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

00000000

PICA

A# 169740-0001 CNR534 P E 019

PICA 169740

CARRIER

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): MB00417045

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOSHER JEFFREY L

3. PATIENT'S BIRTH DATE MM DD YY: 02 21 1957 SEX: X M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): LOSHER JEFFREY L

5. PATIENT'S ADDRESS (No., Street): 2530 DIBRELL TRAIL DR

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

7. INSURED'S ADDRESS (No., Street): 2530 DIBRELL TRAIL DR

CITY: COLLIERVILLE STATE: TN

8. RESERVED FOR NUCC USE

CITY: COLLIERVILLE STATE: TN

ZIP CODE: 38017 TELEPHONE (Include Area Code): (734) 740-1699

ZIP CODE: 38017 TELEPHONE (Include Area Code): (734) 740-1699

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: 1048800701

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: 02 21 1957 SEX: M X F

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.

SIGNED: SIGNATURE ON FILE DATE: 12/11/20

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 SPENCER HAUSER MD

17a. 1GOTH000

17b. NPI 1407122203

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 M4802 B M4312 C M50222 D M5412
E S22000A 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 11 20		11		72141		ABCD	1046 00	1		NPI	1669553764
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.: 10242162D

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

28. TOTAL CHARGE: $ 1046 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.)

SAMUEL P BILYEU MD
SIGNED 12/15/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DIPC MRI SIEMENS
6401 POPLAR AVE
MEMPHIS TN 38119-

a. 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

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

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WCMS-1500CS-12

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C/O ACCOUNTS PAYABLE
4735 MELISSA WAY
BIRMINGHAM AL 35243

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HEALTH INSURANCE CLAIM FORM

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

00000000

PICA

A# 227283-0001 CNR534 P E 001

227283 PICA

CARRIER

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): MB00302794

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KIRBY EMILY G

3. PATIENT'S BIRTH DATE MM DD YY: 07 05 2002 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): KIRBY PHILIP

5. PATIENT'S ADDRESS (No., Street): 6680 KAMALI AVE

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

7. INSURED'S ADDRESS (No., Street): 6680 KAMALI AVE

CITY: MEMPHIS STATE: TN

8. RESERVED FOR NUCC USE

CITY: MEMPHIS STATE: TN

ZIP CODE: 38134 TELEPHONE (Include Area Code): (901) 654-9335

ZIP CODE: 38134 TELEPHONE (Include Area Code): (901) 654-9335

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) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 01 29 1975 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: 12/11/20

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 N644 B N6022 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 11 20		11		76641	LT	A	240 00	1		NPI	1740247485
2 12 11 20		11		76641	RT	BA	240 00	1		NPI	1740247485
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.: 10243012D

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

28. TOTAL CHARGE: $ 480 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.)

LOUIS S PARVEY MD

SIGNED 12/15/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DIPC US
6401 POPLAR AVE
MEMPHIS TN 38119-

a b

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

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

a 1699725812 b ZZ2085R0202X

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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# 227224-0001 CNR534 P E 019

227224 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	MB04808844
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX
BENJAMIN JENNIFER G	04 25 1978 / F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	BENJAMIN JENNIFER G
5. PATIENT'S ADDRESS (No., Street)	6425 KESWICK DR
6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
6425 KESWICK DR	6425 KESWICK DR
CITY / STATE	CITY / STATE
MEMPHIS TN	MEMPHIS TN
ZIP CODE / TELEPHONE (Include Area Code)	ZIP CODE / TELEPHONE (Include Area Code)
38119 (901) 351-7955	38119 (901) 351-7955
8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER	1048800701
a. INSURED'S DATE OF BIRTH MM DD YY / SEX	04 25 1978 / M F X
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME	EVOCARE
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.

SIGNED: SIGNATURE ON FILE DATE: 12/08/20

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 / MM DD YY TO	
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 / MM DD YY TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ACTUAL INVOICE COST	
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. R062 B. R0789 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 08 20	11		71260	Q6	AB	761 00	1		NPI	1669553764
2 12 08 20	11		Q9967	Q6	AB	7 33	80		NPI	1669553764
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	10238145	X YES NO	$ 768 33	$

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.)

SAMUEL P BILYEU MD
SIGNED 12/14/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DIPC CT
6401 POPLAR AVE
MEMPHIS TN 38119-

a. 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

PHYSICIAN OR SUPPLIER INFORMATION

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FIRST FOLD WHCF.16-ENV WHCF.16-ENV-SS

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C/O ACCOUNTS PAYABLE
4735 MELISSA WAY
BIRMINGHAM AL 35243

5689

HEALTH INSURANCE CLAIM FORM

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

00000000

PICA

A# 227249-0001 CNR534 P E 019

227249 PICA

CARRIER

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): MB00783752

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HOUSEY JAMES L

3. PATIENT'S BIRTH DATE MM DD YY: 11 11 1964 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): HOUSEY JAMES L

5. PATIENT'S ADDRESS (No., Street): 5276 ANNANDALE

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

7. INSURED'S ADDRESS (No., Street): 5276 ANNANDALE

CITY: MEMPHIS STATE: TN

8. RESERVED FOR NUCC USE

CITY: MEMPHIS STATE: TN

ZIP CODE: 38125 TELEPHONE (Include Area Code): (901) 643-6201

ZIP CODE: 38125 TELEPHONE (Include Area Code): (901) 643-6201

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: 1048800701

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: 11 11 1964 SEX M X F

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.

SIGNED: SIGNATURE ON FILE DATE: 12/09/20

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 MM DD YY TO

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 MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ACTUAL INVOICE COST

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 K5730 B B1920 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 09 20	11		74178		AB	1063 00	1		NPI	1669553764
2	12 09 20	11		Q9967		AB	7 33	80		NPI	1669553764
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO: 10239374D

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

28. TOTAL CHARGE: $ 1070 33

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.)

SAMUEL P BILYEU MD

SIGNED 12/14/20 DATE

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DIPC CT
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MEMPHIS TN 38119-

a. b.

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

a. 1699725812 b. ZZ2085R0202X

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FIRST FOLD WHCF 10-ENV WHCF 10-ENV SS

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