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# 226303-0001 CNR534 P E 019

226303 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): MB00321416

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TALBOT JILLIAN

3. PATIENT'S BIRTH DATE: 06 06 1984 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): TALBOT JILLIAN

5. PATIENT'S ADDRESS (No., Street): 1076 HEATHER LAKE DR

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

7. INSURED'S ADDRESS (No., Street): 1076 HEATHER LAKE DR

CITY: COLLIERVILLE STATE: TN

8. RESERVED FOR NUCC USE

CITY: COLLIERVILLE STATE: TN

ZIP CODE: 38017 TELEPHONE (Include Area Code): (901) 335-9821

ZIP CODE: 38017 TELEPHONE (Include Area Code): (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) YES NO X

a. INSURED'S DATE OF BIRTH: 06 06 1984 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: 10/22/20

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 FREDERICK AZAR MD

17a. ZZ207X00000X

17b. NPI 1821084633

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. M25519 B. 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 10 22 20		11		71550		A	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.: 10196293

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 10/28/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION

DIPC MRI SIEMENS
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

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WCMS-1500CS-12

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HEALTH INSURANCE CLAIM FORM

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

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PICA

A# 226392-0001 CNR534 P E 003

226392 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): 1048800701

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)
CARVER MARY	12 05 1983	M F X	CARVER MARY

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
8765 MOUNT CARMEL ROAD	Self X Spouse Child Other	8765 MOUNT CARMEL ROAD

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

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
38011	(901) 610-8803	38011	(901) 610-8803

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
		MSSC
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: 12 05 1983 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.

PATIENT AND INSURED INFORMATION

SECOND FOLD

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: 10/27/20

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	17a. 1GOTH000	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN SAMYA CRUZ MD	17b. NPI 1417056409	

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	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. R7611 B. Z111 C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER

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

PHYSICIAN OR SUPPLIER INFORMATION

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 10 27 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	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	$	

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	DIPC R&F	DIAGNOSTIC IMAGING PC
SIGNED 10/30/20 DATE	6401 POPLAR AVE	PO BOX 1000 DEPT 275
	MEMPHIS TN 38119-	MEMPHIS, TN 381480275
	a. NPI b.	a. 1699725812 b. ZZ2085R0202X

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WCMS-1500CS-12

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HEALTH INSURANCE CLAIM FORM

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

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PICA

A# 226422-0001 CNR534 P E 001

226422 PICA

CARRIER

PATIENT AND INSURED INFORMATION

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): MB03464678

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MUMMERT VALLI

3. PATIENT'S BIRTH DATE MM DD YY: 09 08 1961 SEX M ( ) F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MUMMERT VALLI

5. PATIENT'S ADDRESS (No., Street): 3120 MARR CV

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

7. INSURED'S ADDRESS (No., Street): 3120 MARR CV

CITY: BARTLETT STATE: TN

8. RESERVED FOR NUCC USE

CITY: BARTLETT STATE: TN

ZIP CODE: 38134 TELEPHONE (Include Area Code): (901) 388-6712

ZIP CODE: 38134 TELEPHONE (Include Area Code): (901) 388-6712

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: 1048800213

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: 09 08 1961 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: 10/28/20

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. N200 B. K429 C. K5730 D. R310
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

PHYSICIAN OR SUPPLIER INFORMATION

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 10 28 20		11		74176		ABCD	604 00	1		NPI	1740247485
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.: 10200996

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

28. TOTAL CHARGE: $ 604 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 10/30/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION
DIPC CT
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

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EVOCARE
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# 225239-0001 CNR534 P E 003

225239 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#)	MB01573350
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) UNDERWOOD BRYAN	3. PATIENT'S BIRTH DATE MM DD YY: 07 02 1997 SEX: M X F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) UNDERWOOD JEAN
5. PATIENT'S ADDRESS (No., Street) 6680 BOOTH FORREST CV	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child X Other 7. INSURED'S ADDRESS (No., Street) 6680 BOOTH FORREST CV
CITY: BARTLETT STATE: TN	8. RESERVED FOR NUCC USE CITY: BARTLETT STATE: TN
ZIP CODE: 38135 TELEPHONE (Include Area Code): (901) 605-8640	ZIP CODE: 38135 TELEPHONE (Include Area Code): (901) 605-8640
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 MM DD YY: 04 26 1966 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.
SIGNED: SIGNATURE ON FILE DATE: 11/30/20

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 ZIAD YOUNES MD	17a. ZZ207RG0100X 17b. NPI 1285619874	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. R1013 B. R945 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 11 30 20	11		76700		AB	294 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 EIN X	10231074	X YES NO	$ 294 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 12/02/20 DATE	DIPC US 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

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