# EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

| APPROVED BY NATIONAL UNIFORM CLAIM COMMIT   | TEE (NUCC) 02/12 000   | 00000   |                           |   |  |
|---|--|---|---------------------------|---|--|
| A# 226355-000   | The second secon | E 003   |                           |   | 226355 <sup>PICA</sup>   |
| 1. MEDICARE MEDICAID TRICARE  (Medicare #) (Medicaid #) (ID#/DoD#)  |  | ROUP<br>EALTH PLAN BLK LUNG<br>((D#)                            | OTHER                     | 1a. INSURED'S I.D. NUMBER                                   | (For Program in Item 1)  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle In   | itial) 3 PATIE   | NT'S BIRTH DATE   | X <sup>(ID#)</sup><br>SEX | MB02903989 4. INSURED'S NAME (Last Name                     | First Name Middle Initial)   |
| BROWN JACQUELINE D  | 0.6  | 18 1962   | FX                        | BROWN JAMES   | SUL STREET, CONTROL OF STREET, C |
| 5. PATIENT'S ADDRESS (No., Street)  | 6 PATIE  | NT RELATIONSHIP TO INSU   | RED                       | 7 INSURED'S ADDRESS (No., S                                 |  |
| 3611 THISTLE VALLEY   |  | Spouse X Child  | Other                     | 3611 THISTL   | E VALLEY LN  |
| BARTLETT  |  | RVED FOR NUCC USE   |                           | CITY  | STATE  |
| ZIP CODE TELEPHONE (Includ  | TN e Area Code)  |   |                           | BARTLETT ZIP CODE   | TELEPHONE (Include Area Code)  |
| 38135 (901) 343   | 3-1587   |   |                           | 38135   | / \  |
| 9. OTHER INSURED'S NAME (Last Name, First Name,   |  | TIENT'S CONDITION RELAT   | ED TO:                    | 11. INSURED'S POLICY GROUP                                  | 901 343-1587<br>OR FECA NUMBER   |
|   |  |   |                           | 1048800604  |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER   | a. EMPLC   | DYMENT? (Current or Previou                                     |                           | a INSURED'S DATE OF BIRTH                                   | SEX  |
| b. RESERVED FOR NUCC USE  | b. AUTO  | ACCIDENT?   | 105 (0)                   | b. OTHER CLAIM ID (Designated I                             |  |
|   |  | YES XNO   | ACE (State)               | b. OTHER CEARM ID (Designated )                             | by NOCC)   |
| c. RESERVED FOR NUCC USE  | c. OTHER   | ACCIDENT?   |                           | c. INSURANCE PLAN NAME OR                                   | PROGRAM NAME   |
| A INCURANCE DIAMANA   |  | YES XNO   |                           | EVOCARE   |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME  | 10d. CLAI  | M CODES (Designated by NU                                       | ICC)                      | d. IS THERE ANOTHER HEALTH                                  | BENEFIT PLAN?  |
| READ BACK OF FORM BEI   | ORE COMPLETING & SIGNING   | G THIS FORM   |                           |   | yes, complete items 9, 9a and 9d.  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATU to process this claim. I also request payment of gove below. | RE I authorize the release of an<br>nment benefits either to myself  | y medical or other information<br>or to the party who accepts a | necessary<br>ssignment    | payment of medical benefits to<br>services described below. | PERSON'S SIGNATURE I authorize the undersigned physician or supplier for   |
| SIGNATURE ON FI   |  | 10/30/2   |                           | SIGNATI   | URE ON FILE  |
| SIGNED  |  | DATE  |                           | SIGNED  | OKE ON FILE  |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNAMM   DD   YY  | STATE OF STA |   | ſΥ                        | MINI DD YY  | WORK IN CURRENT OCCUPATION MM DD YY  |
| QUAL  <br>17. NAME OF REFERRING PROVIDER OR OTHER SOI   | QUAL.   17a   772 (  | 20100000  |                           | FROM  18 HOSPITALIZATION DATES RE                           | TO   |
| DN AMBER GRAHAM MD  | 1/4 2/42(  | 08100000X<br>579849483  |                           | FROM DD YY  | MM DD YY   |
