

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

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

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02		226355 PICA
PICA A# 226355-0001 CNR5		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
1. MEDICARE MEDICARD THORAGO	MPVA GROUP HEALTH PLAN BLIK LUNG X (ID#) (ID#) X (ID#)	MB02903989
(Medicare #) (Medicaid #) (ID#/DoD#) (Medicaid #) 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)
	06 18 1962 FX	BROWN JAMES
BROWN JACQUELINE D 5 PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
3611 THISTLE VALLEY LN	Self Spouse X Child Other	3611 THISTLE VALLEY LN
CITY ST	TATE 8. RESERVED FOR NUCC USE	CITY
BARTLETT	TN	BARTLETT TN FILEPHONE (Include Area Code)
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
38135 (901) 343-1587		38135 (901) 343-1587
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	TO A COLOR OF CALL
	TARK ON A FENT ON CONTRACT PROVIDERS	1048800604 a INSURED'S DATE OF BIRTH SEX
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	03 25 1955 MX
	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
b. RESERVED FOR NUCC USE	YES X NO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
G. REGERVED FOR ROOF SEE	YES X NO	BARTLETT ZIP CODE 38135 (901) 343-1587 11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800604 a. INSURED'S DATE OF BIRTH MM DD YY 03 25 1955 b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	177
		YES X NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMP	LETING & 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 authoriz to process this claim. I also request payment of government benef	its either to myself or to the party who accepts assignment	services described below.
SIGNATURE ON FILE	10/25/20	SIGNATURE ON FILE
SIGNED	DATE	SIGNED
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	QUAL. MM DD YY	FROM TO TO YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a ZZ208100000X	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN AMBER GRAHAM MD	17b. NPI 1679849483	FROM TO TO
19, ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	1.0.1 0.1 2.0 1.5 2.5 2.5	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	22. RESUBMISSION CODE ORIGINAL REF NO.
M4312 B M50221	c. M50222 D. M48061	OS PRIOR ALCHORIZATION NUMBER
M4316 M5124	G. M546	23. PRIOR AUTHORIZATION NUMBER
1	PROCEDURES, SERVICES, OR SUPPLIES E	F. G. H. L. J.
From To PLACE OF	(Explain Unusual Circumstances) DIAGNOSI	
MM DD YY MM DD YY SERVICE EMG C	PT/HCPCS MODIFIER POINTER	S CHANGES UNITS PIBE MONE.
1 10 25 20 11 7	2141 ABC	1046 00 1 NPI 1669553764
10 25 20		
2 10 25 20 11 7	2148 DE	1068 00 1 NPI 1669553764
		1660553764
3 10 25 20 11 7	2146 FG	1068 00 1 NPI 1669553764
1	1 1 1 1	NPI NPI
4		1971
5		NPI NPI
6		NPI
	TENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
621116618 X 10	199057 X YES NO	s 3182 00 s
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SEF	RVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (901) 387-2340
	C MRI SIEMENS	DIAGNOSTIC IMAGÌNG PC
The second secon	1 POPLAR AVE	PO BOX 1000 DEPT 275
DIE:022	IPHIS TN 38119-	MEMPHIS, TN 381480275
10/29/20 _{ATE}	b.	1699725812 LZZ2085R0202X



EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 352 HEALTH INSURANCE CLAIM FOR	43 M				
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUC	000000				
A# 405332-0001 CN 1. MEDICARE MEDICAID TRICARE	R534 P E CHAMPVA GROUP	019 FECA OTHER	1a. INSURED'S I.D. NUMBER		05332 PICA or Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) HEALTH PLA	BLK LUNG X (ID#)	MB01591496	, , , , , , , , , , , , , , , , , , ,	or racgitalitilities in the
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTI		4. INSURED'S NAME (Last Na	me, First Name, Midd	lle Initial)
CANNADY DEBBIE R	03 01		CANNADY DE		
5. PATIENT'S ADDRESS (No., Street)		IONSHIP TO INSURED	7. INSURED'S ADDRESS (No.		
4747 HALLBROOK DR	Self X Spouse		4747 HALLB	ROOK DR	STATE
MILLINGTON	TN		MILLINGTON		TN
ZIP CODE TELEPHONE (Include Area C			ZIP CODE	TELEPHONE (Inc	
38053 (901) 268-78			38053		268-7893
9. OTHER INSURED'S NAME (Last Name, First Name, Middle In	itial) 10 IS PATIENT'S C	CONDITION RELATED TO	11. INSURED'S POLICY GROU	JP OR FECA NUMBI	R
a, OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT?	(Current or Previous)	1048800103 a. INSURED'S DATE OF BIRT	Н	SEX
a. OTHER INSURED S POLICY OF GROOF NOMEET		ES XNO	03 01 19	55 M	FX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDEN		L OTHER OLAHAIR (Designed		
		ES XNO			
c. RESERVED FOR NUCC USE	c. OTHER ACCIDE		c INSURANCE PLAN NAME (OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		ES X NO S (Designated by NUCC)	d. IS THERE ANOTHER HEAL	TH BENEFIT PLAN?	
d. Hooffyddol i Ediffinal Common Carlot			YES XNO	If yes, complete ite	ms 9, 9a and 9d.
READ BACK OF FORM BEFORE CO			13 INSURED'S OR AUTHORIZ	ED PERSON'S SIG	NATURE I authorize
to process this claim. I also request payment of government to below.	penefits either to myself or to the	party who accepts assignment	services described below.	s to the undersigned	priyation of aupplier to
SIGNATURE ON FILE		11/03/20	Name and Advisor	TURE ON	FILE
SIGNED	DATE MP) 15. OTHER DATE		SIGNED	TO WORK IN CURE	RENT OCCUPATION
MM , DD , YY	QUAL	MM DD YY	FROM DD		M DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a ZZ207X0	X0000	18. HOSPITALIZATION DATES		RENT SERVICES M , DD , YY
DN CHRISTOPHER POKABLA M	ID 17b NPI 16292	95209	FROM	ТО	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20 OUTSIDE LAB?	\$ CHAP	RGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate	A-L to service line below (24E)	ICD Incl. 0	YES X NO		
M12831 S63501A	C	IGD Ind U	CODE	ORIGINAL REF	NO.
E L F. L	G	н	23. PRIOR AUTHORIZATION	NUMBER	
)	К	LL			
24. A. DATE(S) OF SERVICE B. C. From To PLACE OF	D PROCEDURES, SERVICES (Explain Unusual Circums		F. G. DAYS R \$ CHARGES UNITS	H. I. EPSDT ID	J. RENDERING
MM DD YY MM DD YY SERVICE EMG	WRIST	ODIFIER POINTE	R S CHARGES UNITS	s Family QUAL	PROVIDER ID #
11 03 20 11	73221 RT	AB	1023 00 1	NPI	1669553764
				NPI	
		1 1 1	1	NIDI	
				NPI	
				NPI	
				NPI	
				NDI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. F	PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
	L0205706	X YES NO	s 1023 00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	SERVICE FACILITY LOCATION I	NFORMATION	33. BILLING PROVIDER INFO	8 PH # (90	/
(I certify that the statements on the reverse D	DIAGNOSTIC				
6401 POPLAR AVE			PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275		
SAMUEL P BILYEU MD MEMPHIS TN 38119-			MEMPHIS, IN	1 20T480	4/5

1699725812 | ZZ2085R0202X

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

5689

BIRMINGHAM AL 35243
IEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMM	TTEE (NUCC) 02/12 0000000	
A# 226485-00	A STATE OF THE PROPERTY OF THE	226485 PICA
1 MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#) (ID#) X(ID#)	MB01853450
2. PATIENT'S NAME (Last Name, First Name, Middle	MM DD YY	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
KEYS THOMAS D 5. PATIENT'S ADDRESS (No., Street)	08 18 1967 X F	KEYS THOMAS D 7. INSURED'S ADDRESS (No., Street)
		FROI 2002 ASSESSMENT OF THE PERSON
5900 STONEWALL DRIV	STATE 8. RESERVED FOR NUCC USE	5900 STONEWALL DRIVE
OLIVE BRANCH	MS	OLIVE BRANCH MS
ZIP CODE TELEPHONE (Inc.		ZIP CODE TELEPHONE (Include Area Code)
38654 (901) 6	74-4322	38654 (901) 674-4322
9. OTHER INSURED'S NAME (Last Name. First Nam	e, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		OLIVE BRANCH MS ZIP CODE TELEPHONE (Include Area Code) 38654 901 674-4322 11. INSURED'S POLICY GROUP OR FECA NUMBER 1048800303 a. INSURED'S DATE OF BIRTH MM DD YY 08 18 1967 M X
a. OTHER INSURED'S POLICY OR GROUP NUMBE	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	b AUTO ACCIDENT?	08 18 1967 MX
b. RESERVED FOR NUCC USE	PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	
C. HESERVED FOR NOCO USE	YES XNO	
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.
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 SIGN/ to process this claim. I also request payment of g below. 	TURE I authorize the release of any medical or other information necessary overnment benefits either to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON 1	FILE 10/30/20	SIGNATURE ON FILE
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PRE	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY
QUAL	QUAL	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER	22207KA0201K	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
DN PHIL LIEBERMAN MI 19. ADDITIONAL CLAIM INFORMATION (Designated)		FROM TO 1 20 OUTSIDE LAB? \$ CHARGES
, , , , , , , , , , , , , , , , , , , ,	3, 55-33	YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJU	RY Relate A-L to service line below (24E) ICD Ind. 0	22 RESUBMISSION
A. [R519 B. [C D	CODE ORIGINAL REF. NO.
E.L F.L	G L H L	23. PRIOR AUTHORIZATION NUMBER
J. L.	K.	
24. A. DATE(S) OF SERVICE B. From To PLACE	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. DAYS EPSOT ID. RENDERING
MM DD YY MM DD YY SERVIO		\$ CHARGES UNITS Finity QUAL. PROVIDER ID. #
10 30 20 1:	70220 A	99 00 1 NPI 1649220120
10 30 20	70220 A	99 00 1 NPI 1649220120 NPI NPI
		NPI NPI
	+	NPI
		NPI NPI
		NPI
1 1 1 1 1		
		NPI
		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
621116618 X	10205532 (For govt. claims, see back)	s 99 00 s
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	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	DIAGNOSTIC IMAGING PC
	6401 POPLAR AVE	PO BOX 1000 DEPT 275
ROBERT A DUKE MD	MEMPHIS TN 38119-	MEMPHIS, TN 381480275
SIGNED 11/06/20 TE	a. b.	1699725812 ZZ2085R0202X



