

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

HEALTH INSURANCE CLAIM FORM								
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000							227221 PICA	
A# 227221-0001 MEDICARE MEDICAID TRICARE	CNR534 CHAMPVA	P E GROUP	003 FECA	OTHER	1a. INSURED'S I.I	D. NUMBER		(For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#)	HEALTH PI	LAN BLK LUNG	X (ID#)	MB0327			
2 PATIENT'S NAME (Last Name, First Name, Middle Ini	tial)	PATIENT'S BIR		EX	4 INSURED'S NA	ME (Last Name, I	First Name,	Middle Initial)
RING ANNA 5 PATIENT'S ADDRESS (No. Street)			2003 LITIONSHIP TO INSUI	FX	RING (azati.	
The Control of the Co		Self Spour		Other				oria pp
5266 HIDDEN MEADOWS		RESERVED FO		Other	5266 F	HIDDEN	MEAD	OWS DR
ARLINGTON	TN				ARLING	TON		TN
ZIP CODE TELEPHONE (Include					ZIP CODE		ELEPHONE	(Include Area Code)
38002 (901) 605	-6929				38002		(90	
OTHER INSURED'S NAME (Last Name First Name.)	Middle Initial)	0. IS PATIENT'S	CONDITION RELAT	ED TO.	11 INSURED'S P		R FECA NU	JMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER		EMPLOYMENT	7 (Current or Previou	g)	104880			SEX
			YES X NO		MM , E		M	X
b. RESERVED FOR NUCC USE	1	AUTO ACCIDE	NITO	ACE (State)	b. OTHER CLAIM		NUCC)	Δ
			YES X NO	1				
c RESERVED FOR NUCC USE		OTHER ACCID	ENT?		c. INSURANCE P	LAN NAME OR P	ROGRAM N	AME
			YES X NO	10.0	EVOCA			
d INSURANCE PLAN NAME OR PROGRAM NAME	1	od. CLAIM CODI	ES (Designated by NI	JCC1	d IS THERE AND			1
READ BACK OF FORM BE	ORE COMPLETING 8	SIGNING THIS	FORM.		13 INSURED'S OF	Λ		e items 9, 9a and 9d SIGNATURE I authorize
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATU to process this claim. I also request payment of gove	RE I authorize the rele	ase of any medic	al or other information	n necessary ssignment		dical benefits to the		ned physician or supplier for
SIGNATURE ON FI	TE		12/08/2	0	ç	SIGNATU	IRE O	N FILE
SIGNED		DATE		.	SIGNED	3 - 01 11 1 0		.,
14 DATE OF CURRENT ILLNESS, INJURY or PREGN.	ANCY (LMP) 15. O	THER DATE	MM DD	YY	16. DATES PATIE	NT UNABLE TO V	WORK IN C	JRRENT OCCUPATION MM DD YY
QUAL	QUAL				FROM		то	
17 NAME OF REFERRING PROVIDER OR OTHER SO	77.65	ZZ207X			MM	DD YY		CURRENT SERVICES MM DD YY
DN CHRISTOPHER POKABI 19 ADDITIONAL CLAIM INFORMATION (Designated by		NPI 1629:	295209		FROM 20 OUTSIDE LAB	2	10 \$ C	HARGES
ACTUAL INVOICE COST					YES	X NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Relate A-L to service	line below (24E)	ICD Ind 0		22 RESUBMISSIC CODE	N	RIGINAL RE	E NO
A M25511 B S43401	.A 💍 S	40011A	D					- 110
ELF.L	G.		H. 1		23. PRIOR AUTHO	DRIZATION NUME	BER	
24. A DATE(S) OF SERVICE B.	C D PROCEI	NIBES SERVICE	S OR SUPPLIES	l E	F	G	H. I.	,
From To PLACE OF	(Explai	n Unusual Circum	stances)	DIAGNOSIS	0.01140000	DAYS E	SOT ID	RENDERING
MM DD YY MM DD YY SERVICE		ULDER	MODIFIER	POINTER	\$ CHARGES	UNITS	QUAL	PROVIDER ID #
12 09 20 11	73222			ABC	1255	00 1	NPI	1649220120
12 09 20 11	A9575			ABC	17 !	50 5	NPI	1649220120
B	i i	1 1				1 1	- Limi	
							NPI	
		1				1	NPI	
							7,000,00	
, i							NPI	
6		T I						
25. FEDERAL TAX I D NUMBER SSN EIN	26. PATIENTS AC	COUNT NO	27 ACCEPT ASSI	GNMENT?	28 TOTAL CHAR	GE 29 4	NPI AMOUNT PA	AID 30. Rsvd for NUCC use.
621116618 X	102413		X YES			2 50 8		1
31 SIGNATURE OF PHYSICIAN OR SUPPLIER	32 SERVICE FAC				33 BILLING PRO		1 / (9	01 387-2340
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	DIPC MR				DIAGNO			
1,00%	6401 PC				PO BOX			
ROBERT A DUKE MD	MEMPHIS	S TN 38119-		MEMPHIS, TN 381480275 1699725812 ZZ2085R0202X				
SIGNED 12/11/20TE	a	b.			*T033.75	08TZ 🖟 Z	77708	5KU2U2X