| 10 ADDITIONAL CLAIM INFORMATION (D.   |  |   | 20 OUTSIDE LAB?           | \$ CHARGES  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)                      |  |   | YES X NO                  |   |  |
| 4 K7689 R9389   | Helate A-L to service line below   | V (24E) ICD Ind. 0  |                           | 22. RESUBMISSION<br>CODE                                    | DRIGINAL REF. NO.  |
| A. K7003  | C. L   | D   |                           | 23. PRIOR AUTHORIZATION NUM                                 | DED  |
|   | G L  | Н.  |                           | 23. PRIOR AUTHORIZATION NUM                                 | BER  |
| 24. A. DATE(S) OF SERVICE B. From To PLACE OF   | C. D. PROCEDURES, SI<br>(Explain Unusual   | ERVICES, OR SUPPLIES  | E                         |   | H. I. J.   |
|   | EMG CPT/HCPCS I  | MODIFIER  | DIAGNOSIS<br>POINTER      |   | PSDT ID RENDERING Smily QUAL PROVIDER ID #   |
| 10 30 20 11   | 76705  |   |                           |   |  |
| 11  | 76705  |   | AB                        | 226 00 1  | NPI 1649220120   |
|   |  |   |                           |   | NPI  |
|   |  |   |                           |   |  |
|   |  |   |                           |   | NPI  |
|   |  |   |                           |   | 0  |
|   |  | 1   |                           |   | NPI C  |
|   |  |   |                           |   | NDI  |
|   |  |   |                           |   | (N)  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN   | 26. PATIENT'S ACCOUNT NO   | 27 400007 4000  | MATERIA                   | 00 70741 6  | NPI  |
| 621116618 X   | 10203032   | (For govt. claims, s  | ee back)                  |   | MOUNT PAID 30. Rsvd for NUCC use   |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OF CREDENTIALS                                   | 32. SERVICE FACILITY LOCA  |   | NO :                      | \$ 226 00 \$  | # (001) 207 0240   |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.)            | DIPC US  |   |                           | DIAGNOSTIC IM   | 301 387-2340   |
|   | 6401 POPLAR  |   |                           | PO BOX 1000 D   |  |
| ROBERT A DUKE MD  | MEMPHIS TN   | 38119-  |                           | MEMPHIS, TN 3   |  |
| SIGNED 11/03/29 <sub>ATE</sub>  | a.   | D.  |                           |   | Z2085R0202X  |



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

| HEALTH INSURANCE CLAIM F  | WILLIAM 19914  |   |                       |                        |                  |                   |                               | CAR            |
|---|--|---|-----------------------|------------------------|------------------|-------------------|-------------------------------|----------------|
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE  | 00   | 000000  |                       |                        |                  |                   | 226131 PICA                   | пĬ             |
| 1. MEDICARE MEDICAID TRICARE  | - Wester in the Control of the Contr | P E 003 GROUP FEC   | CA OTHER              | 1a. INSURED'S          | I.D. NUMBER      |                   | (For Program in Item 1)       | - <del>*</del> |
| (Medicare #) (Medicard #) (ID#/DoD#)  | (Member ID#)   | HEALTH PLAN BLIF (ID#)                                      | X (ID#)               | 10488                  | 300103           |                   |                               |                |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial  |  | TIENT'S BIRTH DATE  | SEX                   | 4 INSURED'S N          | IAME (Last Name  | e, First Name,    | Middle Initial)               |                |
| EVANS TRASSEY   |  | 4 30 1975   | FX                    | EVANS                  | TRASS            |                   |                               | 41             |
| 5. PATIENT'S ADDRESS (No., Street)  | Self   |   | Other                 | -417544 Martineria     | BURLOE           |                   |                               |                |