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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000

PICA A# 174559-0001 CNR53	4 PE 003	174559 PICA
1. MEDICARE MEDICAID TRICARE CHAMP	, HEALTH PLAN, BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicard #) (ID#/DoD#) (Member 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Control Married A United	MB03331769
	MM + DD + YY	INSURED'S NAME (Last Name, First Name, Middle Initial)
JOYNER TANYA L 5. PATIENT'S ADDRESS (No., Street)	06 05 1968 FX	JOYNER PHILIP 7. INSURED'S ADDRESS (No., Street)
4240 RALEIGH LAGRANGE	Self Spouse X Child Other	4240 RALEIGH LAGRANGE
	E 8. RESERVED FOR NUCC USE	CITY STATE
ROSSVILLE	N	ROSSVILLE TN
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
38066 (901) 336-0790		38066 (901) 336-0790
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
		1048800701
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	01 30 1964 M X F
U. NEGENVES FOR NOGO OGE	PLACE (State)	U. OTHER CEARM TO (Designated by NOCC)
c. RESERVED FOR NUCC USE	c OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
or the carried state of the ca	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 X NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETI	NG & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits ei below. 	ther to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE	11/03/20	SIGNATURE ON FILE
SIGNED	DATE	SIGNED
MM DD YY	OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY
COAL	JAL JAR DO CO	FROM TO 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
The state of the s	ZZ208800000X	MM DD YY MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	10. NPI 1710945860	FROM TO 1 20 OUTSIDE LAB? \$ CHARGES
		YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to se	rvice line below (24E) ICD Ind. 0	22. RESUBMISSION
N200 B Z9049	100 1101	CODE ORIGINAL REF. NO.
E.L. F.L. G.	Н	23. PRIOR AUTHORIZATION NUMBER
J. L. K.		
24. A. DATE(S) OF SERVICE B. C. D. PRO From To PLACE OF (E)	CEDURES, SERVICES, OR SUPPLIES E. COLOR DIAGNOSIS	F. G. H. I. J DAYS EPSDT ID RENDERING
10 1202 01	CPCS MODIFIER POINTER	S CHARGES UNITS Family QUAL PROVIDER ID. #
11 03 20 11 741	76	
11 03 20 11 741	76 AB	604 00 1 NPI 1649220120
		100
		NPI
		NPI
		NPI
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. LOT ACCOUNT ACCOUNTS	NPI NPI
	ACCOUNT NO. 27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
	5870 X YES NO FACILITY LOCATION INFORMATION	\$ 604 00 \$ 33. BILLING PROVIDER INFO & PH. # (901) 387-2340
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse DIPC (301 307 2340
apply to this bill and are made a part thoront	POPLAR AVE	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275
	IS TN 38119-	MEMPHIS, TN 381480275
SIGNED 11/05/29 _{ATE} a.	b.	1699725812 ZZ2085R0202X
SIGNED		TOTAL MAZOUNIKUZUZA

