



12/16/2020

From: Diagnostic Imaging, PC  
Phone: 901-387-2340  
Fax: 901-680-1902  
Company Name:

To: ALBERTO CHAN

Phone:  
Fax: 205-737-4948

**Confidentiality Notice:** The documents accompanying this fax transmission contain confidential information belonging to the sender that may be legally privileged. This information is intended only for the use of the individual or entity named above. The Authorized recipient of this confidential information is prohibited from disclosing this information to any other party. If you have received this transmission in error, please notify the sender immediately and arrange for the return of the documents.

**Comments:**

CLAIMS THAT HAVE NOT BEEN PAID AND EMAILED YOU ABOUT SO I AM FAXING THEM TO YOU.

THANK YOU AND BE SAFE!

THANK YOU

Lisa J

Urgent  For Review  Please Comment  Please Reply  Please Recycle



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

**HEALTH INSURANCE CLAIM FORM**

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

5689

0000000

PICA 131613

(For Program in Item 1)

PICA		A# 131613-0001 CNR534		P E 019			
1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DoD#)	CHAMPA (Member ID#)	GROUP (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/>	1a. INSURED'S I.D. NUMBER MB2752759
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/>		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 Sel <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Chi d <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE		9.0 FLETCHER DR.	
CITY COLLIERVILLE	STATE TN			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: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800701			
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 05 24 1963			
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)			
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENTS 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 _____ DATE 10/19/20				SIGNATURE ON FILE SIGNED _____ DATE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 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 FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
20. OUTSIDE LAB? S CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind 0 A. N83.201 B. N85.00 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS MODIFIER	
1 10 19 20		11		76830 Q6		F. E. I. J. RENDERING S CHARGES G. DAYS OR UNITS H. EPDS Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
2						NPI	
3						NPI	
4						NPI	
5						NPI	
6						NPI	
25. FEDERAL TAX I.D. NUMBER 621116618		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 10192219D		27. ACCEPT ASSIGNMENT? (For govt claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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		32. SERVICE FACILITY LOCATION INFORMATION DIPC US 6401 POPLAR AVE MEMPHIS TN 38119-		28. TOTAL CHARGE \$ 263 00		29. AMOUNT PAID \$	
SIGNED 12/16/20		a. b.		30. Rsrd for NUCC use			
33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 a. 1699725812 b. ZZ2085R0202X							



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

### HEALTH INSURANCE CLAIM FORM

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

5689

0000000

PICA

A# 140371-0001 CNR534

P E 021

140371

PICA

140371

PICA		0000000										PICA	
A# 140371-0001 CNR534 P E 021												140371	
1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)		OTHER <input checked="" type="checkbox"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>GRAHAM CAYCE M</b>												3. PATIENT'S BIRTH DATE MM DD YY <b>11 28 1975</b> <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) <b>3482 EVENING LIGHT</b>												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY <b>BARTLETT</b>		STATE <b>TN</b>		8. RESERVED FOR NUCC USE									
ZIP CODE <b>38135</b>		TELEPHONE (Include Area Code) <b>(901) 647-1209</b>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>1048800604</b>											
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY <b>11 28 1975</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>EVCARE</b>											
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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.												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												10/22/20	
SIGNED _____ DATE _____												SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>DN SAMYA CRUZ MD</b>		17a. 1GOTH000		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. R928 B. N6321 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS EPSDT Family Plan		H. I. J. ID. QUAL. 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 ID. NUMBER <b>621116618</b>		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>10195972D</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 473 00</b>		29. AMOUNT PAID <b>\$</b>		30. Rsrd 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.) <b>CASEY S TAYLOR MD</b>		32. SERVICE FACILITY LOCATION INFORMATION <b>DIPC MAMMO 6401 POPLAR AVE MEMPHIS TN 38119-</b>		33. BILLING PROVIDER INFO & PH. # <b>(901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275</b>									
SIGNED 12/16/20		a. <b>109850</b>		b. <b>1699725812</b>		c. <b>ZZ2085R0202X</b>							



