

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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000	226244 PICA
PICA A# 226244-0001 CNR534 P E 019	OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#)	X (ID#) MB02134492
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  MM   DD   YY	F X FINLEY DEBBIE J
FINLEY DEBBIE J 10 29 1970 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSU	
FOA W DOWELL.	Other 504 W POWELL STATE
CITY STATE 8. RESERVED FOR NOCO OSE	CITY  COLLIERVILLE  ZIP CODE  38017  TELEPHONE (Include Area Code)  38017  (901) 610-9541  INSURED'S POLICY GROUP OR FECA NUMBER  1048800701  a. INSURED'S DATE OF BIRTH  MM
COLLIERVILLE TN ZIP CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Include Area Code)
20017 (001) 610-9541	38017 901 610-9541 5
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  10. IS PATIENT'S CONDITION RELA	TED TO: 11 INSURED'S POLICY GROUP ON PECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previo	a. INSURED'S DATE OF BIRTH MM DD YY
YES XINC	10 29 1970 M F X
b. RESERVED FOR NOCC OSE	PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)
YES X NC	c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE  C. OTHER ACCIDENT?  YES X NO.	c. INSURANCE PLAN NAME OR PROGRAM NAME  EVOCARE  NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other informat to process this claim. I also request payment of government benefits either to myself or to the party who accept to process this claim.	s assignment services described below
SIGNATURE ON FILE 10/20/	20 SIGNATURE ON FILE
SIGNEDDATE	SIGNED  16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM . DD . YY  MM , DD , YY  A
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM   DD   YY   QUAL     QUAL	FROM
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178. 1GOTHO00	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FEOM TO
DN SAMYA CRUZ MD 176 NPI 1417056409	FROM 10 20 OUTSIDE LAB? \$ CHARGES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	YES X NO
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. C	22 RESUBMISSION ORIGINAL REF. NO.
A. J449 B. J189 C. D.	23. PRIOR AUTHORIZATION NUMBER
E F G H	
1. DATE(S) OF SERVICE B C D. PROCEDURES, SERVICES, OR SUPPLIES From To PLACE OF (Explain Unusual Circumstances)	DIAGNOSIS
From To PLACE OF MM DD YY MM DD YY SERVICE EMG CPT/HCPCS I MODIFIER	POINTER \$ CHARGES UNITS PAIN QUAL. PROVIDER ID. #
1 10 20 20 11 71046 Q6	AB 81 00 1 NPI 1669553764
10 20 20	NPI NPI
2	AB 81 00 1 NPI 1669553764
3	NPI NPI
	NDI C
4	
5	NPI NPI
25. EEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT	ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
25. FEDERAL TAX 15. NUMBER  SSN EIN  10195436  X YES	NO \$ 81 00 \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH. # (901) 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
SAMUEL P BILYEU MD MEMPHIS TN 38119-	MEMPHIS, TN 381480275
SIGNED 10/23/20 a	a1699725812 b ZZ2085R0202X