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/	0000000	PICA FITTI		
A# 227221-0001 CNR53		227221		
	per ID#) HEALTH PLAN BLK LUNG (ID#) (ID#)	MB03274607		
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)		
RING ANNA	03 21 2003 F X	RING CHRIS		
5. PATIENT'S ADDRESS (No., Street)	Self Spouse Child V Other	7 INSURED'S ADDRESS (No. Street)		
5266 HIDDEN MEADOWS DR	TE 8. RESERVED FOR NUCC USE	5266 HIDDEN MEADOWS DR		
ARLINGTON	ГN	ARLINGTON TN		
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)		
38002 901 605-6929	10 IS PATIENT'S CONDITION RELATED TO	38002 901 605-6929 11 INSURED'S POLICY GROUP OR FECA NUMBER		
S OTTEN MOUNTED S WANTE (East Name : not Name; mount many	IN INTERIOR OFFICIAL REPORTS	1048800103		
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX		
	YES X NO	05 24 1971 X		
b. RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	A OTHER OLDINARY IN THE STREET		
© 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?		
DEAD DAAY OF FORM DEFORM	THE A CIONAL THE SOR!	YES XNO If yes, complete items 9, 9a and 9d.		
READ BACK OF FORM BEFORE COMPLE 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits.	he release of any medical or other information necessary	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	12/08/20	MANUFACTURE OF THE PROPERTY OF		
SIGNATURE ON TIME	DATE	SIGNATURE ON FILE		
MM DD YY	15 OTHER DATE MM , DD , YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY		
COME	QUAL	FROM TO		
	17a ZZ207X00000X 17b NPI 1629295209	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	1029295209	20. OUTSIDE LAB? \$ CHARGES		
		YES X NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to	ICD Ind. 1	22. RESUBMISSION CODE ORIGINAL REF NO		
F))	S40011A	23. PRIOR AUTHORIZATION NUMBER		
E FL	H L	E.S. FIRM AN INCHESTION TO MILET		
	ROCEDURES SERVICES OR SUPPLIES E Explain Unusual Circumstances)	F. G. H I. J		
MM DD YY MM DD YY SERVICE EMG CPT/	HCPCS MODIFIER POINTER			
	SHOULDER	105 00 1		
12 09 20 11 233	350 RT ABC	425 00 1 NPI 1649220120		
12 09 20 11 A45	ABC	50 00 1 NPI 1649220120		
	1 1 1 1 1	50 00 1 NPI 1649220120		
	1 1 1	NPI NPI		
	1 1 3 1 1	NPI NPI		
		N/Ft		
		NPI		
25. FEDERAL 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		
	2980 X YES NO	\$ 475 00 \$		
	E 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.)	PROF AND SURGICAL	DIAGNOSTIC IMAGING PC		
6401	PO BOX 1000 DEPT 275			
12/11/20	IIS TN 38119-	MEMPHIS, TN 381480275		
SIGNED 12/11/29ATE		1699725812 ZZ2085R0202X		