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITT	TEE (NUCC) 02/12 0000000				
A# 226487-0001				20 C 4 2 FICA TTT	
MEDICARE MEDICAID TRICARE (Medicare #) (Medicaid #) (ID#/DoD#)	CHAMPVA GROUP FECA	OTHER	1a. INSURED'S I.D. NUMBER	226487 (For Program in Item 1)	
(Medicare #) (Medicaid #) (ID#/DoD#) 2 PATIENT'S NAME (Last Name, First Name, Middle Ini	(Member ID#) (ID#) (ID#)	X (1D#)	MB00116802 4 INSURED'S NAME (Last Name,		
GRAY-HAYES SHARON L	MM DD VV				
5. PATIENT'S ADDRESS (No., Street)	GRAY-HAYES S 7. INSURED'S ADDRESS (No., Str	SHARON L			
9295 CHASTAIN PL	6. PATIENT RELATIONSHIP TO INS	Other			
CITY	STATE 8 RESERVED FOR NUCC USE		9295 CHASTA	N PL STATE	
CORDOVA ZIP CODE TELEPHONE (Include	TN		CORDOVA	TN	
/ \			ZIP CODE	ELEPHONE (Include Area Code)	
38018 901 351 9. OTHER INSURED'S NAME (Last Name. First Name. M	4868 Middle Initial) 10. IS PATIENT'S CONDITION RELA	TED TO:	38018 11. INSURED'S POLICY GROUP C	901 351-4868	
470		120 10.	March 40 CONTRACTOR CONTRACTOR SALES	R FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previo	us)	1048800303 a. INSURED'S DATE OF BIRTH	SEX	
b. RESERVED FOR NUCC USE	YES X NO		12 25 1973	M F X	
S. HESERVED FOR NOCE USE		PLACE (State)	b. OTHER CLAIM ID (Designated by	NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR P	200004444445	
	YES X NO			ROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by N	IUCC)	d. IS THERE ANOTHER HEALTH B	ENEFIT PLAN?	
DEAD DADY OF SCHOOL OF			YES XNO If y	es, complete items 9, 9a and 9d	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. Lales request payment of course	ORE COMPLETING & SIGNING THIS FORM. RE I authorize the release of any medical or other information in the party who accepts are the party who accept	n necessary	13. INSURED'S OR AUTHORIZED F	ERSON'S SIGNATURE I authorize e undersigned physician or supplier for	
SIGNATURE ON FI			services described below.		
SIGNATURE ON FI	LE 10/30/2	20	SIGNATU	RE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNA	NCY (LMP) 15 OTHER DATE	in.	16. DATES PATIENT UNABLE TO V	ORK IN CURRENT OCCUPATION	
QUAL	QUAL	YY	FROM WIN DD YY	TO MM DD YY	
DN SAMYA CRIIZ MD	TGOTHOOO		18 HOSPITALIZATION DATES REL	ATED TO CURRENT SERVICES	
DN SAMYA CRUZ MD 19. ADDITIONAL CLAIM INFORMATION (Designated by N	17b. NPI 1417056409		FROM 20 OUTSIDE LAB?	ТО	
ACTUAL INVOICE COST			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		
A I2694 B J8410	c. R000		CODE	RIGINAL REF. NO.	
F	G H		23. PRIOR AUTHORIZATION NUMBI	R	
24. A. DATE(S) OF SERVICE B.	C D. PROCEDURES, SERVICES, OR SUPPLIES	E.	E C II		
From TO PLACE OF MM DD YY SERVICE E	(Explain Unusual Circumstances)	DIAGNOSIS	F G H DAYS EPS OR Fair	DI ID. RENDERING	
9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	MG CPT/HCPCS MODIFIER	POINTER	\$ CHARGES UNITS PI	"Y QUAL PROVIDER ID #	
10 30 20 11	71275	ABC	1032 00 1	NPI 1649220120	
10 30 20 11	00007	- parameter		NPI 1649220120 NPI 1649220120	
10 30 20 11	Q9967	ABC	7 33 80	NPI 1649220120	
	+ - + 1 1 1			ND	
				NPI C	
	1 1 1			2	
				NPI CONTRACTOR OF THE PROPERTY	
	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIG	SNMENT?	28. TOTAL CHARGE 29. AM	OUNT PAID 30. Rsvd for NUCC use	
621116618 X	10203099 X YES	NO :	1039 33 \$	1	
			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 thereol.)				GING PC	
ROBERT A DUKE MD 6401 POPLAR AVE MEMPHIS TN 38119-			PO BOX 1000 DEPT 275		
SIGNED 11/04/20 TE	a. b.		MEMPHIS, TN 381480275 1699725812 ZZ2085R0202X		
			TUJJIC 10 1/1	71165 PH 7117 V	