#### **EVOCARE** C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)	131613 PICA		
PICA A# 131613-0001 CNR	2534 PE 019	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
1 MEDICARE MEDICAID TRICARE C	HEALTH PLAN BLK LUNG	MB2752759	
(Medicare #) (Medicaru #)	Member (ID#) (ID#) (ID#) (ID#)  3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	MM   DD   YY	DARDEN CHERYL D	
DARDEN CHERYL D	05 24 1963 F X	7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)	Self X Spouse Child Other	90 FLETCHER DR	
90 FLETCHER DR	STATE 8. RESERVED FOR NUCC USE		
CITY	TOWN THE COLUMN TO THE COLUMN	COLLIERVILLE TN	
COLLIERVILLE	TN	ZIP CODE TELEPHONE (Include Area Code)	
( 0.01) 0.53 0.19		38017 (901) 853-9181	
38017 (901) 853 – 918 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initi		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name: 1 list Name; Miles		1048800701	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	
a OTHER INSURED'S POLICY ON GROOT HOME	YES X NO	05 24 1963 X	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
b. RESERVED FOR NOOS SEE	YES X NO	PROCESS OF PROCESS NAME	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME  EVOCARE  d is there another health benefit plan?	
C. NEDERVED FOR THE	YES X NO	EVOCARE  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		
		23	
READ BACK OF FORM BEFORE CO	DMPLETING & SIGNING THIS FORM.  bourze the release of any medical or other information necessary.	INSURED S OR AUTHORIZED PERSONS SIGNATURE     payment of medical benefits to the undersigned physician or supplier for services described below.	
READ BACK OF FORM BEFORE CO.  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorized payment of government by the process this claim. I also request payment of government by the payment by the p	enefits either to myself or to the party who accepts assignment	SIGNATURE ON FILE	
SIGNATURE ON FILE	10/19/20	SIGNATORE ON TIE	
SIGNED	DATE	SIGNED  16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  VY	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (L		FROM DD YY	
QUAL	17a ZZ207VX0201X	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	1407611760	FROM DD YY TO	
DN DAVID ENGLE		20. OUTSIDE LAB? \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		YES X NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate	e A-L to service line below (24E)	22. RESUBMISSION ORIGINAL REF NO	
iii	D.L		
N83201 N8500	0.	23. PRIOR AUTHORIZATION NUMBER	
E F	G. L		
1. 24. A. DATE(S) OF SERVICE B. C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNO.	F. G. H. I.  DAYS EPROT ID RENDERING PROVIDER ID. #  SCHARGES OR FAMILY QUAL PROVIDER ID. #	
From To PLACE OF	(Explain Unusual Circumstances) DIAGNO CPT/HCPCS   MODIFIER POINTE	SIS DAYS PEROT ID HENDEHING PROVIDER ID. #	
MM DD YY MM DD YY SERVICE EMG			
10 19 20 11	76830 Q6 AB	263 00 1 NPI 1669553764	
		NPI	
2		INFT	
		NPI	
3		i i i i i i i i i i i i i i i i i i i	
1		NPI NPI	
4			
5		NPI	
6		NPI	
	PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT (For goot claims, see back)		
621116618 X	10192219 X YES NO	\$ 263 00 \$	
21 SIGNATURE OF PHYSICIAN OR SUPPLIER 32.	SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # 901 387-2340	
INCLUDING DEGREES OR CHEDENTIALS  Usertify that the statements on the reverse	OIPC US	DIAGNOSTIC IMAGING PC	
	5401 POPLAR AVE	PO BOX 1000 DEPT 275	
SAMUEL P BILYEU MD M	MEMPHIS TN 38119-	MEMPHIS, TN 381480275	



#### **EVOCARE** C/O ACCOUNTS PAYABLE 1735 MELISSA WAY

BIRMINGHAM AL 35243		CARRI
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	0000000	226240 PICA
PICA A# 226240-0001 CNR534	PE 001  GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
MEDICARE MEDICARD (Member II	HEALTH PLAN BLK LUNG (ID#)	MB03230393
(Medicare #) (Medicaid #) (ID#/DOD#) (Weinber it 2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
OBRIEN MARCIA K	07 02 1957 FX	OBRIEN MARCIA K
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSTILL TO INCOME	7. INSURED'S ADDRESS (No., Street)
6034 KERIN DRIVE	Self X Spouse Child Other  8 RESERVED FOR NUCC USE	6034 KERIN DRIVE
CITY	8. RESERVED FOR NOCC USE	STATE   STATE   TN
BARTLETT TNO TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
( 221 ) 222 7624		38135 (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
V. Official and Control of the Contr		1048800203
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH  MM DD YY   O 7 O 2 1 1957
	b. AUTO ACCIDENT? PLACE (State)	07 02 1957 W X b. OTHER CLAIM ID (Designated by NUCC)
b. RESERVED FOR NUCC USE	YES X NO	b. OTHER CLAIM ID (Designated by NUCC)
PROSERVED FOR MUCO LIGH	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME  EVOCARE
c. RESERVED FOR NUCC USE	YES X NO	1 / O O 1 1 1 1 1
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES XNO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING	G & SIGNING THIS FORM. release of any medical or other information necessary	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE   authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING  12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eit below.	ner to myself or to the party who accepts assignment	SIGNATURE ON FILE
SIGNATURE ON FILE	10/20/20	SIGNATURE ON FIDE
SIGNED	OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY	JAL.   MM   DD   YY	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.	ZZ207X00000X	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM   DD   YY
THOUGH AND A CONTROL OF THE CONTROL	NPI 1891967147	FROM
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 0010182 2501
	nies lies bolow (24E)	YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to se	rvice line below (24E) ICD (nd. 0	CODE ORIGINAL REF. NO.
A M25512 B S42212A C.	D. L.	23. PRIOR AUTHORIZATION NUMBER
F G.		
J.   K   24. A. DATE(S) OF SERVICE   B.   C.   D. PR.	OCEDURES, SERVICES, OR SUPPLIES E	F. G. H. I. J. DAYS EPSDT ID. RENDERING
From To PLACE OF	xplain Unusual Circumstances)  DIAGNOSIS  DIAGNOSIS  POINTER	OR Family QUAL PROVIDER ID #
S	HOULDER	561 00 1 NPI 1740247485
10 20 20 11 732	00 LT AB	561 00 1 NPI 1740247485
		NPI NPI
3		NPI NPI
1		NPI NPI
		NPI NPI
		TWT
6		NPI
	S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
621116618 X 1019	3977 X YES NO	s 561 00 s
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE	FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (901) 387 - 2340
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse  DIPC		DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275
	POPLAR AVE HIS TN 38119-	PO BOX 1000 DEPT 2/5 MEMPHIS, TN 381480275
LOUIS S PARVEY MD MEMPH	MEMPHIS, IN SOLIOUZIS	

