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

BIRMINGHAM AL 35243
TH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02 PICA A# 227387-0001 CNR53	0000000	227387 PICA
1. MEDICARE MEDICAID TRICARE CHAN	1a INSURED'S I.D. NUMBER (For Program in Item 1)	
	ber ID#) HEALTH PLAN BLK LUNG (ID#) X (ID#)	MB00296623
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)
TODD ANGELA 5 PATIENT'S ADDRESS (No., Street)	02 04 1971 F X	TODD ANGELA  7. INSURED'S ADDRESS (No., Street)
3215 YUKON DR	Self X Spouse Child Other	3215 YUKON DR
CITY	ATE 8 RESERVED FOR NUCC USE	CITY STATE
LAKELAND ZIP CODE TELEPHONE (Include Area Code)	ΓN	LAKELAND TN  ZIP CODE TELEPHONE (Include Area Gode)
38002 (901) 382-3190		38002 (901) 382-3190
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)	1048800403 a INSURED'S DATE OF BIRTH SEX
	YES X NO	02 04 1971 M
b RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	The state of the s
© RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	A INCLIDANCE DI AN NAME OD DDOGGANANA
C HESCHYLD FOIL HOUGH OSE	YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME  EVOCARE
d INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d: IS THERE ANOTHER HEALTH BENEFIT PLAN?
2012		YES X NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLE  12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize I  15 process this claim. I also request payment of government benefits.	TING & SIGNING THIS FORM.  The release of any medical or other information necessary attention myself or to the party who accords according to the party who accords according to the party who according to the p	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	12/17/20	SIGNATURE ON FILE
SIGNED	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 FROM TO MM DD YY TO
AT THE OF PERSONS PRODUCED OF STREET	17a. ZZ207RC0000X	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	17b. NPI 1508088162	FROM DD YY MM DD YY
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to	service line below (24E) ICD Ind 0	YES X NO
A I I S 1	I340 D I10	CODE ORIGINAL REF NO
ELFLG		23. PRIOR AUTHORIZATION NUMBER
1	ROCEDURES SERVICES OR SUPPLIES E	
From To PLACE OF	Explain Unusual Circumstances) DIAGNOSIS	P G. H. J.  DAYS EPSOT ID. RENDERING  Family  OR Family
MM DD YY MM DD YY SERVICE EMG CPT/	HCPCS   MODIFIER POINTER	S CHARGES UNITS But QUAL PROVIDER ID. #
12 17 20 11 933	ABCD	660 00 1 NPI 1740247485
		NPI NPI
		NPI NPI
		1451
		NPI
		NPI
	1 1 1 1 1	NEW CONTRACTOR
25 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT	S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (For gowl claims, see back)	28 TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
	8037 X YES NO	s 660 00 s
INCLUDING DEGREES OR CREDENTIALS	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 US 6401 POPLAR AVE		DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275
LOUIS S PARVEY MD MEMPH	MEMPHIS, TN 381480275	
SIGNED 12/23/20ATE a	1699725812 ZZ2085R0202X	
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED OMB 0938-1197 FORM 1500 (02-12)



## EVOCARE C/O ACCOUNTS PAYABLE

HEALTH INSURANCE CLAIM FORI	M	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC	0000000	
1 MEDICARE MEDICAID	R534 P E 003 CHAMPVA GROUP FECA OTHER LIA MICHIPEDID IO	126
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#) FECA OTHER 1a. INSURED'S I.D. I	NUMBER (For Prog

