BIRMINGHAM AL 35243

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTE	E (NUCC) 02/12 0000000	PICA		
PICA A# 102817-0001 CNR534 P.E. 019 102817 MEDICARE MEDICARE CHAMPVA GROUP FECA OTHER 1a INSURED'S I.D. NUMBER (For Program in Item 1)				
1 MEDICARE MEDICAID TRICARE (Medicare #) (Medicaid #) (ID#/DoD#) 2. PATIENT'S NAME (Last Name, First Name, Middle Initia	(Member ID#) HEALTH PLAN BLK LUNG (ID#) X (ID#)			
COLLEY BONNIE W 5. PATIENTS ADDRESS (No. Street)	MM DD YY	X COLLEY BONNIE W 7. INSURED'S ADDRESS (No., Street)		
160 ASTON BROOK CV	Self X Spouse Child Other	160 ASTON BROOK CV		
CITY				
EADS ZIP CODE TELEPHONE (Include	TN Area Code)	ZIP CODE TELEPHONE (Include Area Code)		
38028 (901) 603 - 9 OTHER INSURED'S NAME (Last Name. First Name. M	-8526 dddle Initial) 10. IS PATIENT'S CONDITION RELATED TO.	38028 (901) 603-8526 11. INSURED'S POLICY GROUP OR FECA NUMBER		
COLLEY BONNIE W	a: EMPLOYMENT? (Current or Previous)	1048800614 a. INSURED S DATE OF BIRTH SEX		
4G82QK4DI		12 25 1954 M		
b RESERVED FOR NUCC USE	YES X NO	state) b. OTHER CLAIM ID (Designated by NUCC)		
P.O. BOX 100306	c: OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME		
COLUMBIA SC 29202 d. INSURANCE PLAN NAME OR PROGRAM NAME	YES X NO 10d. CLAIM CODES (Designated by NUCC)	EVOCARE d is there another health benefit plan?		
MEDICARE TENN MSP		YES X NO If yes, complete items 9, 9a and 9d.		
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATUR	ORE COMPLETING & SIGNING THIS FORM. E I authorize the release of any medical por other information necessing and property and the property and property and property and property and property and property assignment and property as a second property as a	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
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 12/09/20		SIGNATURE ON FILE		
SIGNATURE ON FIL	DATE	SIGNED		
14. DATE OF CURRENT ILLNESS. INJURY. or PREGNA MM DD YY QUAL.	NCY (LMP) 15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO		
17 NAME OF REFERRING PROVIDER OR OTHER SOU	IRCE 17a ZZ207X00000X	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
DN OWEN B TABOR JR MD	17b NPI 1346215209	FROM TO 20 OUTSIDE LAB? \$ CHARGES		
19 ADDITIONAL CLAIM INFORMATION (Designated by	NOCCI	YES X NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Relate A-L to service line below (24E) ICD Ind O	22 RESUBMISSION ORIGINAL REF. NO.		
A M1711 B M898X6	M25561 M5136	23. PRIOR AUTHORIZATION NUMBER		
E M545	G H			
24. A. DATE(S) OF SERVICE B. From To PLACE OF MM. DD YY MM DD YY SERVICE	C D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) EMG CPT/HCPCS MODIFIER POIN			
12 09 20 11	73560 Q6 RT AE			
12 09 20 11	72100 Q6 DE	BE 85 00 1 NPI 1669553764		
12 09 20	72100 20			
		NPI NPI		
		NPI NPI		
		NPI		
		NPI NPI		
25. FEDERAL TAX D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMET (For govt claims, see bac	(8)		
621116618 X	10239929D X YES NO	\$ 151 00 \$ 33 BILLING PROVIDER INFO & PH # (901) 387-2340		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS If certify that the statements on the reverse DIPC R&F		DIAGNOSTIC IMAGING PC		
apply to this bill and are made a part thereof)	6401 POPLAR AVE	PO BOX 1000 DEPT 275		
SAMUEL P BILYEU MD	MEMPHIS TN 38119-	MEMPHIS, TN 381480275		
SIGNED 12/14/20 TE	a b.	1699725812 ZZ2085R0202X		