LOUIS S PARVEY MD

1699725812 ZZ2085R0202X



## EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243 HEALTH INSURANCE CLAIM FORM			CARR
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/	0000000		1
PICA A# 181800-0001 CNR53	34 PE 019	1818 C	
1 MEDICARE MEDICAID TRICARE CHAM	HEALTH PLAN BLK LUNG	MB00127586	
(Medicare #) (Medicard #)	ber ID#) (ID#) (ID#) X (ID#)  3 PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) VANWART ROBERT L	03 18 1983 X	VANWART VANESSA R	
VANWART ROBERT L 5 PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
5035 TRENT CV	Self Spouse X Child Other	5035 TRENT CV	STATE
CITY	ATE 8: RESERVED FOR NUCC USE	CITY	TINI C
DAKTHETT	TN	BARTLETT ZIP CODE TELEPHONE (Include Area	TN a Code) -5336
ZIP CODE TELEPHONE (Include Area Code)		()	-5336
38002 (901) 834-5336	10. IS PATIENT'S CONDITION RELATED TO:	38002 (901) 834	3330
9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)	10. IS PATIENT S CONDITION THE STEEL TO	1048800604	,
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	0
a. OTHER INSCREDS POLICY ON GROOT NOME.	YES X NO	10 17 1982	FX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
Control of the Contro	YES X NO		
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
	YES X NO	EVOCARE  d IS THERE ANOTHER HEALTH BENEFIT PLAN?	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	YES NO If yes, complete items 9, 9a	and 9d.
READ BACK OF FORM BEFORE COMPL	ETING & SIGNING THIS FORM	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Lauthorize
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize     to process this claim. I also request payment of government benefit	the release of any medical or other information necessary is either to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician services described below.	or supplier for
signature on file	10/19/20	SIGNATURE ON FIL	E
SIGNATURE ON THE	DATE	SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE MM , DD , YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCH MM , DD , YY MM , DI	CUPATION D YY
MM DD YY QUAL	QUAL	FROM TO	
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a ZZ207R00000X	18. HOSPITALIZATION DATES RELATED TO CURRENT SE	D YY
DN MICHELLE PATTAT FNP	17b NPI 1699717272	FROM TO 1 20. OUTSIDE LAB? \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		YES X NO	
ACTUAL INVOICE COST  21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L t	to service line below (24E) (CD Ind. 0	22. RESUBMISSION	
J320 R590	K148	CODE OHIGINAL REF NO.	
A 0320	G	23. PRIOR AUTHORIZATION NUMBER	
E. L.	K		
21.71	PROCEDURES, SERVICES. OR SUPPLIES (Explain Unusual Circumstances)	F. G. H. I. DAYS EPSDT ID. RE	J ENDERING
	PT/HCPCS   MODIFIER POINTER	\$ CHARGES DAYS EPSDT OR Family QUAL PRO	OVIDER ID. #
10 10 00 11 11 70	1492 06 ABC	806 00 1 NPI 1669	553764
10 19 20   11   70	0492 Q6 ABC	800 00 1 1 1005	333,01
2 10 19 20   11   Q9	9967 Q6 ABC	7 33 80 NPI 1669	9553764
	7		
3		NPI	
4		NPI	
5		NPI	
		NO.	
6		NPI	
	ENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOTAL CHARGE 29 AMOUNT PAID 30.	Rsvd for NUCC use
Est TEDELTITE (1971) Est Tedeltite (1971)	192649 X YES NO	s 813 33 s	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERV	VICE FACILITY LOCATION INFORMATION	\ /	37-2340
	C CT	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275	
040.	apply to this bill and are made a part thereof.)  SAMUEL P BILYEU MD  6401 POPLAR AVE  MEMPHIS TN 38119-		
SAMUEL P BILYEU MD MEM	MEMPHIS, TN 381480275	0.011	