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

APPROVED BY NATIONAL UN

NIFORM CLAIM COMMITTEE (NUCC) 02/12	00000000
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A# 227221-0001	L CNR534 P E 003	2272	21 100
1, MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a INSURED'S I D NUMBER (For Progra	am in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#) (ID#) X (ID#)	MB03274607	
2 PATIENT'S NAME (Last Name, First Name, Middle Ini	MM I DD I YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
RING ANNA 5 PATIENT'S ADDRESS (No. Street)	03 21 2003 F X	RING CHRIS 7 INSURED'S ADDRESS (No., Street)	
			ND.
5266 HIDDEN MEADOWS	STATE 8 RESERVED FOR NUCC USE	5266 HIDDEN MEADOWS D	STATE
ARLINGTON ZIP CODE TELEPHONE (Include	TN le Area Code)	ARLINGTON ZIP CODE TELEPHONE (Include Are	TN
38002 (901) 605	5-6929	38002 (901) 605	-6929
9 OTHER INSURED'S NAME (Last Name, First Name, I		11. INSURED'S POLICY GROUP OR FECA NUMBER	-6929
		1048800103	
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX	K
	YES X NO	05 24 1971 M X	F
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
	YES X NO		
g 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?	
		YES XNO If yes, complete items 9, 9a	and 9d.
READ BACK OF FORM BEI	FORE COMPLETING & SIGNING THIS FORM. JRE I authorize the release of any medical or other information necessary.	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE payment of medical benefits to the undersigned physician 	
to process this claim. I also request payment of gove below	JRE I authorize the release of any medical or other information necessary armment benefits either to myself or to the party who accepts assignment	services described below.	3. 2.4
SIGNATURE ON FI	ILE 12/08/20	SIGNATURE ON FIL	Æ
SIGNED	DATE	SIGNED	
14 DATE OF CURRENT ILLNESS, INJURY, or PREGN.	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCI MM , DD , YY MM , DD	CUPATION D YY
QUAL	QUAL	FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SO	2220721000001	18. HOSPITALIZATION DATES RELATED TO CURRENT SE MM DD YY MM DI	ERVICES D YY
DN CHRISTOPHER POKABI	The state of the s	FROM TO 20 OUTSIDE LAB? \$ CHARGES	1
19 ADDITIONAL CLAIM INFORMATION (Designated by	(NOCC)	The state of the s	
ACTUAL INVOICE COST 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Y Relate A-L to service line below (24E) ICD Ind 0	YES X NO	
M25511 R S43401	17 C400117	CODE ORIGINAL REF NO.	
A		23 PRIOR AUTHORIZATION NUMBER	
E F	G H		
24. A. DATE(S) OF SERVICE B	C D PROCEDURES, SERVICES, OR SUPPLIES E.	F G H I	J.
From To PLACE OF MM DD YY SERVICE	(Explain Unusual Circumstances) DIAGNOSIS EMG CPT/HCPCS I MODIFIER POINTER	OB Family	NDERING VIDER ID. #
WIM DD 11 WIM DD 11 SERVICE	SHOULDER POINTER	SOUTHOUS ONLY PRO	VIDER ID. #
12 09 20 11	73040 RT ABC	293 00 1 NPI 1649	220120
	'		
12 09 20 11	Q9966 ABC	16 43 5 NPI 1649	220120
		NPI	
		NPI	
1 1 7		NPI	
OF FEDERAL TAY IN MUMBER	OR DATIENTS ACCOUNT NO. 102 ACCEPT ACCUSANCE	NPI	Day of Co. Approximately
25 FEDERAL TAX I D NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?		Rsvd for NUCC use
621116618 X 10241305 X yes NO \$ 309 43 \$ 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 R&F	DIAGNOSTIC IMAGING PC	1-2340
apply to this bill and are made a part thereof)	6401 POPLAR AVE	PO BOX 1000 DEPT 275	
ROBERT A DUKE MD	MEMPHIS TN 38119-	MEMPHIS, TN 381480275	
10/11/00	MEMERIES IN SOLLS-	#EMPHIS, IN 381480275	12X
SIGNED 12/11/20TE	0.	*1033/23017 777082K070	12A

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/15 PICA A# 145304-0001 CNR53	0000000		PICA [
1 MEDICARE MEDICAID TRICARE CHAMP	VA GROUP FECA OTHER	1a INSURED'S LD NUMBER (For Program in It	tem 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member 2. PATIENT'S NAME (Last Name First Name Middle Initial)	(ID#) (ID#) (ID#)	MB00792777	
SESTINA JAMES	MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	01 17 1974 X F	SESTINA JAMES 7. INSURED'S ADDRESS (No Street)	
4778 TRACY RD	Self X Spouse Child Other	4778 TRACY RD	
CITY	8 RESERVED FOR NUCC USE		ATE
ATOKA TELEPHONE (Include Area Code)	N	ATOKA ZIP CODE TELEPHONE (Include Area Code	TN
38004 (901) 626-4452		/ \	
9 OTHER INSURED'S NAME (Last Name First Name Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	38004 901 626-44	452
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	1048800203	
	YES XNO	MM DD YY MI	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
DECEDIES EST ALLOS LIST	YES XNO		
a. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c: INSURANCE PLAN NAME OR PROGRAM NAME	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
		YES NO If yes, complete items 9, 9a and 9d.	
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eithelow.	IG & SIGNING THIS FORM. release of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I author payment of medical benefits to the undersigned physician or supp	rize
SIGNATURE ON FILE		services described below	danci ioi
SIGNED	12/15/20	SIGNATURE ON FILE	
4 DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) 15 MM , DD , YY	OTHER DATE MM , DD , YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	ION
7 NAME OF PETERDING PROVIDER OF STUEP COURSE	AL	FROM TO MM DD	YY
	DDITITIOOOOX	The state of the s	S
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	NPI 1548277957	FROM TO 20 OUTSIDE LAB? \$ CHARGES	
A PHONON DE LA COMPANIA DE LA COMPAN		YES X NO	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to ser	vice line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.	
A M5136 B M545 C L	D L	23. PRIOR AUTHORIZATION NUMBER	
FL GL	н	23. PRIOR AUTHORIZATION NUMBER	
A DATE(S) OF SERVICE B C D. PRO From To PLACE OF (Ex)	DEDURES, SERVICES, OR SUPPLIES E.	F G H I J	
the many that the state of the	PCS MODIFIER POINTER	S CHARGES DAYS Paril QUAL PROVIDER II	
12 15 20 11 7210	10	05 00 1	
	0 AB	85 00 1 NPI 1740247	485
		NPI	
		NPI	
		NPI NPI	
		NPI	
		NPI NPI	
5 FEDERAL TAX I D. NUMBER SSN EIN 26 PATIENTS	CCOUNT NO 27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28 TOTAL CHARGE 29. AMOUNT PAID 30 Rsvd for I	NUCC use
		s 85 00 s	
621116618 X 10245			
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32 SERVICE FA	CILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH. # (901) 387-2.	340
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).	CILITY LOCATION INFORMATION	BILLING PROVIDER INFO & PH # (901) 387-2. DIAGNOSTIC IMAGING PC	340
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 F/ DIPC R 6401 P	CILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH. # (901) 387-2.	340