| 3375 BURLOE LANE  |  | SERVED FOR NUCC USE   |                       | CITY                   | DURLUE           | LANE              | STATE                         | _              |
| BARTLETT  | TN   |   |                       | BARTI                  | ETT              |                   | TN                            | C              |
| ZIP CODE TELEPHONE (Include A   | ACCOUNT OF A COUNTY  |   |                       | ZIP CODE               |                  | TELEPHONI         | E (Include Area Code)         | MA             |
| 38133 (901) 619-  |  |   |                       | 38133                  |                  | 90                |                               | INFORMATION    |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Mid   | idle Initial) 10. IS   | PATIENT'S CONDITION   | RELATED TO:           | 11. INSURED'S          | POLICY GROUP     | OR FECA N         | JMBER                         | Ž              |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER   | a. EMI   | PLOYMENT? (Current or                                       | Previous)             | MSSC<br>a. INSURED'S E | DATE OF BIRTH    |                   | SEX                           | _ H            |
|   |  |   | NO                    |                        | 30 197           | 7.5 M             | FX                            | O N            |
| b. RESERVED FOR NUCC USE  | b, AU  | TO ACCIDENT?  | PLACE (State)         | b. OTHER CLAIR         |                  |                   |                               |                |
|   |  |   | X NO                  |                        |                  |                   |                               | DNA            |
| c. RESERVED FOR NUCC USE  | c. OTH   | HER ACCIDENT?   | 7                     | c. INSURANCE           |                  | PROGRAM N         | NAME                          | F              |
| d. INSURANCE PLAN NAME OR PROGRAM NAME  | ind C  | YES   | M NO                  | EVOCA                  |                  | H BENEEIT PI      | AN?                           | _ TIT          |
| d. Hoofinger Pena Maine Off Frodram Maine   | Tod. C   | DEMIN CODES (Designate                                      | a by (1000)           | YES                    |                  |                   | te items 9, 9a and 9d.        | Ω              |
| READ BACK OF FORM BEFO  |  |   |                       | 13. INSURED'S          | OR AUTHORIZE     | D PERSON'S        | SIGNATURE I authorize         | -              |
| 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of governr below. | ent benefits either to my  | of any medical or other into<br>self or to the party who ac | cepts assignment      | services desc          | ribed below.     | o the undersig    | ned physician or supplier for |                |
| SIGNATURE ON FII  | ĿΕ   | 10/1  | 5/20                  |                        | SIGNAT           | URE O             | N FILE                        |                |
| SIGNED  | OV WARD THE OTHER  | DATE  |                       | SIGNED _               | ENER INVESTOR TO | e meens mise      |                               | _ *            |
| MM   DD   YY  | CY (LMP) 15 OTHER  | MM DE   | YY                    | FROM                   | DD Y             | Y WORK IN C       | URRENT OCCUPATION MM DD YY    | 1              |
| QUAL   17. NAME OF REFERRING PROVIDER OR OTHER SOUR   |  | 207V00000   | X                     |                        | ATION DATES F    |                   | CURRENT SERVICES              | -              |