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

## HEALTH INSURANCE CLAIM FORM

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

5689

0000000

PICA A# 140371-0001 CNR534

P E 021

140371 PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> X (ID#)	1a. INSURED'S I.D. NUMBER MB00829154 (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>GRAHAM CAYCE M</b>											4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>GRAHAM CAYCE M</b>	
5. PATIENT'S ADDRESS (No., Street) <b>3482 EVENING LIGHT</b>											7. INSURED'S ADDRESS (No., Street) <b>3482 EVENING LIGHT</b>	
CITY <b>BARTLETT</b>		STATE <b>TN</b>		CITY <b>BARTLETT</b>		STATE <b>TN</b>						
ZIP CODE <b>38135</b>		TELEPHONE (Include Area Code) <b>(901) 647-1209</b>		ZIP CODE <b>38135</b>		TELEPHONE (Include Area Code) <b>(901) 647-1209</b>						
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> X NO	
b. RESERVED FOR NUCC USE											b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> X NO PLACE (State)	
c. RESERVED FOR NUCC USE											c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> X NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME											10d. CLAIM CODES (Designated by NUCC)	
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.											d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> X NO If yes, complete items 9, 9a and 9d.	
SIGNATURE ON FILE SIGNED _____ DATE <b>10/22/20</b>											11. INSURED'S POLICY GROUP OR FECA NUMBER <b>1048800604</b>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____											15. OTHER DATE MM DD YY QUAL. _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>DN SAMYA CRUZ MD</b>											17a. <b>1GOTH000</b> 17b. NPI <b>1417056409</b>	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. <b>R928</b> B. <b>N6321</b> C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. MODIFIER	F. DIAGNOSIS POINTER 0	G. \$ CHARGES	H. DAYS OR UNITS 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		
25. FEDERAL TAX I.D. NUMBER <b>621116618</b>	SSN EIN <input checked="" type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. <b>10195980D</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 240 00</b>	29. AMOUNT PAID <b>\$</b>	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.)  <b>CASEY S TAYLOR MD</b>											32. SERVICE FACILITY LOCATION INFORMATION <b>DIPC US 6401 POPLAR AVE MEMPHIS TN 38119-</b>	33. BILLING PROVIDER INFO & PH. # <b>(901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275</b>
SIGNED <b>12/16/20</b>	DATE	a.	b.			1699725812	b.	ZZ2085R0202X				



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

## HEALTH INSURANCE CLAIM FORM

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

5689

00000000

PICA		A# 181800-0001 CNR534		P E 019	PICA		181800	
							(For Program in Item 1)	
1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DoD#)	CHAMPAVA (Member ID#)	GROUP (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/>	1a. INSURED'S I.D. NUMBER 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 <input checked="" type="checkbox"/> X <input type="checkbox"/> 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 <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 5035 TRENT CV		
CITY BARTLETT	STATE TN	8. RESERVED FOR NUCC USE		CITY BARTLETT	STATE TN	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: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800604		
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 10 17 1982		
c. RESERVED FOR NUCC USE		PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)		
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)				c. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE		
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				10/19/20				
SIGNED	DATE			SIGNATURE ON FILE				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN MICHELLE PATTAT FNP				17a. ZZ207R00000X		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ACTUAL INVOICE COST								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. J320 B. R590 C. K148 D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. MODIFIER	DIAGNOSIS POINTERS	F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 10 19 20	11	70492	Q6			ABC	806 00 1	
2 10 19 20	11	Q9967	Q6			ABC	7 33 80	
3							NPI	
4							NPI	
5							NPI	
6							NPI	
25. FEDERAL TAX I.D. NUMBER 621116618	SSN EIN <input checked="" type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. 10192649D		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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				32. SERVICE FACILITY LOCATION INFORMATION DIPC CT 6401 POPLAR AVE MEMPHIS TN 38119-		33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 1699725812 b. ZZ2085R0202X		
SIGNED 12/16/20	DATE	a. <input type="checkbox"/> b. <input type="checkbox"/>						

↑ CARRIER

SECOND FOLD ↑ PATIENT AND INSURED INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION



