

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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTE				6
TI PICA		9		169740
1. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP HEALTH PLAN	DUNCTIONS.	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare #) (Medicard #) (ID#/DoD#)	(Member (D#) (ID#) (a) 3. PATIENT'S BIRTH DA	(ID#) X(ID#)	MB00417045 4 INSURED'S NAME (Last Name, First N	lame, Middle Initial)
2 PATIENT'S NAME (Last Name, First Name, Middle Init	MM DD + YY 02 21 19		LOSHER JEFFRE	L
LOSHER JEFFREY L 5 PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONS	HIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
2530 DIBRELL TRAIL I	OR Self X Spouse	Child Other	2530 DIBRELL S	STATE
CITY	STATE 8 RESERVED FOR NUC	000	COLLIERVILLE	TN
COLLIERVILLE ZIP CODE TELEPHONE (Include	Area Code)		ZIP CODE TELEI	PHONE (Include Area Code)
)-1699	UTION DELATED TO	38017 11 INSURED'S POLICY GROUP OR FE	734 740-1699
9 OTHER INSURED'S NAME (Last Name, First Name, I	Middle Initial) 10 IS PATIENT'S CONE	ITTON NELATED TO	1048800701	C
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Cur	rent or Previous)	a. INSURED'S DATE OF BIRTH	SEX F
	YES	XNO	02 21 1957 b. OTHER CLAIM ID (Designated by NU	X
b RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (Designated by NO	501
c RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	_X	c. INSURANCE PLAN NAME OR PROG	TN PHONE (Include Area Code) 734 740-1699 CA NUMBER SEX M X CC) RAM NAME
U HEDERYED I DITTION ONE	YES	XNO	EVOCARE d is there another health beni	EIT PLAN?
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Do	esignated by NUCC)		complete items 9, 9a and 9d
READ BACK OF FORM BE	FORE COMPLETING & SIGNING THIS FORM	l.	13 INSURED'S OR AUTHORIZED PER payment of medical benefits to the u	SON'S SIGNATURE Lauthorize
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATI to process this claim. I also request payment of government. 			services described below	
SIGNATURE ON F		2/11/20	SIGNATUR	E ON FILE
SIGNED	DATE		116 DATES PATIENT UNABLE TO WOR	RK IN CURRENT OCCUPATION
MM DD YY	QUAL MM	DD YY	FROM DD YY	TO
17 NAME OF REFERRING PROVIDER OR OTHER S			18 HOSPITALIZATION DATES RELATION DD YY FROM	TO TO CURRENT SERVICES MM DD YY TO
DN SPENCER HAUSER MD 19. ADDITIONAL CLAIM INFORMATION (Designated by	17b. NPI 140712	2203	20. OUTSIDE LAB?	S CHARGES
			YES X NO	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJUR		CD Ind. 0	22 RESUBMISSION CODE ORIG	INAL REF. NO
M4802 B M4312	M50222	M5412	23. PRIOR AUTHORIZATION NUMBER	
E S22000A	G K	H		
24. A. DATE(S) OF SERVICE B. From To PLACE OF	C. D PROCEDURES, SERVICES, C (Explain Unusual Circumstance	R SUPPLIES E DIAGNOSIS	F G. H	ID RENDERING
From To PLACE OF MM DD YY SERVICE	EMG CPT/HCPCS MODI	FIER POINTER	S CHARGES UNITS Frame	QUAL PROVIDER ID #
1 12 11 20 11	72141	ABCI	1046 00 1	NPI 1669553764
11 11 10				4101
2				NP)
3				NPI
			1 1 1	MOL
4				NPI
5				NPI
			Y	NO.
