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# 140371-0001 CNR534 P E 021

140371 PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
MB00829154

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
GRAHAM CAYCE M

3. PATIENT'S BIRTH DATE MM DD YY SEX
11 28 1975 M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
GRAHAM CAYCE M

5. PATIENT'S ADDRESS (No., Street)
3482 EVENING LIGHT

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

7. INSURED'S ADDRESS (No., Street)
3482 EVENING LIGHT

CITY
BARTLETT

STATE
TN

8. RESERVED FOR NUCC USE

CITY
BARTLETT

STATE
TN

ZIP CODE
38135

TELEPHONE (Include Area Code)
(901) 647-1209

ZIP CODE
38135

TELEPHONE (Include Area Code)
(901) 647-1209

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 SEX
11 28 1975 M ( ) F (X)

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

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 10/22/20

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 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 (X) NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. R928 B. N6321 C. D.
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

| 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 | | 76641 | LT | AB | 240 00 | 1 | | NPI | 1790044147 |
| 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.
10195980

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

28. TOTAL CHARGE
$ 240 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.)
CASEY S TAYLOR MD
SIGNED 10/27/20 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

NUCC Instruction Manual available at: www.nucc.org

*PLEASE PRINT OR TYPE*

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# 140371-0001 CNR534 P E 021

140371 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): MB00829154

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): GRAHAM CAYCE M

3. PATIENT'S BIRTH DATE: 11 28 1975 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): GRAHAM CAYCE M

5. PATIENT'S ADDRESS (No., Street): 3482 EVENING LIGHT

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

7. INSURED'S ADDRESS (No., Street): 3482 EVENING LIGHT

CITY: BARTLETT STATE: TN

8. RESERVED FOR NUCC USE

CITY: BARTLETT STATE: TN

ZIP CODE: 38135 TELEPHONE (Include Area Code): (901) 647-1209

ZIP CODE: 38135 TELEPHONE (Include Area Code): (901) 647-1209

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: 11 28 1975 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.
SIGNATURE ON FILE SIGNED _____ 10/22/20 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: 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 X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. R928 B. N6321 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 | | 77065 | LT | AB | 330 00 | 1 | | NPI | 1790044147 |
| 2 10 22 20 | | 11 | | G0279 | | AB | 143 00 | 1 | | NPI | 1790044147 |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

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

26. PATIENT'S ACCOUNT NO.: 10195972

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

28. TOTAL CHARGE: $ 473 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.)
CASEY S TAYLOR MD
SIGNED 10/27/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION
DIPC MAMMO
6401 POPLAR AVE
MEMPHIS TN 38119-
a. NPI b. 109850

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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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# 226247-0001 CNR534 P E 003

226247 PICA

CARRIER

| | |
|---|---|
| 1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER: (Medicare #) / (Medicaid #) / (ID#/DoD#) / (Member ID#) / (ID#) / (ID#) X | 1a. INSURED'S I.D. NUMBER (For Program in Item 1): MB00674951 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HART JARED C | 3. PATIENT'S BIRTH DATE MM DD YY: 07 05 1977 SEX: M X F |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial): HART JARED C | |
| 5. PATIENT'S ADDRESS (No., Street): 588 FELLOWSHIP BAPTIST CH RD | 6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other |
| 7. INSURED'S ADDRESS (No., Street): 588 FELLOWSHIP BAPTIST CH RD | |
| CITY: MILLINGTON STATE: TN | 8. RESERVED FOR NUCC USE |
| CITY: MILLINGTON STATE: TN | |
| ZIP CODE: 38053 TELEPHONE (Include Area Code): (901) 848-9093 | |
| ZIP CODE: 38053 TELEPHONE (Include Area Code): (901) 848-9093 | |
| 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 X NO |
| a. INSURED'S DATE OF BIRTH MM DD YY SEX: 07 05 1977 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: 10/26/20

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 X NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0<br>A. R0789 B. R062 C. R05 D.<br>E. F. G. H.<br>I. J. K. L. | 22. RESUBMISSION CODE ORIGINAL REF. NO.<br>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 20 20 | 11 | | 71046 | Q6 | ABC | 81 00 | 1 | | NPI | 1649220120 |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

| | | | | |
|---|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER SSN EIN: 621116618 | 26. PATIENT'S ACCOUNT NO.: 10195584 | 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.)<br>ROBERT A DUKE MD<br>SIGNED 10/28/20 DATE | 32. SERVICE FACILITY LOCATION INFORMATION<br>DIPC R&F<br>6401 POPLAR AVE<br>MEMPHIS TN 38119-<br>a. NPI b. | | 33. BILLING PROVIDER INFO & PH. # (901) 387-2340<br>DIAGNOSTIC IMAGING PC<br>PO BOX 1000 DEPT 275<br>MEMPHIS, TN 381480275<br>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# 226247-0001 CNR534 P E 003

226247 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): MB00674951

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HART JARED C

3. PATIENT'S BIRTH DATE MM DD YY: 07 05 1977 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): HART JARED C

5. PATIENT'S ADDRESS (No., Street): 588 FELLOWSHIP BAPTIST CH RD

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

7. INSURED'S ADDRESS (No., Street): 588 FELLOWSHIP BAPTIST CH RD

CITY: MILLINGTON STATE: TN

8. RESERVED FOR NUCC USE

CITY: MILLINGTON STATE: TN

ZIP CODE: 38053 TELEPHONE (Include Area Code): (901) 848-9093

ZIP CODE: 38053 TELEPHONE (Include Area Code): (901) 848-9093

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: 07 05 1977 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: 10/26/20

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. R0781 B. S2231XA 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 26 20 | | 11 | | 71101 | | AB | 91 00 | 1 | | NPI | 1649220120 |
| 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.: 10198216

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

28. TOTAL CHARGE: $ 91 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 10/28/20 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

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