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

### HEALTH INSURANCE CLAIM FORM

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

0000000

5689

PICA

A# 191200-0001 CNR534

P E 003

191200 PICA

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)		OTHER <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER MB00723887 (For Program in Item 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SONES ELISHA B														3. PATIENT'S BIRTH DATE MM DD YY 06 23 1979 <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SONES STEVEN				
5. PATIENT'S ADDRESS (No., Street) 7560 RAMERO DR														6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 7560 RAMERO DR				
CITY ARLINGTON		STATE TN		8. RESERVED FOR NUCC USE				CITY ARLINGTON		STATE TN										
ZIP CODE 38002		TELEPHONE (Include Area Code) (901) 262-0614						ZIP CODE 38002		TELEPHONE (Include Area Code) (901) 262-0614										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)														10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800604				
														b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 02 05 1980 M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
														c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC) 				
														d. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE		c. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE				
d. INSURANCE PLAN NAME OR PROGRAM NAME														d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		# 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.														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														10/05/20		SIGNATURE ON FILE				
SIGNED _____ DATE _____																SIGNED _____				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.							15. OTHER DATE MM DD YY QUAL.							16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN SAMYA CRUZ MD							17a. 1GOTH000							18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. N200 B. D259 C. R319 D. M545 E. F. G. H. I. J. K. L.														22. RESUBMISSION CODE ORIGINAL REF. NO.						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY							B. PLACE OF SERVICE EMG		C. CPT/HCPCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER		F. ICD IND. 0		G. DAYS OR UNITS EPSDT Family Plan		H. I. J. ID. QUAL. RENDERING PROVIDER ID. #	
1 10 05 20							11		74176   Q6		ABCD		604   00   1		NPI   1649220120					
2															NPI					
3															NPI					
4															NPI					
5															NPI					
6															NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN 621116618 <input type="checkbox"/> X							26. PATIENT'S ACCOUNT NO. 10179463D		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 604 00		29. AMOUNT PAID \$		30. Rsrd 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							32. SERVICE FACILITY LOCATION INFORMATION DIPC CT 6401 POPLAR AVE MEMPHIS TN 38119-		33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275		a 1699725812		b ZZ2085R0202X							
SIGNED 12/16/20							a. b.													



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

### HEALTH INSURANCE CLAIM FORM

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

5689

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PICA

A# 225236-0001 CNR534

P E 001

225236 PICA

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 MB02368893 (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MCNEECE DANA</b>													
5. PATIENT'S ADDRESS (No., Street) <b>2744 GARDEN LANE</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>11 02 1982</b> F X							
CITY <b>MEMPHIS</b>						SEX Self X Spouse Child Other							
ZIP CODE <b>38111</b>						STATE <b>TN</b>							
TELEPHONE (Include Area Code) <b>(901) 581-3142</b>						8. RESERVED FOR NUCC USE							
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 X NO							
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? YES X NO PLACE (State)							
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? YES X NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)							
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						DATE <b>9/01/20</b>							
SIGNED _____						DATE _____							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____						15. OTHER DATE MM DD YY QUAL. _____							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>DN GINA LUM FNP</b>						17a. ZZ363L00000X 17b. NPI 1598920704							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
ACTUAL INVOICE COST													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)													
ICD Ind. 0													
A. R51		B. R42		C. H9202		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
E. _____		F. _____		G. _____		H. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
I. _____		J. _____		K. _____		L. _____		20. OUTSIDE LAB? \$ CHARGES YES X NO					
22. RESUBMISSION CODE ORIGINAL REF. NO.													
23. PRIOR AUTHORIZATION NUMBER													
F. \$ CHARGES		G. DAYS OR UNITS		H. EPSTD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #					
109 01 20		11 70553		ABC		1455 00 1		NPI 1740247485					
209 01 20		11 A9575		ABC		26 25 15		NPI 1740247485					
3								NPI					
4								NPI					
5								NPI					
6								NPI					
25. FEDERAL TAX I.D. NUMBER <b>621116618</b>		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. <b>10148971D</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 1481 25</b>		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.)  <b>LOUIS S PARVEY MD</b>													
32. SERVICE FACILITY LOCATION INFORMATION <b>DIPC MRI SIEMENS 6401 POPLAR AVE MEMPHIS TN 38119-</b>													
33. BILLING PROVIDER INFO & PH. # <b>(901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275</b>													
SIGNED <b>12/16/20</b>		TE		a.		b.		a. 1699725812		b. ZZ2085R0202X			



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

### HEALTH INSURANCE CLAIM FORM

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

5689

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PICA 225401

(For Program in Item 1)

PICA		A# 225401-0001 CNR534		P E 003		225401 PICA	
1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)	
GROUP (ID#)		HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)		OTHER (ID#)	
						<input checked="" type="checkbox"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY			
KONCHONSKI RICHARD A				05 24 1959 <input checked="" type="checkbox"/> F <input type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED			
6481 EAST BRIER				Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY BARTLETT		STATE TN		8. RESERVED FOR NUCC USE		CITY BARTLETT	
ZIP CODE 38135		TELEPHONE (Include Area Code) (901) 288-3792				STATE TN	
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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)			
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				9/10/20			
SIGNED		DATE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN LAURA ERICKSON-BLY NP				17a. ZZ363L00000X 17b. NPI 1659674208			
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. M25511	B. M47814	C. M4180	D.	E.	F.	G.	H.
I.	J.	K.	L.				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER	
1 09 10 20				11 73030 RT		A	
2 09 10 20				11 71046		BC	
3							
4							
5							
6							
25. FEDERAL TAX I.D. NUMBER 621116618		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 10158889D		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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		32. SERVICE FACILITY LOCATION INFORMATION DIPC R&F 6401 POPLAR AVE MEMPHIS TN 38119-		33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275			
SIGNED 12/16/20		a. b.		28. TOTAL CHARGE \$ 153 00		29. AMOUNT PAID \$	
				30. Rsrd for NUCC use			