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

PICA AH 22743	8 - 0 0 0 1		0000000 P E	00 003			227438 PICA
1 MEDICARE MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH P	FECA LAN BLK L	LING	1a INSURED'S LD NUMBER	(For Program in Item 1)
(Medicare #) (Medicaid #) 2. PATIENT'S NAME (Last Name, First N		itial) (Member ID#)	PATIENT'S BIR		X (ID#)	MB02304062 4 INSURED'S NAME (Last Name	e. First Name, Middle Initial)
BARNETT JAMES 5 PATIENT'S ADDRESS (No. Street)		6		1966		BARNETT JAM 7 INSURED'S ADDRESS (No.	
3646 BROADWAY	STREET		Self X Spour		Other	3646 BROADW	
CITY			RESERVED FO	OR NUCC USE		CITY	STATE
BARTLETT ZIP CODE TELE	PHONE (Includ	e Area Code)				BARTLETT ZIP CODE	TELEPHONE (Include Area Code)
38135 9 OTHER INSURED'S NAME (Last Nam		3 - 3 9 4 4 Middle Initial) 10	D. IS PATIENTS	CONDITION RE	LATED TO:	38135	901 488-3944
						1048800604	STATE OF THE STATE
a OTHER INSURED'S POLICY OR GRO	OUP NUMBER	33	EMPLOYMENT	YES X		MM DD YY	6 MX F
b RESERVED FOR NUCC USE		b	AUTO ACCIDE	NT2	PLACE (State)	09 27 196 b. OTHER CLAIM ID (Designated	
© RESERVED FOR NUCC USE		c	OTHER ACCID	YES X	NO	c. INSURANCE PLAN NAME OF	R PROGRAM NAME
				YES X		EVOCARE	
d INSURANCE PLAN NAME OR PROG	HAM NAME	10	Od CLAIM CODE	:S (Designated t	y NUGC)	d IS THERE ANOTHER HEALT	H BENEFIT PLAN? If yes, complete items 9, 9a and 9d
12 PATIENT'S OR AUTHORIZED PERS	ON'S SIGNATU	FORE COMPLETING & JRE I authorize the relea	ase of any medical	al or other inform	ation necessary	13 INSURED'S OR AUTHORIZE payment of medical benefits t	D PERSON'S SIGNATURE I authorize of the undersigned physician or supplier for
to process this claim I also request possible to see the second s			o myself or to the	12/19/		STGNAT	URE ON FILE
SIGNED	IDV or DDECN	ANOVILANDI INS. OT	DATE			SIGNED	
MM DD YY	INT, OF PRECIN	QUAL	HER DATE	MM , DD ,	YY	FROM FROM	O WORK IN CURRENT OCCUPATION MM DD Y TO Y
17 NAME OF REFERRING PROVIDER DN LAURA ERICKS			ZZ363L0			- MM DD Y	
19. ADDITIONAL CLAIM INFORMATION			16596	5/4208		PROM 20 OUTSIDE LAB?	S CHARGES
21 DIAGNOSIS OR NATURE OF ILLNE	SS OR INJURY	Relate A-L to service	line below (24E)	ICD Ind)	YES X NO 22 RESUBMISSION	
д Ј324	R519	C. L		D L		CODE	ORIGINAL REF NO
E F_		G. [H. L.		23 PRIOR AUTHORIZATION NU	MBER
24 A DATE(S) OF SERVICE From To	B PLACE OF	C D PROCED	URES, SERVICE Unusual Circums		S E DIAGNOSIS	F. G DAYS OR	H. I. J. FPSDY ID RENDERING
MM DD YY MM DD	YY SERVICE	EMG CPT/HCPCS	I M	ODIFIER	POINTER	\$ CHARGES OR UNITS	PROVIDER ID. #
12 19 20	11	70551	Y		AB	1033 00 1	NPI 1649220120
			17.00				NPI
							NPI
							INPT
							NPI
							NPI
							NPI
25. FEDERAL TAX I D. NUMBER 621116618	SSN EIN	26 PATIENT'S ACC		(For govt, cli	ASSIGNMENT?	Prof. of all the last of the l	AMOUNT PAID 30 Rsvd to: NUCC use
	JPPLIER .	32 SERVICE FACIL		X YES	NO	s 1033 00 s	PH (901) 387-2340
(I certify that the statements on the re apply to this bill and are made a part	everse	DIPC MRI 6401 POR				DIAGNOSTIC I	MAGING PC
ROBERT A DUKE I		MEMPHIS				PO BOX 1000 MEMPHIS, TN	
SIGNED 12/23/29ATE a			b.				ZZ2085R0202X

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