

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			PICALTTI	
PICA A# 206454-0001 CNR534 P E 003			206454 (For Program in Item 1)		
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) HEALTH PLAN	BLK LUNG (ID#) X (ID#)	MB04682957		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial	MM I DD I	YY	4. INSURED'S NAME (Last Name. JACKSON WILI		
JACKSON PATRICIA D 5 PATIENTS ADDRESS (No., Street)		977 LX	7 INSURED'S ADDRESS (No., St		
720 M MORIAH DR	Self Spouse STATE 8 RESERVED FOR	X Child Other	720 M MORIA	ATT ATT	
SOMERVILLE	TN	1000 002	SOMERVILLE	TN	
ZIP CODE TELEPHONE (Include A			ZIP CODE	TELEPHONE (Include Area Code)	
38068 901 268 -		ONDITION RELATED TO:	38068 11 INSURED'S POLICY GROUP	901 268-6222 DR FECA NUMBER	
			1048800702	SEX	
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (03 16 197	M F F	
b RESERVED FOR NUCC USE	b AUTO ACCIDENT		b. OTHER CLAIM ID (Designated I		
© RESERVED FOR NUCC USE	c OTHER ACCIDEN	Λ	c. INSURANCE PLAN NAME OR	4	
	YE	S X NO	EVOCARE	ű.	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES	(Designated by NUCC)	d IS THERE ANOTHER HEALTH	yes, complete items 9, 9a and 9d	
40 DATIENTS OF AUTHORIZED DEDCOMS SIGNATURE	RE COMPLETING & SIGNING THIS FO	or other information necessary	13 INSURED'S OR AUTHORIZED payment of medical benefits to	PERSON'S SIGNATURE I authorize the undersigned physician or supplier for	
to process this claim. I also request payment of governing below.	ment benefits either to myself or to the p	arty who accepts assignment	services described below.	JRE ON FILE	
SIGNATURE ON FIL	上 DATE	12/02/19	SIGNATO	JRE ON FILE	
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNAN	ICY (LMP) 15 OTHER DATE	MM DD YY	16. DATES PATIENT UNABLE TO MM , DD , YY	WORK IN GURRENT OCCUPATION DD TO	
QUAL 17 NAME OF REFERRING PROVIDER OR OTHER SOUR		0000X	18 HOSPITALIZATION DATES RI	ELATED TO CURRENT SERVICES	
DN LESLIE HAYDEN MD 19 ADDITIONAL CLAIM INFORMATION (Designated by N	94245	FROM TO 120 OUTSIDE LAB? S CHARGES			
9			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	
A Z1231 B F	G	D. H.	23. PRIOR AUTHORIZATION NUI	MBER	
J. L.	K C. D. PROCEDURES, SERVICES.	OR SUPPLIES E	F G	H I J	
From To PLACE OF MM DD YY MM DD YY SERVICE E	(Explain Unusual Circumsta	nices) DIAGNOSIS DIFIER POINTER	\$ CHARGES BAYS OR UNITS	Family QUAL PROVIDER ID. #	
1	77067	A	350 00 1	NPI 1649220120	
12 15 20 11	77067	A			
12 15 20 11	77063	A	143 00 1	NPI 1649220120	
3				NPI	
4		1 1 1		NPI C	
5				NPI	
6				NPI	
25. FEDERAL TAX I.D NUMBER SSN EIN 821116618 X	26. PATIENT'S ACCOUNT NO. 10245298	27 ACCEPT ASSIGNMENT? (For govt claims see back) X YES NO	28 TOTAL CHARGE 29 \$ 493 00 \$	AMOUNT PAID 30. Rsvd for NUCC use	
621116618 X 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OF CREDENTIALS	32 SERVICE FACILITY LOCATION IN		33 BILLING PROVIDER INFO &	(301) 307 2310	
(I certify that the statements on the reverse DIPC MAMMO		DIAGNOSTIC I PO BOX 1000	MAGING PC		
ROBERT A DUKE MD MEMPHIS TN 38119-			MEMPHIS, TN	381480275	
SIGNED 12/28/29ATE a b.109850			1699725812	ZZ2085R0202X	