| DN JAMES K PATTERSON M  |  | 148770272   |                       | FROM MM                | DD I Y           | ТС                | MM DD YY                      |                |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by N   | UCC)   |   |                       | 20 OUTSIDE LA          | B?               | \$ C              | HARGES                        |                |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. F   | Pelata A.I. to convice line I  | holow (24E)   |                       | YES                    | X NO             |                   |                               | _              |
| 71221   | telate A-L to service line i   | ICD Ind   | 0                     | 22. RESUBMISS<br>CODE  | ION              | ORIGINAL R        | EF. NO.                       |                |
| A. 21231 B. E. F. L.  | C. L   | D.  |                       | 23. PRIOR AUTI         | HORIZATION NU    | MBER              |                               | -              |
|   | К.   |   |                       |                        |                  |                   |                               |                |
| 24 A. DATE(S) OF SERVICE B (PLACE OF )  |  | S, SERVICES, OR SUPP.                                       | LIES E<br>DIAGNOSIS   | F.                     | G.<br>DAYS       | H. I.<br>EPSDT ID | J.<br>RENDERING               | - 2            |
| MM DD YY MM DD YY SERVICE EN  | The Park Control of the Control of t | MODIFIER  | POINTER               | \$ CHARGES             | OP               | Family QUAL       | PROVIDER ID. #                |                |
| 10 15 20 11   | 77067  |   | A                     | 250                    | 00 7             |                   | 1640000100                    | _ Z            |
| 10 13 20  | 77067  |   | A                     | 350                    | 00 1             | NPI               | 1649220120                    | INEOB          |
| 10 15 20   11   | 77063  |   | A                     | 143                    | 00 1             | NPI               | 1649220120                    |                |
| 3   |  | 7 11 1  |                       |                        |                  |                   |                               | CHIDDLIFE      |
|   |  |   |                       |                        |                  | NPI               |                               | _ 0            |
| 1   | 1  | 1 1 1   |                       | 1                      |                  | ND                |                               | 0              |
|   |  |   |                       |                        |                  | NPI               |                               | - 2            |
|   | 1  |   |                       |                        |                  | NPI               |                               | - 2            |
|   |  |   |                       |                        |                  |                   |                               | N N            |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN   | DATIENTIS ACCOUNT  | IT NO.  | TACCIONIMENTO         | 00 TOTAL OUT           | DOE LOS          | NPI               | AID IOO D. III III I          | Ω              |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN X   | 26. PATIENT'S ACCOUNT  | (For gov  | T ASSIGNMENT?         | 28. TOTAL CHA          | 3 00 \$          | . AMOUNT PA       | AID 30 Rsvd for NUCC us       | е              |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER  |  | LOCATION INFORMATIO   |                       | 33. BILLING PR         |                  | PH # / 9          | 01) 387-2340                  | +              |
| INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse                                | DIPC MAMM  | 0   |                       |                        | STIC I           | ( )               |                               |                |
| apply to this bill and are made a part thereof.)  | 6401 POPL  |   |                       |                        | 1000             |                   |                               |                |