BIRMINGHAM AL 35243

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 OOOOOOO OOOOOOOOOOOOOOOOOOOOOOOOO			OOTOEO PICA			
A# 227259-0001 CNR534 P E 003 MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER			1a. INSURED'S I.D. NUMBER (For Program in Item 1)			
(Medicare #) (Medicaid #) (ID#/DoD#) 2. PATIENT'S NAME (Last Name, First Name, Middle Init	(Member ID#) (ID#) (ID#) (al) 3. PATIENT'S BIRTH DATE	SEX LUNG				
HORRELL WILLIAM E 5. PATIENT'S ADDRESS (No., Street)	MM DD YY 03 14 1974 6 PATIENT RELATIONSHIP		HORRELL WILLIAM E			
8028 CROSSBOW CV	Self X Spouse Ch		8028 CROSSBOW CV		STATE	
GERMANTOWN	GERMANTOWN TN		GERMANTOW	N TELEBRIONE (I	TN	
	-0485		ZIP CODE TELEPHONE (Include Area Code) 38138 (901) 569-0485		569-0485	
OTHER INSURED'S NAME (Last Name, First Name, N	fiddle Initial) 10. IS PATIENT'S CONDITIO	IN RELATED TO	11. INSURED'S POLICY GR		EH	
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current YES	X NO	MM DD O3 14 1	YY M [SEX F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?		b OTHER CLAIM ID (Design		•	
© RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	Run	c INSURANCE PLAN NAME	OR PROGRAM NAM	E	
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)			d IS THERE ANOTHER HE			
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATU	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.		13 INSURED'S OR AUTHOR payment of medical bene	fits to the undersigned	NATURE Lauthorize	
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 12/10/20		Control of the Contro	services described below. SIGNATURE ON FILE			
SIGNED		DD , YY	SIGNED			
MM DD YY QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOI	QUAL.		FROM 18. HOSPITALIZATION DAT	TO ES RELATED TO CUR	RENT SERVICES	
DN JOHN SPERO TOULIAT 19 ADDITIONAL CLAIM INFORMATION (Designated by	OS MD 17b NPI 13069527	59	FROM DD 20 OUTSIDE LAB?	TO S CHAF	IM DD YY	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)		YES X NO			
A. K449 B. K219 C. R1310 D. ICD Ind. 0			CODE ORIGINAL REF NO 23 PRIOR AUTHORIZATION NUMBER			
E.	К		23 PRIOR AUTHORIZATION	0.000		
24. A DATE(S) OF SERVICE B From To PLACE OF MM DD YY MM DD YY SERVICE	C. D. PROCEDURES, SERVICES, OR SU (Explain Unusual Circumstances) EMG CPT/HCPCS I MODIFIER	PPLIES E. DIAGNOSIS POINTER	F G DA \$ CHARGES UN	The state of the s	RENDERING PROVIDER ID. #	
12 10 20 11	74220	ABC	256 00	1 NPI	1649220120	
				NPI		
				NPI		
				NPI		
				NPI		
25 FEDERAL TAX I D NUMBER SSN EIN	(For	EPT ASSIGNMENT? govt. claims, see back)	28 TOTAL CHARGE	29. AMOUNT PAID	30 Rsvd for NUCC use	
621116618 X 31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	10240497D X YI 32 SERVICE FACILITY LOCATION INFORMA		\$ 256 \ 00	0 & PH # (90:	1) 387-2340	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.) DIPC R&F 6401 POPLAR AVE		DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275				
ROBERT A DUKE MD MEMPHIS TN 38119- 3 12/14/20TE			MEMPHIS, T			
NUCC Instruction Manual available at: www	nucc.org PLEASE PRIN	T OR TYPE	THE RESERVE AND ADDRESS OF THE PERSON OF THE		7 FORM 1500 (02-12)	



