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

DIAGNOSTIC IMAGING PC

PO BOX 1000 DEPT 275

MEMPHIS, TN 381480275 1699725812 | ZZ2085R0202X

DIPC CT

32 SERVICE FACILITY LOCATION INFORMATION

6401 POPLAR AVE

MEMPHIS TN 38119-