| ROBERT A DUKE MD MEMPHIS TN 38119-  |  |   | MEMPHIS, TN 381480275 |                        |                  |                   |                               |                |
| 11/03/20 <sub>ATE</sub>   | a  | 109850  |                       | 1 69972                | 5812             | 77208             | 5R0202X                       |                |

### EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243

| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTE                                    | EE (NUCC) 02/12  |   |  |  |
|--|--|---|--|--|
| TT PICA  | 00000000<br>CNR534 P E 003   | 226475 PICA   |  |  |
| 1. MEDICARE MEDICAID TRICARE   | CHAMPVA GROUP FECA OTHER   |   |  |  |
| (Medicare #) (Medicaid #) (ID#/DoD#)   | (Member 1D#) HEALTH PLAN BLK LUNG (ID#) X(ID#)   | MB02915175  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Init                          | ial) 3. PATIENT'S BIRTH DATE SEX   | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)   |  |  |
| HARRISON BRENDA K  | 05 19 1964 F X   |   |  |  |
| 5. PATIENT'S ADDRESS (No., Street)   | 6. PATIENT RELATIONSHIP TO INSURED   | 7. INSURED'S ADDRESS (No., Street)  |  |  |
| 3892 LEWEIR  | Self X Spouse Child Other  STATE 8. RESERVED FOR NUCC USE  | 3892 LEWEIR   |  |  |
|  |  |   |  |  |
| MEMPHIS  ZIP CODE TELEPHONE (Include   | TN<br>Area Code)   | MEMPHIS TN  ZIP CODE TELEPHONE (Include Area Code)  |  |  |
| 38127 (901) 848  | -9274  | 38127 (901) 848-9274  |  |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, N                              |  | 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  |  |  |
| L DESERVES FOR AUROS LIGH  | b. AUTO ACCIDENT?  | 05 19 1964 X  |  |  |
| b. RESERVED FOR NUCC USE   | PLACE (Stat  | te) b. OTHER CLAIM ID (Designated by NUCC)  |  |  |
| c. RESERVED FOR NUCC USE   | c OTHER ACCIDENT?  | c. INSURANCE PLAN NAME OR PROGRAM NAME  |  |  |
| C. TIEGETTEE FOI HOOD OUL  | YES XNO  | And the second of the product of the second |  |  |
| 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.  |  |  |
|  | ORE COMPLETING & SIGNING THIS FORM. RE I authorize the 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   |  |  |
| to process this claim. I also request payment of gover                         | mment benefits either to myself or to the party who accepts assignment                                       | services described below  |  |  |
| SIGNATURE ON FI  |  | SIGNATURE ON FILE   |  |  |
| SIGNED   | DATE NCY (LMP) 15. OTHER DATE  | SIGNED  |  |  |
| MM DD YY   | QUAL MM DD YY  | MM DD YY MM DD YY   |  |  |
| 17 NAME OF REFERRING PROVIDER OR OTHER SOL                                     |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES   |  |  |
| DN ANNETTE CAPLE NP  | 17b NPI 1013250166   | FROM DD YY MM DD YY   |  |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by                                | NUCC)  | 20. OUTSIDE LAB? \$ CHARGES   |  |  |
| OF BUILDING OF WITHING OF WARRY  | D. I.I. A. I. I  | 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 M25531 B R2231   | C. L D. L  | 23. PRIOR AUTHORIZATION NUMBER  |  |  |
| E F  | _ G L H L  | ESS. ERION AUTHORIZATION NOMBER   |  |  |
| 1. J. J. 24. A. DATE(S) OF SERVICE B.  | C. D PROCEDURES, SERVICES, OR SUPPLIES E.  | F. G. H I J   |  |  |
| From To PLACE OF   | (Explain Unusual Circumstances)  DIAGNOS  EMG CPT/HCPCS I MODIFIER POINTE                                    |   |  |  |
| WW DO IT WIN DO IT CONTROL   | end of infered important   |   |  |  |
| 10 30 20 11  | 73130 RT AB  | 69 00 1 NPI 1649220120  |  |  |
|  |  |   |  |  |
|  |  | NPI NPI   |  |  |
|  |  | NPI NPI   |  |  |
|  |  | NPT NPT   |  |  |
|  |  | NPI NPI   |  |  |
|  |  |   |  |  |
|  |  | NPI   |  |  |
|  |  |   |  |  |
| 25. FEDERAL TAX I D. NUMBER SSN EIN  | 26 PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?  | NPI NPI 30. Rsvd for NUCC use   |  |  |
|  | (For govt. claims, see back)   |   |  |  |