1699725812 b ZZ2085R0202X



# EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY BIRMINGHAM AL 35243 TH INSURANCE CLAIM FORM

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

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (11000		225544		
PICA 74 225544 - 0.001 CNR534 P E 019				
1. MEDICARE MEDICARD	HEALTH PLAN BLK LUNG	MB01775427		
(Medicare #)	Member ID#) (ID#) (ID#) X (ID#)  3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	MM I DD I YY	MANLEY JULIE		
MANLEY JULIE	03 23 1976 F X	7. INSURED'S ADDRESS (No., Street)		
5. PATIENT'S ADDRESS (No., Street)		11946 BROWN ST		
11946 BROWN ST	Self X Spouse Child Other	CITY STATE		
CITY	STATE 8. RESERVED FOR NUCC USE	TINT		
A DI INCTON	TN	ARLINGTON TELEPHONE (Include Area Code)		
ARLINGTON ZIP CODE TELEPHONE (Include Area Con		ZIP CODE		
() 255 605	73	38002 (901) 355-6273		
38002 (901) 355-62 9 OTHER INSURED'S NAME (Last Name, First Name, Middle Init	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER		
9. OTHER INSURED'S NAME (Last Name )				
	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX		
a OTHER INSURED'S POLICY OR GROUP NUMBER	YES X NO	03 23 1976 M		
	THE LOCUPENTS	b. OTHER CLAIM ID (Designated by NUCC)		
b. RESERVED FOR NUCC USE	TEACE (State)			
	YES X NO			
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?			
	YES X NO	EVOCARE		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT FLANT		
A STATE OF THE STA		YES NO If yes, complete items 9, 9a and 9d.		
READ BACK OF FORM BEFORE CO	OMPLETING & SIGNING THIS FORM.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I aut	horize the release of any medical or other information necessary senefits either to myself or to the party who accepts assignment	services described below.		
to process this claim. Laiso request payment of government of	10/16/20	SIGNATURE ON FILE		
SIGNATURE ON FILE	the state of the s	SIGNED		
SIGNED	DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (L	MP) 15. OTHER DATE MM   DD   YY	MM DD YY MM DD TY		
MM DD YY QUAL	QUAL	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a ZZ207Y00000X	MM DD YY MM DD		
DN SRIKANTH NAIDU MD	17b NPI 1427166156	FROM TO TO SCHARGES		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. 001012 2.0		
on one of the original origin		YES X NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate	A-L to service line below (24E) ICD Ind 0	22 RESUBMISSION ORIGINAL REF. NO.		
	C   K219			
A R1310 B R070	C REELS H.L.	23. PRIOR AUTHORIZATION NUMBER		
E.L	G. L			
24 A DATE(S) OF SERVICE B. C.	D. PROCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.		
24. A DATE(S) OF SERVICE B. C. PLACE OF	(Explain Unusual Circumstances) DIAGNOS			
MM DD YY MM DD YY SERVICE EMG	CPT/HCPCS   MODIFIER POINTE	R \$ CHARGES UNITS Final QUAL PROVIDER ID. #		
1	los	680 00 1 NPI 1669553764		
10 16 20 11	70491 Q6 ABC	. 600 00 1 1003333701		
		7 33 80 NPI 1669553764		
2 10 16 20 11	Q9967 Q6 ABC	7 33 80 NPI 1669553764		
3		NPI		
4		NPI		
5		NPI		
6		NPI NPI		
	PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT	The AMERICAN DATE OF BUILDING WAS AND THE OWNER OF THE OWNER O		
25 PEDERAL TAX 1.D. NOMBER	(For govt, claims, see back)	687 33 \$		
021110010	10190965 X YES NO	33. BILLING PROVIDER INFO & PH. # (901) 387-2340		
31. SIGNATURE OF PERSONAL C	SERVICE FACILITY LOCATION INFORMATION			
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	IPC CT	DIAGNOSTIC IMAGING PC		
apply to this bill and are made a part thereof)	401 POPLAR AVE	PO BOX 1000 DEPT 275		
SAMUEL P BILYEU MD M	EMPHIS TN 38119-	MEMPHIS, TN 381480275		
SAMUEL P BILLEO IND 1.	b.	1699725812 ZZ2085R0202X		
LOCATE TO LATE		100 100 100 100 100 100 100 100 100 100		