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

5689

## HEALTH INSURANCE CLAIM FORM

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

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PICA

A# 225544-0001 CNR534

P E 019

225544

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP <input type="checkbox"/> HEALTH PLAN <input type="checkbox"/> (ID#)	FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> X (ID#)	1a. INSURED'S I.D. NUMBER MB01775427 (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MANLEY JULIE											3. PATIENT'S BIRTH DATE MM DD YY 03 23 1976 F X				
5. PATIENT'S ADDRESS (No., Street) 11946 BROWN ST											6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
CITY ARLINGTON		STATE TN		8. RESERVED FOR NUCC USE		CITY ARLINGTON		STATE TN							
ZIP CODE 38002		TELEPHONE (Include Area Code) (901) 355-6273				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. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
											b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
											c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME											10d. CLAIM CODES (Designated by NUCC)				
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.				
SIGNATURE ON FILE											10/16/20				
SIGNED _____ 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.				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: _____											15. OTHER DATE MM DD YY QUAL: _____				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN SRIKANTH NAIDU MD											16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17a. ZZ207Y00000X 17b. NPI 1427166156											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. R1310 B. R070 C. K219 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											22. RESUBMISSION CODE ORIGINAL REF. NO.				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. MODIFIER F. DIAGNOSIS POINTER ICD Ind. 0											23. PRIOR AUTHORIZATION NUMBER 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	
25. FEDERAL TAX I.D. NUMBER 621116618		SSN EIN <input checked="" type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 10190965D		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 687 33		29. AMOUNT PAID \$		30. Rsrd 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 12/16/20 DATE											32. SERVICE FACILITY LOCATION INFORMATION DIPC CT 6401 POPLAR AVE MEMPHIS TN 38119-		33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275		
a. 1699725812 b. ZZ2085R0202X															



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

### HEALTH INSURANCE CLAIM FORM

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

5689

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PICA

A# 225997-0001 CNR534 P E 019 225997  
(For Program in Item 1)

PICA		0000000									
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) BLK LUNG (ID#) X (ID#)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE SEX MM DD YY 02 14 1983 X F				4. INSURED'S I.D. NUMBER MB00516374			
5. PATIENT'S ADDRESS (No., Street) 356UTLEDGE ST				6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other				7. INSURED'S NAME (Last Name, First Name, Middle Initial) TRAUGHBER CORY			
CITY COLLIERVILLE		STATE TN		8. RESERVED FOR NUCC USE		CITY COLLIERVILLE		STATE TN			
ZIP CODE 38017		TELEPHONE (Include Area Code) (901) 833-5775				ZIP CODE 38017		TELEPHONE (Include Area Code) (901) 833-5775			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
a. OTHER INSURED'S POLICY OR GROUP NUMBER											
b. RESERVED FOR NUCC USE											
c. RESERVED FOR NUCC USE											
d. INSURANCE PLAN NAME OR PROGRAM NAME											
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES X NO b. AUTO ACCIDENT? YES X NO PLACE (State) c. OTHER ACCIDENT? YES X NO											
11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800701											
a. INSURED'S DATE OF BIRTH MM DD YY 02 14 1983 M X F b. OTHER CLAIM ID (Designated by NUCC)											
c. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE											
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.											
SIGNATURE ON FILE 10/09/20 SIGNED DATE											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.											
15. OTHER DATE MM DD YY QUAL. 1GOTH000											
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 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 FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? \$ CHARGES YES X NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0											
A. I10 B. C. D. E. F. G. H. I. J. K. L.											
22. RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER											
F. G. H. I. J. \$ CHARGES DAYS OR UNITS EPST Family Plan RENDERING PROVIDER ID. #											
24. A. DATE(S) OF SERVICE From To B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER MM DD YY MM DD YY PLACE OF SERVICE EMG CPT/HCPCS MODIFIER											
1 10 09 20         11   71046   Q6         A   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. 10184570D		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO		28. TOTAL CHARGE \$ 81   00		29. AMOUNT PAID \$		30. Rsrd 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											
32. SERVICE FACILITY LOCATION INFORMATION DIPC R&F 6401 POPLAR AVE MEMPHIS TN 38119-											
33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 a. 1699725812 b. ZZ2085R0202X											
SIGNED 12/16/20											