| 621116618 X  | 10203925 X YES NO  32. SERVICE FACILITY LOCATION INFORMATION   | \$ 69 00 \$   33. BILLING PROVIDER INFO & PH. # ( 901) 3.87 - 234.0   |  |  |
| INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse | DIPC R&F   | DIAGNOSTIC IMAGING PC   |  |  |
| apply to this bill and are made a part thereof.)  DIPC R&F  6401 POPLAR AVE    |  | PO BOX 1000 DEPT 275  |  |  |
| ROBERT A DUKE MD MEMPHIS TN 38119-   |  | MEMPHIS, TN 381480275   |  |  |
| SIGNED 11/03/20TE  |  | 1699725812 ZZ2085R0202X   |  |  |

## 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   | 0  |  |
|---|--|--|
|   | 226338 PICA  |  |
| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP  (Medicare #) (Medicard #) (ID#/DoD#) (Member ID#) (ID#)   | FECA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)   |  |
| PATIENT'S NAME (Last Name, First Name, Middle Initial)     3 PATIENT'S BIRTH  | (ID#) X (ID#) MB04570707  DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)   |  |
| SHAFFREY LAUREN B 11 01 3  5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATION   | YY   |  |
| 1948 ALMADALE FARMS PKWY Self X Spouse  | The state of the s |  |
| CITY STATE 8 RESERVED FOR   | TOTO ALMADALE FARMS PRWY   |  |
| COLLIERVILLE TN ZIP CODE TELEPHONE (Include Area Code)  | COLLIERVILLE TN  ZIP CODE TELEPHONE (Include Area Code)  |  |
| 38017 (901) 262-1693  | 38017 (901) 262-1693   |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CO   | ONDITION RELATED TO: 11 INSURED'S POLICY GROUP OR FECA NUMBER  |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? ((   | 1048800303  Current or Previous) a. INSURED'S DATE OF BIRTH SEX  |  |
| YES   | MM DD YY   |  |
| b. RESERVED FOR NUCC USE b. AUTO ACCIDENTY  | PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)   |  |
| c. RESERVED FOR NUCC USE  | 1  |  |
| c. RESERVED FOR NUCC USE  c. OTHER ACCIDENT  YES  | S HOUSE TEAM NAME OF PROGRAM NAME  |  |
|   | EVOCARE  Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  |  |
|   | YES XNO If yes, complete items 9, 9a and 9d.   |  |
| 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical of to process this claim. I also request payment of government benefits either to myself or to the pa          |  |  |
| DOIOT.  |  |  |
| SIGNATURE ON FILE DATE  | .0/23/20 SIGNATURE ON FILE   |  |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE  | SIGNED   |  |
| QUAL. QUAL.   | M DD YY FROM DD YY TO MM DD YY   |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ZZ207V00  | MM DD VV   |  |
| DN LESLIE HAYDEN MD 17b NPI 160989  | 4245 FROM TO   |  |
| (======================================   | 20 OUTSIDE LAB? \$ CHARGES   |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)  | ICD Ind O 22. RESUBMISSION   |  |
| A. Z1213 B. C. C.   | D. L. ORIGINAL REF. NO.  |  |
| F G   | H. L 23. PRIOR AUTHORIZATION NUMBER  |  |
| 24. A. DATE(S) OF SERVICE B. C. D PROCEDURES, SERVICES, C   | DR SUPPLIES E F. G. H. I. J.   |  |
| From         To         PLACE OF         (Explain Unusual Circumstan           MM         DD         YY         MMDD         YY         SERVICE         EMG         CPT/HCPCS         I         MOD | DIAGNOSIS DAYS EPSOT ID. RENDERING   |  |
| To more more  | FIER POINTER S CHARGES UNITS FAM QUAL PROVIDER ID. #   |  |
| 10 23 20 11 77067   | A 350 00 1 NPI 1649220120  |  |
| 10 23 20 11 77063   |  |  |
|   | A 143 00 1 NPI 1649220120  |  |
|   |  |  |
|   | NPI  |  |
|   | NPI NPI  |  |
|   | NPI  |  |
| 25 FEDERALTAVID ANIMOED   | NPI NPI  |  |
| 601116610   | ACCEPT ASSIGNMENT? (For gout claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use  |  |
| 31 SIGNATURE OF PHYSICIAN OR SUPPLIED 22 SEPURCE FACULTY LOCATION   |  |  |
| (I certify that the statements on the reverse DTPC MAMMO  | DIAGNOSTIC IMAGING PC  |  |
| apply to this bill and are made a part thereof.) 6401 POPLAR AVE  | PO BOX 1000 DEPT 275   |  |
| ROBERT A DUKE MD MEMPHIS TN 3811  | 9- MEMPHIS, TN 381480275   |  |
| SIGNED 11/03/20ATE a 0.1098   |  |  |