6	26 PATIENT'S ACCOUNT NO. 2	7 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AM	IOUNT PAID 30 Revel for NUCC use
25 FEDERAL TAX ID NUMBER SSN EIN X	10242162D	X YES NO	1046 00	
31 SIGNATURE OF PHYSICIAN OR SUPPLIER	32 SERVICE FACILITY LOCATION INF		33: BILLING PROVIDER INFO & PH	() 0 1
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)	DIPC MRI SIEMEN		DIAGNOSTIC IMA PO BOX 1000 DI	AGING PC
SAMUEL P BILYEU MD	6401 POPLAR AVE		MEMPHIS, TN 38	31480275
12/15/20-	a b		1699725812 Z	Z2085R0202X

WCMS-1500CS-12



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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0000000	DICA CASE
A# 227283-0001 CNR534 P E 001	227283
MEDICARE MEDICARD PLATING	OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2 PATIENT'S NAME (Last Name First Name Middle Initial) 3. PATIENT'S BIRTH DATE SEX	MB00302794 4 INSURED'S NAME (Last Name, First Name, Middle Initial)
KIRBY EMILY G 07 05 2002	X KIRBY PHILIP
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Street)
6680 KAMALI AVE Self Spouse Child X Other	6680 KAMALI AVE
	MEMPHIS TN E
MEMPHIS TN ZIP CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Include Area Code)
38134 (901) 654-9335	38134 901 654-9335
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
a OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous)	1048800303 a. INSURED'S DATE OF BIRTH SEX
YES XNO	01 29 1975 MX
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE	(State) b OTHER CLAIM ID (Designated by NUCC)
YES XNO	A A A A A A A A A A A A A A A A A A A
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? YES: XNO	MEMPHIS ZIP CODE 38134 901 654-9335 11 INSURED'S POLICY GROUP OR FECA NUMBER 1048800303 a. INSURED'S DATE OF BIRTH MM DD YY 01 29 1975 C INSURANCE PLAN NAME OR PROGRAM NAME EVOCARE 4 IS THERE ANOTHER HEALTH RENEFIT PLANS
d INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CODES (Designated by NUCC)	EVOCARE d is there another health benefit plan?
St. (Profest Contains of Contains and Contai	YES YOU 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 necessity is claim. I also request payment of government benefits either to myself or to the party who accepts assigning the complete statement of the party who accepts assigning the complete statement of the party who accepts assigning the complete statement of the party who accepts assigning the complete statement of the party who accepts assigning the complete statement of the party who accepts assigning the complete statement of the party who accepts assigning the complete statement of the party who accepts assigning the party who accepts as a party who accepts as a party who accepts as a party who accepts a party who acce	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
belaw.	
SIGNATURE ON FILE 12/11/20	SIGNATURE ON FILE
14 DATE OF CURRENT ILLNESS, INJURY OF PREGNANCY (LMP) 15 OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
QUAL QUAL	FROM
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 1GOTHO 0 0	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO TO
DN SAMYA CRUZ MD 17b NPI 1417056409	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 O	22 RESUBMISSION CODE ORIGINAL REF NO
A N644 B N6022 C	23. PRIOR AUTHORIZATION NUMBER
E	
24. A DATE(S) OF SERVICE B. C D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. F G H I J. GNOSIS DAYS EPSD! ID RENDERING
10 1000	DINTER \$ CHARGES UNITS FIRM QUAL PROVIDER ID #
1 12 11 20 11 76641 LT	A 240 00 1 NPI 1740247485
12 11 20 11 76641 LT	240 00 1 1/4024/465
12 11 20 11 76641 RT F	BA 240 00 1 NPI 1740247485
3	BA 240 00 1 NPI 1740247485
	NPI NPI
5	NPI NPI
6	NPI NPI
25 FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNM	
621116618 X 10243012D X YES NO	
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 DIPC US	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275
LOUIS S PARVEY MD MEMPHIS TN 38119-	MEMPHIS, TN 381480275
SIGNED 12/15/20TE a D	a1699725812 ZZ2085R0202X

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (00000					PICA CITY
1 MEDICARE MEDICAID TRICARE	CNR534 CHAMPVA	P E GROUP	019 FECA	OTHER	1a INSURED'S I.D. NUMBER	í	227224 (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#)	HEALTH F	(ID#)	X (ID#)	MB04808844		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	.3	MM DD	YY	SEX	4 INSURED'S NAME (Last N		
BENJAMIN JENNIFER G 5 PATIENT'S ADDRESS (No., Street)	6	04 25 PATIENT REL	1978 LI ATIONSHIP TO INSU	FLX RED	BENJAMIN J	ENNIF:	ER G
6425 KESWICK DR		Self X Spor	use Child	Other	6425 KESWI		
MEMPILE	12-10-10	RESERVED F	OR NUCC USE		CITY		STATE
MEMPHIS ZIP CODE TELEPHONE (Include Are.	a Code)				MEMPHIS	TELEPHO	NE (Include Area Code)
38119 (901) 351-7					38119	1	01 351-7955
9 OTHER INSURED'S NAME (Last Name, First Name, Middle	e Initial) 10	IS PATIENTS	CONDITION RELAT	ED TO	11 INSURED'S POLICY GRO	UP OR FECA	NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER	a	EMPLOYMEN	F? (Current or Previou		1048800701		SEX
			YES X NO		MM DD Y 04 25 19	/	M F X
b RESERVED FOR NUCC USE	b.	AUTO ACCIDE	NTO	LACE (State)		ted by NUCC)	Δ
c. RESERVED FOR NUCC USE		OTHER ACCID	YES X NO		c. INSURANCE PLAN NAME	OD DDOODAL	
	0,	- THE THOUSE	YES X NO		EVOCARE	UH PHOGHAM	NAME
d INSURANCE PLAN NAME OR PROGRAM NAME	10	d. CLAIM COD	ES (Designated by N	JCC)	d IS THERE ANOTHER HEA	TH BENEFIT F	PLAN?