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTED FICA	0000000	No.		
A# 227355-0003	1 CNR534 P E 019 CHAMPVA GROUP FECA OTHER	1a INSURED'S ID NUMBER (For Program in New 1)		
(Medicare #) (Medicaid #) (ID#/DoD#) 2 PATIENT'S NAME (Last Name, First Name, Middle Ini	(Member (D#) (ID#) BLK LUNG (ID#)	MB04215631 4 INSURED'S NAME (Last Name. First Name. Middle Initial)		
SHIELDS JACK 5 PATIENT'S ADDRESS (No. Street)	06 26 1964 X F	SHIELDS KATHING		
128 SUNNYSIDE DR	Self X Spouse Child Other	7 INSURED'S ADDRESS (No., Street)		
CITY SUMMISTIBE DR	STATE 8 RESERVED FOR NUCC USE	128 SUNNYSIDE DR		
BRIGHTON	TN	BRIGHTON TN		
ZIP CODE TELEPHONE (Include	de amonto de la companya del companya de la companya del companya de la companya	ZIP CODE TELEPHONE (Include Area Code)		
38011 901 633 9 OTHER INSURED'S NAME (Last Name, First Name, I	3 - 4 7 7 9 Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	38011 901 633-4779		
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	1048800803 a. INSURED'S DATE OF BIRTH SLX		
	YES XNO	MM DD YY ME FE		
b. RESERVED FOR NUCC USE	b AUTO ACCIDENT ⁹ PLACE (State)	04 24 1977 X		
c RESERVED FOR NUCC USE	YES XNO			
C RESERVED FOR NUCCUSE	c OTHER ACCIDENT? YES VO	c INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
		YES XNO If yes, complete items 9, 9a and 9d.		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATU	***ORE COMPLETING & SIGNING THIS FORM. RE I authorize the release of any medical or other information necessary mment 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		
SIGNATURE ON FI		services described below		
SIGNED	DATE	SIGNATURE ON FILE		
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNAMM DD YY	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY		
17 NAME OF REFERRING PROVIDER OR OTHER SOL	URCE 170 1 COMMO 0	FROM TO 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
DN SAMYA CRUZ MD	178 1GOTH000 178 NPI 1417056409	MM DD YY MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by	NUCC)	20. OUTSIDE LAB? \$ CHARGES		
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Ralata A.I. to canaca line halow (24E)	YES X NO		
M5136 R M4696	ME 4.1.6	22. RESUBMISSION CODE ORIGINAL REF NO.		
E F	G H5416	23. PRIOR AUTHORIZATION NUMBER		
24 A. DATE(S) OF SERVICE B	К.			
From To PLACE OF	C D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS	F G H I J DAYS ESSET ID RENDERING OR Family Out		
MM DD YY MM DD YY SERVICE	EMG CPT/HCPCS MODIFIER POINTER	S CHARGES WITS PROVIDER ID #		
12 15 20 11	72110 Q6 ABC	117 00 1 NPI 1669553764		
12 15 20 11	72170 Q6 ABC	66 00 1 NPI 1669553764		
		, NPI		
		NPI		
	1 1 1 1 1 1 1 1			
		NPI S		
		NPI		
25. FEDERAL TAX ID. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC use		
31 SIGNATURE OF PHYSICIAN OR SUPPLIER	10246148 X YES NO 32 SERVICE FACILITY LOCATION INFORMATION	\$ 183 00 \$		
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof i	DIPC R&F	DIAGNOSTIC IMAGING PC		
	6401 POPLAR AVE	PO BOX 1000 DEPT 275		
SAMUEL P BILYEU MD	MEMPHIS TN 38119-	MEMPHIS, TN 381480275		
SIGNED 12/18/2 ₁ 0 _{TE}	a. D.	1699725812 ZZ2085R0202X		