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# 102817-0001 CNR534 P E 019

102817 PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare #)	(Medicaid #)	(ID#/DoD#)	(Member ID#)	(ID#)	(ID#)	X (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MB03937671

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): COLLEY BONNIE W

3. PATIENT'S BIRTH DATE MM DD YY: 12 25 1954 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): COLLEY BONNIE W

5. PATIENT'S ADDRESS (No., Street): 160 ASTON BROOK CV

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

7. INSURED'S ADDRESS (No., Street): 160 ASTON BROOK CV

CITY: EADS STATE: TN

8. RESERVED FOR NUCC USE

CITY: EADS STATE: TN

ZIP CODE: 38028 TELEPHONE (Include Area Code): (901) 603-8526

ZIP CODE: 38028 TELEPHONE (Include Area Code): (901) 603-8526

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): COLLEY BONNIE W

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 1048800614

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 4G82QK4DH23

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 12 25 1954 SEX M [ ] F [X]

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: P.O. BOX 100306 COLUMBIA SC 29202

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: EVOCARE

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE TENN MSP

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: 12/09/20

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN OWEN B TABOR JR MD

17a. ZZ207X00000X

17b. NPI 1346215209

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. M1711 B. M898X6 C. M25561 D. M5136
E. M545 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		73560	Q6 RT	ABC	66 00	1		NPI	1669553764
2 12 09 20		11		72100	Q6	DBE	85 00	1		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.: 10239929D

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

28. TOTAL CHARGE: $ 151 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 12/14/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DIPC R&F
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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

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# 227259-0001 CNR534 P E 003

227259 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): MB00721761

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
HORRELL WILLIAM E	03 14 1974	M X F	HORRELL WILLIAM E

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
8028 CROSSBOW CV	Self X Spouse Child Other	8028 CROSSBOW CV

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
GERMANTOWN	TN		GERMANTOWN	TN

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
38138	(901) 569-0485	38138	(901) 569-0485

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
		1048800403
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 SEX: 03 14 1974 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: 12/10/20

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 JOHN SPERO TOULIATOS MD	17a. ZZ207Y00000X 17b. NPI 1306952759	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. K449 B. K219 C. R1310 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 10 20		11		74220		ABC	256 00	1		NPI	1649220120
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	10240497D	X YES NO	$ 256 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
ROBERT A DUKE MD SIGNED 12/14/20 DATE	DIPC R&F 6401 POPLAR AVE MEMPHIS TN 38119- a. b.	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 a. 1699725812 b. ZZ2085R0202X

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# 406737-0001 CNR534 P N 020

406737 PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER [X] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): MB01174758
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ELLIS AMY A	3. PATIENT'S BIRTH DATE MM DD YY: 08 05 1974 SEX: F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ELLIS AMY A	
5. PATIENT'S ADDRESS (No., Street): 12808 SHANE HOLLOW DR	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 12808 SHANE HOLLOW DR	
CITY: ARLINGTON STATE: TN	8. RESERVED FOR NUCC USE
CITY: ARLINGTON STATE: TN	
ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 386-2058	
ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 386-2058	
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: 1048800103	
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: 08 05 1974 SEX: M [ ] F [X]	
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: 11/09/20

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 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ROWENA DESOUZA MD	17a. ZZ208800000X 17b. NPI 1326201567
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	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. Q615 B. N200 C. D. E. F. G. H. I. J. K. L.	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 09 20	11		76775		AB	175 00	1		NPI	1043258247
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.: 10211928	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 175 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.) LOI T VU MD SIGNED 11/12/20 DATE	32. SERVICE FACILITY LOCATION INFORMATION: DIPC US 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

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

NUCC Instruction Manual available at: www.nucc.org

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

WCMS-1500CS-12

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# 226637-0001 CNR534 P E 019

226637 PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X (ID#)	MB01922208
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX
BOWMAN CHARLOTTE	03 02 1959 F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
BOWMAN KENNETH	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
165 FAIR VIEW LN	Self / Spouse X / Child / Other
7. INSURED'S ADDRESS (No., Street)	
165 FAIR VIEW LN	
CITY / STATE	8. RESERVED FOR NUCC USE
OAKLAND TN	
CITY / STATE	
OAKLAND TN	
ZIP CODE / TELEPHONE (Include Area Code)	
38060 (901) 286-7468	
ZIP CODE / TELEPHONE (Include Area Code)	
38060 (901) 286-7468	
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	
1048800203	
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 / SEX	
03 17 1956 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.
SIGNATURE ON FILE SIGNED _____ 11/06/20 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	17a. ZZ2084N0400X	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN OLEKSANDRA DRYN MD	17b. NPI 1366861510	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES / X NO $ CHARGES
ACTUAL INVOICE COST		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind 0		22. RESUBMISSION CODE ORIGINAL REF. NO
A. G939 B. R202 C. D. E. F. G. H. I. J. K. L.		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 06 20	11		70553		AB	1455 00	1		NPI	1669553764
2 11 06 20	11		A9575		AB	35 00	20		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	10209997	X YES / NO	$ 1490 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 11/12/20 SIGNED DATE	DIPC MRI SIEMENS 6401 POPLAR AVE MEMPHIS TN 38119-	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275
	a. NPI	a. 1699725812 b. ZZ2085R0202X

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

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# 18610-0001 CNR534 P E 003

18610 PICA

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
( ) (Medicare #) ( ) (Medicaid #) ( ) (ID#/DoD#) ( ) (Member ID#) ( ) (ID#) ( ) (ID#) X (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
MB03906847

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
DAVIDSON AARON A

3. PATIENT'S BIRTH DATE SEX
MM DD YY
03 31 1968 X M ( ) F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
DAVIDSON AARON A

5. PATIENT'S ADDRESS (No., Street)
120 TIMBERLANE RD

6. PATIENT RELATIONSHIP TO INSURED
Self X Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)
120 TIMBERLANE RD

CITY
ARLINGTON

STATE
TN

8. RESERVED FOR NUCC USE

CITY
ARLINGTON

STATE
TN

ZIP CODE
38002

TELEPHONE (Include Area Code)
(901) 487-6611

ZIP CODE
38002

TELEPHONE (Include Area Code)
(901) 487-6611

SECOND FOLD

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 X NO

a. INSURED'S DATE OF BIRTH SEX
MM DD YY
03 31 1968 M X F ( )

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)
( ) YES X NO

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.

PATIENT AND INSURED INFORMATION

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
SIGNED
11/05/20
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

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

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 STEFFANIE MORRIS NP

17a. ZZ207QA0000X

17b. NPI 1437646510

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES
( ) YES X NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind 0
A. R918 B. J9811 C. J45909 D. F17200
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	05	20			11		71046		ABCD	81 00	1		NPI	1649220120
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
621116618 ( ) X

26. PATIENT'S ACCOUNT NO.
10209559

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
X YES ( ) 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
11/09/20
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

NUCC Instruction Manual available at: www.nucc.org

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