READ BACK OF FORM BEFORE	COMPLETING &	SIGNING THIS	FORM		YES XNO		ete items 9, 9a and 9d.
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I to process this claim. I also request payment of governmen below.	authorize the release of benefits either to	se of any medic myself or to the	al or other information e party who accepts a	necessary ssignment	13 INSURED'S OR AUTHORI, payment of medical benefit services described below	s to the unders	s SIGNATURE I authorize igned physician or supplier for
SIGNATURE ON FILE			12/08/2			TURE (ON FILE
SIGNED 14 DATE OF CURRENT ILLNESS, INJURY or PREGNANCY	WENDY Law OT	DATE_			SIGNED		
MM DD YY	QUAL	ER DATE	MM DD	YY	16 DATES PATIENT UNABLE	YY	CURRENT OCCUPATION MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.]	GOTHO	00		18 HOSPITALIZATION DATES	RELATED TO	CURRENT SERVICES
DN SAMYA CRUZ MD 19 ADDITIONAL CLAIM INFORMATION (Designated by NUC)	17b. NI	1417	056409		FROM	YY	MM DD YY
ACTUAL INVOICE COST					20 OUTSIDE LAB? YES X NO	S	CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Rela	ate A-L to service li	ne below (24E)	ICD Ind 0		22 RESUBMISSION CODE	ODIONAL	255 110
R062 B R0789	c L		D. (ORIGINAL	REF NO.
F	G		н L		23. PRIOR AUTHORIZATION (UMBER	
24. A. DATE(S) OF SERVICE B. C.		RES, SERVICE Jhusual Circum	S, OR SUPPLIES	E	F G.	H	J
MM DD YY MM DD YY SERVICE EMG	ALL A CLUSTER AND AND ADDRESS OF THE		MODIFIER	DIAGNOSIS POINTER	\$ CHARGES DAYS	EPSDT ID. Family Plan QUAL	RENDERING PROVIDER ID #
12 08 20 11	71260	Q6		7 D	761 00 1		
12 00 20	71200	Q6		AB	761 00 1	NPI	1669553764
12 08 20 11	Q9967	Q6		AB	7 33 80	NPI	1669553764
		1			1		
						NEI	
						NPI	
		Y 5			1		
						NPI	
						NPI	
	PATIENT'S ACCO		27 ACCEPT ASSIC	see back)		9. AMOUNT P	AID 30 Rsvd for NUCC use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32	1023814 SERVICE FACILIT		NEORMATION	NO	\$ 768 33 s	& PH # / C	01 387-2340
(I certify that the statements on the reverse apply to this bill and are made a part thereof)		DIAGNOSTIC	(-	,			
6	401 POP				PO BOX 1000		
SIGNED 12/14/20TE	EMPHIS	TM 387	L		MEMPHIS, TN		



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

PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE PICA A# 227249-0001	000	00000 E 019		×	227249 PICA	
MEDICARE MEDICAID TRICARE	CHAMPVA GF	ROUP FECA	JNG	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)	
(Medicare #) (Medicaid #) (ID#/DoD#) PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIE	ENT'S BIRTH DATE	SEX (ID#)	MB00783752 4. INSURED'S NAME (Last Name	e. First Name, Middle Initial)	
HOUSEY JAMES L	11	11 1964	ς F	HOUSEY JAME	S L	
PATIENT'S ADDRESS (No., Street)	_	ENT RELATIONSHIP TO II		7 INSURED'S ADDRESS (No., 9		
5276 ANNANDALE		X Spouse Child	Other	5276 ANNAND	ALE	
	TN			MEMPHIS	TN	