BIRMINGHAM AL 35243

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000								
PICA A# 406737-0001 CNR534 P N 020 406737 PICA								
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX		and the same of th	MB01174758 4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
ELLIS AMY A		MM DD YY O8 05 1974 F X		ELLIS AMY A			e, Micure IIIIIIII)	
12808 SHANE HOLLOW DR		Self X Spouse	Child Oth		7. INSURED'S ADDRESS (No., Street) 12808 SHANE HOLLOW DR			I.OW DR
ARLINGTON		8. RESERVED FOR NU	ICC USE		CITY		11011	STATE
ARLINGTON TN ZIP CODE TELEPHONE (Include Area Code)					ARLI1	IGTON	TELEPHOI	NE (Include Area Code)
38002 (901) 386 - 2058 9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)		10. IS PATIENT'S CON	DITION BELATED	TO	38002		(90	386-2058
		TO TOT ATTENT 5 CON	DITION RELATED	10:	11. INSURED'S	800103	UP OR FECA N	NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Cui			a. INSURED'S DATE OF BIRTH		SEX	
b. RESERVED FOR NUCC USE		L AUTO ACCIDENT?	X NO	E (State)	b. OTHER CLAIR	05 19 M ID (Designate	/4	FX
c. RESERVED FOR NUCC USE		YES OTHER ACCIDENT?	XNO					
		YES	XNO		EVOCA		OR PROGRAM	NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (De	signated by NUCC	()	d IS THERE AN	OTHER HEAL	TH BENEFIT P	LAN?
READ BACK OF FORM BEFOR	E COMPLETING	& SIGNING THIS FORM			13. INSURED'S (XNO OR AUTHORIZ	ED PERSON'S	ete items 9, 9a and 9d. SIGNATURE I authorize
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.			payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNATURE ON FILE 11/09/20 SIGNED DATE		SIGNATURE ON FILE						
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY QUAL QUAL QUAL Y		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM , DD , YY MM , DD , YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ZZ208800000X		FROM TO TO TO THE PROPERTY SERVICES						
DN ROWENA DESOUZA MD 17b. NPI 1326201567		FROM MM DD YY TO MM DD YY						
		YES YES	X NO	\$ (CHARGES			
N200		22 RESUBMISSION CODE ORIGINAL REF. NO.						
C. D.		23. PRIOR AUTHORIZATION NUMBER						
1. J. 24. A. DATE(S) OF SERVICE B. C.	D PROCED	OURES, SERVICES, OR	L L SUPPLIES	E .	F	G.	H. I.	
From To PLACE OF SERVICE MM DD YY MM DD YY SERVICE EMC	(Explain	Unusual Circumstances	DIA DIA	GNOSIS	\$ CHARGES	DAYS OR UNITS	EPSOT ID. Family Plan QUAL.	RENDERING PROVIDER ID. #
11 09 20 11	76775		P	ΔB	175	00 1	NPI	1043258247
	1							
							NPI	
							NPI	
							NPI	8
			1				NPI	HA WILLIAM
							INFI	Ž
	PATIENT'S ACC		CCEPT ASSIGNMI or govt claims see b	ENT?	28. TOTAL CHAR	GE 29	NPI AMOUNT PA	
621116618 X 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32	1021192 SERVICE FACIL	28 X	YES NO			5 00 s		
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof).		33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC			01) 387-2340			
6401 POPLAR AVE		PO BOX 1000 DEPT 275						
77 / 70 / 00			MEMPHIS, TN 381480275 1699725812 DZZ2085R0202X					

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0 0 0 0 0 0 0 0				
A# 226637-0001 CNR534 P E 019	226637 PICA			
HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX	MB01922208 4 INSURED'S NAME (Last Name, First Name, Middle Initial)			
BOWMAN CHARLOTTE 03 02 1959 X	BOWMAN KENNETH			
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)			
165 FAIR VIEW LN Self Spouse X Child Other	165 FAIR VIEW LN			
CITY STATE 8. RESERVED FOR NUCC USE	CITY STATE			
OAKLAND TN ZIP CODE TELEPHONE (Include Area Code)	OAKLAND TN ZIP CODE TELEPHONE (Include Area Code)			
38060 (901) 286-7468	(Indiade Area Code)			
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10 IS PATIENT'S CONDITION RELATED TO.	38060 (901) 286-7468 11. INSURED'S POLICY GROUP OR FECA NUMBER			
	1048800203			
a. OTHER INSURED'S POLICY OR GROUP NUMBER a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX			
B YES NO b. RESERVED FOR NUCC USE b. AUTO ACCIDENT?	03 17 1956 X			
PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME			
YES X NO	EVOCARE			
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	YES XNO 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.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for specific described habitures.			
SIGNATURE ON FILE 11/06/20	services described below.			
SIGNED DATE	SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM , DD , YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM , DD , YY			
QUAL. QUAL.	FROM			
DN OLEKSANDRA DRYN MD 17b NPI 1366861510	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	FROM TO 20 OUTSIDE LAB? \$ CHARGES			
ACTUAL INVOICE COST	YES X NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)	22. RESUBMISSION CODE ORIGINAL REF NO			
A G939 B. R202 C. L.				
E F G H	23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E	F. G. H. L. J.			
From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS MM DD YY MM DD YY SERVICE EMG CPT/HCPCS J MODIFIER POINTER	DAYS EPSOT ID. RENDERING OR Family QUAL PROVIDER ID. #			
11 06 20				
11 06 20 11 70553 AB	1455 00 1 NPI 1669553764			
11 06 20 11 A9575 AB	35 00 20 NPI 1669553764			
Ab	35 00 20 NPI 1669553764			
	NPI NPI			
	NPI			
	NPI NPI			
	NPI NPI			
OF FEDERAL TANKS NUMBER	NPI NPI			
25. FEDERAL TAX I.D NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt claums see back)	28 TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION	\$ 1490 00 \$ 33 BILLING PROVIDER INFO & PH # (901) 387-2340			
(I certify that the statements on the reverse DTPC MRT STEMENS	DIAGNOSTIC IMAGING PC			
6401 POPLAR AVE	PO BOX 1000 DEPT 275			
SAMUEL P BILYEU MD MEMPHIS TN 38119-	MEMPHIS, TN 381480275			
11/12/20 _{ATE} a 1699725812 ZZ2085R0202X				

