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# 226244-0001 CNR534 P E 019

226244 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): MB02134492

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): FINLEY DEBBIE J

3. PATIENT'S BIRTH DATE MM DD YY: 10 29 1970 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): FINLEY DEBBIE J

5. PATIENT'S ADDRESS (No., Street): 504 W POWELL

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

7. INSURED'S ADDRESS (No., Street): 504 W POWELL

CITY: COLLIERVILLE STATE: TN

8. RESERVED FOR NUCC USE

CITY: COLLIERVILLE STATE: TN

ZIP CODE: 38017 TELEPHONE (Include Area Code): (901) 610-9541

ZIP CODE: 38017 TELEPHONE (Include Area Code): (901) 610-9541

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 NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 10 29 1970 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: 10/20/20

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. J449 B. J189 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 20 20		11		71046	Q6	AB	81 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.: 10195436

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X 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.)

SAMUEL P BILYEU MD

SIGNED 10/23/20 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

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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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WCMS-1500CS-12

5689

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

HEALTH INSURANCE CLAIM FORM

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

00000000

131613 PICA

PICA A# 131613-0001 CNR534 P E 019

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): MB2752759

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DARDEN CHERYL D

3. PATIENT'S BIRTH DATE MM DD YY: 05 24 1963 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DARDEN CHERYL D

5. PATIENT'S ADDRESS (No., Street): 90 FLETCHER DR

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

7. INSURED'S ADDRESS (No., Street): 90 FLETCHER DR

CITY: COLLIERVILLE STATE: TN

8. RESERVED FOR NUCC USE

CITY: COLLIERVILLE STATE: TN

ZIP CODE: 38017 TELEPHONE (Include Area Code): (901) 853-9181

ZIP CODE: 38017 TELEPHONE (Include Area Code): (901) 853-9181

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: 05 24 1963 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.

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.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED: SIGNATURE ON FILE DATE: 10/19/20

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 DAVID ENGLE

17a. ZZ207VX0201X

17b. NPI 1487611760

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. N83201 B. N8500 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 19 20		11		76830	Q6	AB	263 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.: 10192219

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

28. TOTAL CHARGE: $ 263 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 10/23/20 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

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C/O ACCOUNTS PAYABLE
4735 MELISSA WAY
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5689

HEALTH INSURANCE CLAIM FORM

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PICA

A# 226240-0001 CNR534 P E 001

226240 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)
MB03230393

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
OBRIEN MARCIA K

3. PATIENT'S BIRTH DATE MM DD YY 07 02 1957 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
OBRIEN MARCIA K

5. PATIENT'S ADDRESS (No., Street)
6034 KERIN DRIVE

6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
6034 KERIN DRIVE

CITY
BARTLETT

STATE
TN

8. RESERVED FOR NUCC USE

CITY
BARTLETT

STATE
TN

ZIP CODE
38135

TELEPHONE (Include Area Code)
(901) 230-7624

ZIP CODE
38135

TELEPHONE (Include Area Code)
(901) 230-7624

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 NO X

a. INSURED'S DATE OF BIRTH MM DD YY 07 02 1957 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 10/20/20

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 TYLER CANNON MD

17a. ZZ207X00000X

17b NPI 1891967147

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? YES NO X $ CHARGES

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

A. M25512 B. S42212A 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 20 20		11		73200 SHOULDER LT		AB	561 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.
10193977

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

28. TOTAL CHARGE $ 561 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 10/23/20 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

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

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# 181800-0001 CNR534 P E 019

181800 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): MB00127586

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

3. PATIENT'S BIRTH DATE MM DD YY: 03 18 1983 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): VANWART VANESSA R

5. PATIENT'S ADDRESS (No., Street): 5035 TRENT CV

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

7. INSURED'S ADDRESS (No., Street): 5035 TRENT CV

CITY: BARTLETT STATE: TN

8. RESERVED FOR NUCC USE

CITY: BARTLETT STATE: TN

ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 834-5336

ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 834-5336

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 NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 10 17 1982 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: 10/19/20

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 MICHELLE PATTAT FNP

17a. ZZ207R00000X

17b. NPI 1699717272

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

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

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. J320 B. R590 C. K148 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 19 20		11		70492	Q6	ABC	806 00	1		NPI	1669553764
2 10 19 20		11		Q9967	Q6	ABC	7 33	80		NPI	1669553764
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.: 10192649

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

28. TOTAL CHARGE $ 813 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 10/23/20 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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WCMS-1500CS-12

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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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C/O ACCOUNTS PAYABLE
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BIRMINGHAM AL 35243

5689

HEALTH INSURANCE CLAIM FORM

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00000000

225544 PICA

PICA A# 225544-0001 CNR534 P E 019

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): MB01775427
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MANLEY JULIE	3. PATIENT'S BIRTH DATE MM DD YY: 03 23 1976 — SEX M F X
5. PATIENT'S ADDRESS (No., Street): 11946 BROWN ST	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
CITY: ARLINGTON — STATE: TN	8. RESERVED FOR NUCC USE
ZIP CODE: 38002 — TELEPHONE (Include Area Code): (901) 355-6273	
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 NO X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO X — PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

7. INSURED'S ADDRESS (No., Street): 11946 BROWN ST	
CITY: ARLINGTON — STATE: TN	
ZIP CODE: 38002 — TELEPHONE (Include Area Code): (901) 355-6273	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY: 03 23 1976 — SEX 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 NO X — *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.
SIGNED: SIGNATURE ON FILE — DATE: 10/16/20

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
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SRIKANTH NAIDU MD	17a. ZZ207Y00000X — 17b. NPI 1427166156
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) — ICD Ind. 0	
A. R1310 B. R070 C. K219 D.	
E. F. G. H.	
I. J. K. L.	

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO	
20. OUTSIDE LAB? YES NO X — $ CHARGES	
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 16 20		11		70491	Q6	ABC	680 00	1		NPI	1669553764
2 10 16 20		11		Q9967	Q6	ABC	7 33	80		NPI	1669553764
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 621116618 — SSN EIN X	26. PATIENT'S ACCOUNT NO.: 10190965	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE $ 687 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (901) 387-2340
SAMUEL P BILYEU MD	DIPC CT 6401 POPLAR AVE MEMPHIS TN 38119-	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275
SIGNED 10/21/20 DATE	a. NPI b.	a. 1699725812 b. ZZ2085R0202X

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