MEMPHIS P CODE TELEPHONE (Include A				ZIP CODE	TELEPHONE (Include Area Code)	
38125 (901) 643-		ATIENT'S CONDITION RE	LATED TO	38125	901 643-6201	
OTHER INSURED'S NAME (Last Name, First Name, Mid	ule linital)	ATIENT O CONTAINON III	LITTED TO	1048800701		
OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPL	OYMENT? (Current or Pro	evious)	a INSURED'S DATE OF BIRTH	SEX F	
	is alter	YES X		11 11 196	34 X	
RESERVED FOR NUCC USE	, AUTO	YES X	PLACE (State)	b OTHER CLAIM ID (Designated	Tay Noce)	
RESERVED FOR NUCC USE	c. OTHE	ER ACCIDENT?		c INSURANCE PLAN NAME OF	R PROGRAM NAME	
		YES X		EVOCARE		
INSURANCE PLAN NAME OR PROGRAM NAME	10d CL	AIM CODES (Designated	by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES VINO If yes, complete items 9, 9a and 9d		
READ BACK OF FORM BEFO	RE COMPLETING & SIGNI	ING THIS FORM.	nation naceceany	13 INSURED'S OR AUTHORIZE	D PERSON'S SIGNATURE I authorize to the undersigned physician or supplier for	
 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. 			services described below			
SIGNATURE ON FIL	ıΕ	12/09	/20	SIGNATURE ON FILE		
DATE OF CURRENT ILLNESS, INJURY or PREGNAN	ICY (LMP) 15 OTHER D	DATE	VV	16 DATES PATIENT UNABLE T	O WORK IN CURRENT OCCUPATION Y MM , DD , YY	
MM DD YY QUAL	QUAL.	MM DD	YY I	FROM	TO	
NAME OF REFERRING PROVIDER OR OTHER SOUR		OTH000			RELATED TO CURRENT SERVICES MM DD YY TO	
N SAMYA CRUZ MD ADDITIONAL CLAIM INFORMATION (Designated by N		L417056409		20 OUTSIDE LAB?	\$ CHARGES	
ACTUAL INVOICE COST				YES X NO		
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Relate A-L to service line be	elow (24E) ICD Ind	0	22 RESUBMISSION CODE	ORIGINAL REF NO.	
K5730 B B1920	C	D. L.		23 PRIOR AUTHORIZATION N	UMBER	
J. L	K L	L				
4 A DATE(S) OF SERVICE B. From To PLACE OF		s, SERVICES, OR SUPPLI sual Circumstances)	DIAGNOSIS	F. G. DAYS	H. 1 EPSDT ID RENDERING	
MM DD YY MM DD YY SERVICE E	MG CPT/HCPCS I	MODIFIER	POINTER	\$ CHARGES UNITS	QUAL PROVIDER ID #	
2 09 20 11	74178		AB	1063 00 1	NPI 1669553764	
	00055		7.0	7 22 00	NPI 1669553764	
2 09 20 11	Q9967		AB	7 33 80	1009555704	
					NPI	
		g 9 i		1	MDI	
					NPI NPI	
					NPI	
5 FEDERAL TAX I D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT	T NO 27 ACCEPT	ASSIGNMENT?	28 TOTAL CHARGE 2	NPI 30. Rsvd for NUCC us	
621116618 X	102393741	(For govt	NO NO	1070 33		
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32 SERVICE FACILITY L		V	33 BILLING PROVIDER INFO	701 307 2310	
(i certify that the statements on the reverse apply to this bill and are made a part thereof.) DIPC CT 6401 POPLAR AVE		DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275				
SAMUEL P BILYEU MD	MEMPHIS TI			MEMPHIS, TN		
SAMUEL P BILYEU MD MEMPHIS IN 38119-		1699725812 ZZ2085R0202X				