EVOCARE C/O ACCOUNTS PAYABLE

4735 MELISSA WAY	243	CARRIER
HEALTH INSURANCE CLAIM FO	AM	CAR
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (N	0000000	199832 PICA
A# 199832-0001 C	CHAMPVA GROUP FECA OT	HER 1a. INSURED'S LD NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#:DoD#) 2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	(Member ID#) (ID#) (ID#) (ID#) (ID#) (ID#)	MB02366630 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
STUTTS SHARON		X STUTTS SHARON
5 PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self V Spouse Child Other	7. INSURED'S ADDRESS (No. Street) 7.290 PLEASANT RIDGE RD
7290 PLEASANT RIDGE RI	STATE 8. RESERVED FOR NUCC USE	CITY STATE
ARLINGTON	TN	ARLINGTON TELEPHONE (Include Area Code)
38002 TELEPHONE (Include Are 901) 604-4		38002 (901) 604-4755
9. OTHER INSURED'S NAME (Last Name, First Name, Middl		and the same are an experienced and the same are a same and the same are a sa
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	1048800103 a. INSURED'S DATE OF BIRTH MM DD YY
	YES X NO	11 07 1971 X
b. RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO 10d. CLAIM CODES (Designated by NUCC)	EVOCARE d is there another health benefit plan?
d INSURANCE PLAN NAME OR PROGRAM NAME	10d. GLAIM CODES (Designated by NOSCS)	YES NO If yes, complete items 9, 9a and 9d
THE PARTY OF THE PROPERTY OF THE PROPERTY OF THE PARTY OF	E COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information neces	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of government below	ent benefits either to mysell of to the party who accepts assignif	services described below SIGNATURE ON FILE
SIGNATURE ON FIL	DATE	SIGNED
14 DATE OF CURRENT ILLNESS INJURY, or PREGNANCE MM , DD , YY	CY (LMP) 15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY
QUAL 17 NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
DN AMANDA PRICE FNP	176 NPI 1639119753	FROM TO 20 OUTSIDE LAB? \$ CHARGES
19 ADDITIONAL CLAIM INFORMATION (Designated by NU ACTUAL INVOICE COST		YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R	elate A-L to service line below (24E) ICD Ind O	22 RESUBMISSION ORIGINAL REF NO.
A D259 B R109	c Z9884 D	23. PRIOR AUTHORIZATION NUMBER
E J	K	F F G H I J
24. A. DATE(S) OF SERVICE B C From To PLACE OF	(Explain Unusual Circumstances) DIA(GNOSIS DAYS EPSDT ID. RENDERING
MM DD YY MM DD YY SERVICE EN	IG CPT/HCPCS I MODIFIER PO	
12 24 20 11	74177 A	BC 898 00 1 NPI 1649220120
2 12 24 20 11	Q9967 A	BC 7 33 80 NPI 1649220120
3		NPI
4		NPI NPI
5	1 1 1 1 1 1	NPI NPI
6		100
	26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNM	
621116618 X	10255883 X YES NO	905 33
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32 SERVICE FACILITY LOCATION INFORMATION DIPC CT	DIAGNOSTIC IMAGING PC
(I certify that the statements on the reverse apply to this bill and are made a part thereof)	6401 POPLAR AVE	PO BOX 1000 DEPT 275
PORERT A DIIKE MD	MEMPHIS TN 38119-	MEMPHIS, TN 381480275

