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# 226309-0001 CNR534 P E 019

226309 PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): MB01942101
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHAPPLEY JERRY	3. PATIENT'S BIRTH DATE MM DD YY: 02 09 1989 SEX: X M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SHAPPLEY JERRY	
5. PATIENT'S ADDRESS (No., Street): 5137 FARMLAND WAY	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 5137 FARMLAND WAY	
CITY: ARLINGTON STATE: TN	8. RESERVED FOR NUCC USE
CITY: ARLINGTON STATE: TN	
ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 233-9723	
ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 233-9723	
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 X NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX: 02 09 1989 M X F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: EVOCARE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes,* complete items 9, 9a and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 10/22/20

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN PATRICK KELLY DC	17a. ZZ111N00000X 17b. NPI 1548277957
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. M5136 B. M545 C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 10 22 20	11		72100	Q6	AB	85 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.: 10197739	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE: $ 85 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 10/28/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION
DIPC R&F
6401 POPLAR AVE
MEMPHIS TN 38119-
a. NPI b.

33. BILLING PROVIDER INFO & PH. # (901) 387-2340
DIAGNOSTIC IMAGING PC
PO BOX 1000 DEPT 275
MEMPHIS, TN 381480275
a. 1699725812 b. ZZ2085R0202X

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

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4735 MELISSA WAY
BIRMINGHAM AL 35243

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HEALTH INSURANCE CLAIM FORM

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PICA

A# 226363-0001 CNR534 P E 003

226363 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): MB04146401

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ARCHDEACON TED	07 15 1966	M X F	ARCHDEACON TED

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
4471 SIR GALAHAD CN	Self X Spouse Child Other	4471 SIR GALAHAD CN

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
BARTLETT	TN		BARTLETT	TN

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
38135	(901) 734-1711		38135	(901) 734-1711

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		1048800604
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX: 07 15 1966 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: EVOCARE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes,* complete items 9, 9a and 9d.

PATIENT AND INSURED INFORMATION

SECOND FOLD

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 10/26/20

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN SAMYA CRUZ MD	1GOTH000	
	17b. NPI 1417056409	

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	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. K228 B. Z9884 C. D. E. F. G. H. I. J. K. L.		
	23. PRIOR AUTHORIZATION NUMBER	

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 26 20	11		74240		AB	317 00	1		NPI	1649220120
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 X	10197952	X YES NO	$ 317 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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (901) 387-2340
ROBERT A DUKE MD	DIPC R&F	DIAGNOSTIC IMAGING PC
SIGNED 10/28/20 DATE	6401 POPLAR AVE	PO BOX 1000 DEPT 275
	MEMPHIS TN 38119-	MEMPHIS, TN 381480275
	a. NPI	a. 1699725812 b. ZZ2085R0202X

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