BIRMINGHAM AL 35243			0 0 0		
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	0000000		Š		
PICA A# 18610-0001 CNR534	P E 003		18610 PICA		
1. MEDICARE MEDICAID TRICARE CHAMPVA	HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)		
(Medicare #) (Medicaid #) (ID#/DoD#) (Member IL 2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	MB03906847 4. INSURED'S NAME (Last Name, First	Name, Middle Initial)		
DAVIDSON AARON A	DAVIDSON AARON A				
5. PATIENT'S ADDRESS (No., Street)	7. INSURED'S ADDRESS (No., Street)				
120 TIMBERLANE RD	Self X Spouse Child Other 8. RESERVED FOR NUCC USE	120 TIMBERLANE RD			
ARLINGTON TN		ARLINGTON	TN		
ZIP CODE TELEPHONE (Include Area Code)			PHONE (Include Area Code) (901) 487-6611		
38002 (901) 487-6611	10. IS PATIENT'S CONDITION RELATED TO:	38002 (901) 487-6611			
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	TO. IS PATIENT'S CONDITION RELATED TO.	1048800604	ECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX F		
	YES X NO	03 31 1968	Δ		
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES X NO	b. OTHER CLAIM ID (Designated by NU	CC)		
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROG			
	YES X NO	EVOCARE			
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENE	Complete items 9, 9a and 9d.		
READ BACK OF FORM BEFORE COMPLETING	& SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PER	SON'S SIGNATURE I authorize		
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize their to process this claim. I also request payment of government benefits eith below. 	elease of any medical or other information necessary or to myself or to the party who accepts assignment	payment of medical benefits to the u services described below.	ndersigned physician or supplier for		
SIGNATURE ON FILE	11/05/20		E ON FILE		
SIGNED	OTHER DATE	SIGNED	IK IN CURRENT OCCUPATION		
MM DD YY QUAL QUA	MM DD YY	FROM DD YY	TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO YY 20. OUTSIDE LAB? \$ CHARGES				
DN STEFFANIE MORRIS NP 17b. NPI 1437646510 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
	YES X NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to serv	ICD Ind	22 RESUBMISSION CODE ORIG	INAL REF. NO.		
A, Line B	J45909 F17200	23. PRIOR AUTHORIZATION NUMBER			
E.L. F.L. G.L. K.L.	H.L.				
	EDURES, SERVICES, OR SUPPLIES lain Unusual Circumstances) E DIAGNOSIS	F G H DAYS EPSDT	I. J ID. RENDERING		
MM DD YY MM DD YY SERVICE EMG CPT/HCF		\$ CHARGES OR Family Plan	QUAL. PROVIDER ID. #		
11 05 20 11 7104	6 ABCD	81 00 1	NPI 1649220120		
			NPI		
			NPI		
			NPI		
			NPI		
OF FEDERALTAVID MUMBER CONFINE OF PATERITIES	ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMC	NPI OUNT PAID 30. Rsvd for NUCC use		
25 FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S 10209	(For govt. claims, see back)	s 81 00 s	JUL HAVO TOF NOCC USE		
The state of the s	ICILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #	20- 00		
(I certify that the statements on the reverse apply to this bill and are made a part thereof)	DIAGNOSTIC IMAGING PC				

ROBERT A DUKE MD

6401 POPLAR AVE

MEMPHIS TN 38119-

PO BOX 1000 DEPT 275

MEMPHIS, TN 381480275

1699725812 LZZ2085R0202X