ROBERT A DUKE MD

MEMPHIS TN 38119-

1699725812 ZZ2085R0202X

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY BIRMINGHAM AL 35242

HEALTH INSUHANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COM PICA A# 178911-00	2.2	0000000			
1 MEDICARE MEDICAID TRICARE (Medicare #) (Medicaid #) (ID#/DoD	CHAMPVA	HEALTH PLAN - BLK	LUNG	THE STATE OF THE TANKER	178911 PICA (For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Midd		3 PATIENT'S BIRTH DATE	SEX (ID#)	MB01430656	Park Marine De La Constantina
DONALDSON REBECCA 5. PATIENT'S ADDRESS (No., Street)		MM DD YY 08 06 1963 ^M 6 PATIENT RELATIONSHIP TO	FX	DONALDSON RO	OGER
338 HARRIS ST		Self Spouse X Child	Other	7 INSURED'S ADDRESS (No. S	
COLLIERVILLE ZIP CODE TELEPHONE (IC	TN	6 RESERVED FOR NUCC USE		COLLIERVILL	STATE
38017 (901)4	71-9789			38017	TELEPHONE (Include Area Code)
9 OTHER INSURED'S NAME (Last Name First Na		10. IS PATIENT'S CONDITION F	RELATED TO:	11 INSURED'S POLICY GROUP	901 471-9789 OR FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMB	ER .	a EMPLOYMENT? (Current or P	1	a INSURED'S DATE OF BIRTH	SEX
b. RESERVED FOR NUCC USE		b AUTO ACCIDENT?	NO PLACE (State	10 24 1960 b. OTHER CLAIM ID (Designated by	N NUCC)
RESERVED FOR NUCC USE		OTHER ACCIDENT?	NO	c. INSURANCE PLAN NAME OR F	PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME		YES X	NO by NUCC)	EVOCARE d IS THERE ANOTHER HEALTH	
READ BACK OF FORM				YES X NO #	ves, complete items 9, 9a and 9d
to process this claim. I also request payment of g below.	overnment benefits either	ease of any medical or other inform to myself or to the party who acce	opts assignment	payment of medical benefits to I services described below.	PERSON'S SIGNATURE I authorize he undersigned physician or supplier for
SIGNATURE ON I		12/11	/20	SIGNATU	RE ON FILE
4 DATE OF CURRENT ILLNESS, INJURY or PREMM. DD YY QUAL	QUAL	THER DATE MM DD	YY	16 DATES PATIENT UNABLE TO Y	MM . BD . VY
ON SAMYA CRUZ MD	178.	1GOTH000		18 HOSPITALIZATION DATES REL	ATED TO CURRENT SERVICES
9 ADDITIONAL CLAIM INFORMATION (Designated	by NUCC)	NPI 1417056409		FROM 20 OUTSIDE LAB?	TO \$ CHARGES
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJU	RY. Relate A-L to service	line below (24E) ICD Ind. (YES X NO	
Z1231	_ c L_	D. L			RIGINAL REF NO
A. DATEISLOE SERVICE	G K	н		23. PRIOR AUTHORIZATION NUMB	ER
From To PLACE 0	C D PROCED (Explain EMG CPT/HCPCS	URES, SERVICES, OR SUPPLIE Unusual Circumstances)	DIAGNOSIS		ID RENDERING
2 11 20 11	77067	MODIFIER	POINTER	\$ CHARGES OH PROPERTY OF THE P	QUAL PROVIDER ID #
			A	350 00 1	NPI 1649220120
2 11 20 11	77063		A	143 00 1	NPI 1649220120
					NPI
					NPI
					NPI
FEDERAL TAX I D NUMBER SSN FIN	200 01-				NPI
621116618 X	1024190	(For govt clair	SSIGNMENT?		OUNT PAID 30 Rsvd for NUCC use
SIGNATURE OF PHYSICIAN OR SUPPLIER NOLUDING DEGREES OR CREDENTIALS 32 SERVICE FACILITY LOCATION INFORMATION 23 10 certify that the statements on the reverse apply to this bill and are made a part thereof 0 10 CHING THE STATE OF T			493 00 \$ BILLING PROVIDER INFO & PH # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275		
SIGNED 12/24/20 a b 109850 IUCC Instruction Manual available at; www.nucc.org PLEASE PRINT OF				1699725812 ZZ	2085R0202X 0938-1197 FORM 1500 (02-12)