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

### HEALTH INSURANCE CLAIM FORM

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

5689

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PICA

A# 226240-0001 CNR534 P E 001 226240

(For Program in Item 1)

PICA		MEDICARE MEDICAID TRICARE CHAMPVA		GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER				
<input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (ID#)		<input type="checkbox"/> (ID#)	<input type="checkbox"/> (ID#)	<input checked="" type="checkbox"/> (ID#)	MB03230393				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		OBRIEN MARCIA K		3. PATIENT'S BIRTH DATE		SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
				MM / DD / YY	07 / 02 / 1957	F <input checked="" type="checkbox"/>	OBRIEN MARCIA K				
5. PATIENT'S ADDRESS (No., Street)		6034 KERIN DRIVE		6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)				
CITY BARTLETT		STATE TN		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			6034 KERIN DRIVE				
ZIP CODE 38135		TELEPHONE (Include Area Code) (901) 230-7624		8. RESERVED FOR NUCC USE			CITY BARTLETT				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			STATE TN				
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)			ZIP CODE 38135				
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			TELEPHONE (Include Area Code) (901) 230-7624				
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?		PLACE (State)					
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?							
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)			11. INSURED'S POLICY GROUP OR FECA NUMBER				
							1048800203				
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				10/28/20							
SIGNED				DATE							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE		MM / DD / YY	MM / DD / YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
MM / DD / YY		QUAL.		MM / DD / YY	MM / DD / YY	FROM	TO				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. ZZ207X00000X		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
DN TYLER CANNON MD		17b. NPI 1891967147		MM / DD / YY	MM / DD / YY	FROM	TO				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)											
A. M25512		B. S42212A		C. _____	D. _____	ICD Ind. 0	22. RESUBMISSION CODE				
E. _____		F. _____		G. _____	H. _____		ORIGINAL REF. NO.				
I. _____		J. _____		K. _____	L. _____		23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From MM DD YY		To MM DD YY		CPT/HCPCS		MODIFIER					
SHOULDER											
1 10 20 20		11	73200	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	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		<input type="checkbox"/> X	10193977D		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 561 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.)											
LOUIS S PARVEY MD											
SIGNED 12/16/20											
32. SERVICE FACILITY LOCATION INFORMATION											
DIPC CT 6401 POPLAR AVE MEMPHIS TN 38119-											
a.		b.		33. BILLING PROVIDER INFO & PH. #		(901) 387-2340					
1699725812		ZZ2085R0202X		DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275							



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

### HEALTH INSURANCE CLAIM FORM

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

5689

0000000

PICA A# 226244-0001 CNR534

P E 019

226244 PICA

(For Program in Item 1)

1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)		GROUP (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/>	1a. INSURED'S I.D. NUMBER MB02134492	CARRIER	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>FINLEY DEBBIE J</b>												4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>FINLEY DEBBIE J</b>	
5. PATIENT'S ADDRESS (No., Street) <b>504 W POWELL</b>												7. INSURED'S ADDRESS (No., Street) <b>504 W POWELL</b>	
CITY <b>COLLIERVILLE</b>		STATE <b>TN</b>		CITY <b>COLLIERVILLE</b>		STATE <b>TN</b>							
ZIP CODE <b>38017</b>		TELEPHONE (Include Area Code) <b>(901) 610-9541</b>		ZIP CODE <b>38017</b>		TELEPHONE (Include Area Code) <b>(901) 610-9541</b>							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:	
												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)	
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.												11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800701	
SIGNATURE ON FILE												12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE <b>10/20/20</b>												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.												15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN <b>SAMYA CRUZ MD</b>												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. <b>1GOTH000</b>												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17b. NPI <b>1417056409</b>												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind: <b>0</b>												23. PRIOR AUTHORIZATION NUMBER	
A. <b>J449</b>	B. <b>J189</b>	C. _____	D. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES			
1 10 20 20				11 71046		Q6		AB		81 00 1			
2										NPI			
3										NPI			
4										NPI			
5										NPI			
6										NPI			
25. FEDERAL TAX I.D. NUMBER <b>621116618</b>		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. <b>10195436D</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 81 00		29. AMOUNT PAID \$			
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.)  <b>SAMUEL P BILYEU MD</b>												32. SERVICE FACILITY LOCATION INFORMATION <b>DIPC R&amp;F 6401 POPLAR AVE MEMPHIS TN 38119-</b>	
33. BILLING PROVIDER INFO & PH. # <b>(901) 387-2340</b> <b>DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275</b>													
34. SIGNED <b>12/16/20</b> DATE												35. a. <b>1699725812</b> b. <b>ZZ2085R0202X</b>	