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

HEALTH INSUHANCE CLAM 35243

APPROVED BY NATIONAL UNIFORM CLAIM COMMI		0000000	0					
A# 227414-000 1 MEDICARE MEDICAID TRICARE	1 CNR534		0.03 FECA	OTHER	Tag INCURED	OLD MUNDS		227414 PICA
(Medicare #) (Medicard #) (ID#/DoD#)	(Member ID	- HEALTH PLA	N BLK LUI	VG (ID#)		280028		(For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle I TOLDI LISA	Initial)	3 PATIENT'S BIRTI	YY	SEX	4 INSURED'S	NAME (Last N	lame. First Nam	e. Middle Initial)
5 PATIENT'S ADDRESS (No., Street)		02 01 6 PATIENT RELAT	1964 ONSHIP TO INS	FLX	TOLD 7 INSURED'S	I LISA ADDRESS (N	A Street)	
217 EAST LAWNWOOD	STATE	Self X Spouse 8 RESERVED FOR		Other	217	EAST I	LAWNWO	OD
COLLERVILLE	TN	o neserved for	NUCC USE		COLL	ERVILI	г	STATE
ZIP CODE TELEPHONE (Inclu	de Area Code)				ZIP CODE	CKVILI	TELEPHO	NE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name First Name,	3 - 4845 Middle Initial)	10. IS PATIENT'S C	ONDITION RELA	ATED TO	3801'	7 B POLICY GRO	UP OR FECA	01 413-4845
a. OTHER INSURED'S POLICY OR GROUP NUMBER		- FMD OWNERS			10488	800303	3	
The state of the s		a. EMPLOYMENT?			Towns of the Contract of the C	DD Y	Υ	SEX M F
b RESERVED FOR NUCC USE		b. AUTO ACCIDENT	7	PLACE (State)	The second company of the second	01 19 IM ID (Designa		X
c RESERVED FOR NUCC USE		OTHER ACCIDEN			c. INSURANCE	DI AN NAME	OR BROODAN	NIGARE
d INSURANCE PLAN NAME OR PROGRAM NAME		YE	Δ		EVOCA		OH PHOGHAM	NAME
THOUTANGE PERFUNDING OF PROGRAM NAME		10d CLAIM CODES	(Designated by	NUCC)	d. IS THERE A	NOTHER HEA		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATI to process this claim. I also request payment of governor below.	FORE COMPLETING URE I authorize the rele	& SIGNING THIS FO	RM.	n necassan	13 INSURED'S	OR AUTHORI	ZED DEDSON	ete items 9, 9a and 9d 3 SIGNATURE I authorize
below SIGNATURE ON F					services des	cribed below.		gned physician or supplier for
SIGNED		DATE	2/18/2	20	SIGNED_	SIGNA	TURE C	ON FILE
14 DATE OF CURRENT ILLNESS. INJURY, or PREGN	IANCY (LMP) 15 O'	THER DATE	M DD	YY	IVIIVI	IENT UNABLE	YY	CURRENT OCCUPATION MM DD YY
17 NAME OF REFERRING PROVIDER OR OTHER SO		1GOTH000)		FROM 18. HOSPITALIZ	ATION DATES	RELATED TO	CURRENT SERVICES
DN SAMYA CRUZ MD 19. ADDITIONAL CLAIM INFORMATION (Designated by	17b	NPI 141705			FROM	DD	YY	MM DD YY
					20 OUTSIDE LA	X NO	\$ (CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A J J 984	Relate A-L to service	line below (24E)	ICD Ind 0		22 RESUBMISS CODE		ORIGINAL F	IEF NO
а J984 в J189	C		D		23. PRIOR AUTH	HORIZATION N		
1 L J. L 24. A DATE(S) OF SERVICE B	K L	UDEA ACELUARIA					5000211	
From To PLACE OF MM DD YY MM DD YY SERVICE	C. D. PROCEE (Explain	URES, SERVICES, O Unusual Circumstan	OH SUPPLIES ces)	E. DIAGNOSIS	CANCEL BUILDING TO SERVE	G. DAYS	Eamin	RENDERING
12 10 20	I _	MOD MOD	FIER	POINTER	\$ CHARGES		Plan QUAL	PROVIDER ID. #
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							Life	NAME OF THE OWNER OWNER OF THE OWNER OWNER OF THE OWNER OWNE
25. FEDERAL TAX ID NUMBER SSN EIN	26. PATIENT'S ACC		ACCEPT ASSI	GNMENT? see back)	28 TOTAL CHAP	RGE 2	9 AMOUNT PA	
621116618 X 31 SIGNATURE OF PHYSICIAN OR SUPPLIER	1024938 32 SERVICE FACIL	B1 [:	X YES RMATION	NO	\$ 65.	2 00 s	DH # /	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		33 BILLING PROVIDER INFO & PH # (901) 387-2340 DIAGNOSTIC IMAGING PC						
POPERT A DIVIL NO		PO BOX	PO BOX 1000 DEPT 275					
SIGNED 12/24/20ATE	MEMPHIS TN 38119-		MEMPHIS, TN 381480275 1699725812 ZZ2085R0202X					

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

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)	0000000			
A# 227446-0001 CNR		227446 PICA		
	HAMPVA GROUP FECA OTHE HEALTH PLAN BLK LUNG X (ID#)	The state of the second st		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	INSURED'S NAME (Last Name, First Name, Middle Initial)		
MCCRARY JOHN C	06 29 1985 X	MCCRARY JOHN C		
5 PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street)		
135 MADELINE BLVD	STATE 8. RESERVED FOR NUCC USE	CITY STATE		
PIPERTON	TN	PIPERTON TN		
ZIP CODE TELEPHONE (Include Area Code		ZIP CODE TELEPHONE (Include Area Code)		
38017 (901) 826 - 9784 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial		38017 (901) 826-9784 11 INSURED'S POLICY GROUP OR FECA NUMBER		
		1048800203		
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? PLACE (Sta	06 29 1985 X		
	YES X NO			
c RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME		
d INSURANCE PLAN NAME OR PROGRAM NAME	YES X NO	EVOCARE d IS THERE ANOTHER HEALTH BENEFIT PLAN?		
		YES X NO If yes, complete items 9, 9a and 9d.		
READ BACK OF FORM BEFORE COMM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author to process this claim. I also request payment of government benefits.	PLETING & SIGNING THIS FORM. ze the release of any medical or other information necessar	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthouze		
below below				
SIGNATURE ON FILE	12/21/20	SIGNATURE ON FILE		
14. DATE OF CURRENT ILLNESS. INJURY: or PREGNANCY (LMP		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM , DD , YY MM DD , YY		
QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	QUAL 17a ZZ207Q00000X	FROM TO 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
DN HUGO CABALLERO MD	FROM DD YY MM DD YY			
19, ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17b. NPI 1881672152	20. OUTSIDE LAB? \$ CHARGES		
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L	to carring line heles (245)	YES X NO		
N200	ICD Ind. O	22. RESUBMISSION CODE ORIGINAL REF. NO.		
A N200 B C D		23. PRIOR AUTHORIZATION NUMBER		
J. J.	K L			
From To PLACE OF	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DIAGNO	F. G. H. I. J. DAYS EPSOT ID RENDERING CAS EPSOT ID PROVIDER ID #		
MM DD YY MM DD YY SERVICE EMG C	PT/HCPCS MODIFIER POINT			
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2		Luci Luci		
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	ENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT	P 28 TOTAL CHARGE 29 AMOUNT PAID 30 Rsvd for NUCC use		
22 9 23 24 26 26 26 27	251700 X YES NO	294 00 8		
INCLUDING DEGREES OR CREDENTIALS	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION			
(I certify that the statements on the reverse apply to this hill and are made a part thereof)	C US 1 POPLAR AVE	DIAGNOSTIC IMAGING PC		
	PHIS TN 38119-	PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275		
SIGNED 12/23/20ATE a b.		1699725812 ZZ2085R0202X		