1. MEDICARE MEDICAID TRICARE	I E 003	126613 PICA
(Medicare #) (Medicaid #) (ID#/DoD#)  2. PATIENT'S NAME (Last Name, First Name, Middle In	(Member ID#) (ID#) BLK LUNG (ID#)	ta. INSURED'S LD NUMBER (For Program in Item 1)  MB03447814
GARRISON JAMIE L	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	10 09 1982 F X	GAMSON EDWARD 7 INSURED'S ADDRESS (No., Street)
12311 LONGHORN DR	Self Spouse X Child Other	
ARLINGTON	STATE 8 RESERVED FOR NUCC USE	12311 LONGHORN DR
ZIP CODE TELEPHONE (Includ	e Area Code)	ARLINGTON TN
38002 (901) 517		TELEPHONE (Include Area Code)
OTHER INSURED'S NAME (Last Name, First Name, I	Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	38002 901 517-8119 11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	1048800702 a. INSURED'S DATE OF BIRTH
b DECEDUED FOR LUIS	YES XNO	MM   DD   YY
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	12 19 1977 M X
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	
	YES X NO	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?
READ BACK OF FORM BEF	FORE COMPLETING & SIGNING THIS FORM.	YES XNO If yes, complete items 9, 9a and 9d
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of government.</li> </ol>	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	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 FI	LE 12/04/20	sorvices described below.
SIGNED	DATE	SIGNATURE ON FILE
MM DD YY  OUAL	NCY (LMP) 15. OTHER DATE OUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD YY TO MM DD YY
17 NAME OF REFERRING PROVIDER OR OTHER SOL		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN SAMYA CRUZ MD  19. ADDITIONAL CLAIM INFORMATION (Designated by	17b NPI 1417056409	FROM MM DD YY MM DD YY
18 ADDITIONAL CLAIM INFORMATION (Designated by	NUCC)	20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Relate A-L to service line below (24E) ICD Ind. 0	YES X NO 22. RESUBMISSION
A. [R2232]		CODE ORIGINAL REF. NO.
F	H	23. PRIOR AUTHORIZATION NUMBER
	C. D. PROCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J
To	(Explain Unusual Circumstances)  EMG CPT/HCPCS   MODIFIER POINTER	S CHARGES DAYS EPSOT ID RENDERING ON Family OUAL PROVIDER ID #
12 04 20 11	76882	
11	76882 A	92 00 1 NPI 1649220120
		NPI NPI
		92 00 1 NPI 1649220120
		NPI NPI
		NPI
		, NPI
		NPI
25 FEDERAL TAX ID. NUMBER SSN EIN   621116618  X	(For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER	10235562 X YES NO 32 SERVICE FACILITY LOCATION INFORMATION	\$ 92 00 \$ 33. BILLING PROVIDER INFO & PH. # (901) 3.9.7. 23.4.0
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	DIDG III	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 38119-		MEMPHIS, TN 381480275
SIGNED 12/08/29ATE	DI SACE PRINT OF THE	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				
A# 227265-0001 CNR534 P E 019			1a. INSURED'S LD. NUMBER (Fr	227265 PICA
(Medicare #) (Medicaid #) (ID#/DeD#)  2 PATIENT'S NAME (Last Name, First Name, Middle	(Member ID#) HEALTH (ID#) Initial) 3 PATIENT'S B	PLAN BLK LUNG (ID#)	ME03058721  4. INSURED'S NAME (Last Name, First Name, Middle)	or Program in Item 11
WINKLER AMBER	MM I DD		WINKLER AMBER	e inmai)
5. PATIENT'S ADDRESS (No., Street)	6 PATIENT REI	LATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Street)	
7950 OAK PEBBLE CV	Self X Spo		7950 OAK PEBBLE CV	
MILLINGTON	TN		MILLINGTON	TN
ZIP CODE TELEPHONE (Inclu 38053 (901) 64	7 - 8 9 3 3		ZIP CODE TELEPHONE (Incl	ude Area Code)
9. OTHER INSURED'S NAME (Last Name. First Name		S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBE	647-8933
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMEN	IT? (Current or Previous)	1048800103 a INSURED'S DATE OF BIRTH	ScX
		YES XNO	03 24 1983 M	FX
b. RESERVED FOR NUCC USE	b AUTO ACCID	PLACE (State)		
© RESERVED FOR NUCC USE	c. OTHER ACCII	YES XNO DENT?	c INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM COD	YES XNO DES (Designated by NUCC)	EVOCARE d is there another health benefit plan?	
	300 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T 1 T		YES XNO If yes, complete item	s 9. 9a and 9a
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNAT to process this claim. I also request payment of government.	FORE COMPLETING & SIGNING THIS URE I authorize the release of any medi	FORM. cal or other information necessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGN/ payment of medical benefits to the undersigned of	ATHER I sufferning
SIGNATURE ON F		12/10/20	services described below.	
SIGNED	DATE_	12/10/20	SIGNATURE ON	FILE
14 DATE OF CURRENT ILLNESS, INJURY, or PREGRAMM DD YY QUAL	VANCY (LMP) 15 OTHER DATE	MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRE MM DD YY TO MM	NT OCCUPATION DD , YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ZZ363L00000X 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				ENT SERVICES DD YY
DN LAURA ERICKSON-BL  19 ADDITIONAL CLAIM INFORMATION (Designated by		674208	FROM DD YY MM TO 20 OUTSIDE LAB? \$ CHARG	
- 1931 A			YES X NO	ES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJUR	Y. Relate A-L to service line below (24E	ICD Ind 0	22 RESUBMISSION CODE ORIGINAL REF NO	)
B 110002			23 PRIOR AUTHORIZATION NUMBER	
24 A. DATE(S) OF SERVICE B	к	H		
24 A. DATE(S) OF SERVICE   B.	C. D. PROCEDURES SERVICE (Explain Unusual Circum	nstances) DIAGNOSIS		J RENDERING
	or thror co	MODIFIER POINTER	\$ CHARGES UNITS Par QUAL	PROVIDER ID #
12 10 20 11	71046	AB	81 00 1 NPI 16	669553764
			NPI NPI	
			NPI NPI	
			MPI	8
			NPI	OH COLOR
	,		I NF1	2
25 FEDERAL TAX LD NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO	27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 AMOUNT PAID	
621116618 X	10242899D	X YES NO	\$ 81 00 \$	30 Rsyd for NUCC use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	32. SERVICE FACILITY LOCATION	INFORMATION	33. BILLING PROVIDER INFO & PH # (901)	387-2340
apply to this bill and are made a part thereof.) 6401 POPLAR AVE		DIAGNOSTIC IMAGING F PO BOX 1000 DEPT 275		
SAMUEL P BILYEU MD MEMPHIS TN 38119-		MEMPHIS, TN 381480275		
		1699725812 ZZ2085R0202X		

# EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243

APPROVED BY NATIONAL UNIFORM CLAIM COMMITT	00000			PICA CTC	
A# 227290-0001 CNR534 P E 003  1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER			1a. INSURED'S I.D. NUMBER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
(Medicare #) (Medicaid #) (ID#/DoD#)  2 PATIENT'S NAME (Last Name, First Name, Middle In:	tial) (Member ID#) (ID#)	BIRTH DATE  BLK LUNG  (ID#)  X(ID#)	MB03549704 4 INSURED'S NAME (Last Name	First Name Middle Initial)	
RICE NANCY J 5 PATIENT'S ADDRESS (No. Street)		.9 1959 F X	RICE TIMOTH	Y	
4405 HWY 76			7 INSURED'S ADDRESS (No., Street) 4405 HWY 76		
CITY	STATE 8. RESERVED	FOR NUCC USE	CITY CITY	STATE	
MOSCOW  ZIP CODE TELEPHONE (Include	TN		MOSCOW ZIP CODE	TN TELEPHONE (Include Area Code)	
38057 (901) 331 9. OTHER INSURED'S NAME (Last Name, First Name, I		IT'S CONDITION RELATED TO	38057	901 331-1981	
	TO. IO PATIEN	TO CONDITION RELATED TO	1048800702	OR FEGA NUMBER	
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYME	ENT <sup>o</sup> (Current or Previous)	a INSURED'S DATE OF BIRTH	SEX	
b RESERVED FOR NUCC USE	b AUTO ACC	YES XNO PLACE (State)	07 23 1960		
c. RESERVED FOR NUCC USE	OTHER ACC	YES XNO			
	c OTHER ACC	YES XNO	© INSURANCE PLAN NAME OR P  EVOCARE		
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM C	ODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH I		
READ BACK OF FORM BET	ORE COMPLETING & SIGNING TH	IIS FORM.	13 INSURED'S OR AUTHORIZED	yes, complete items 9, 9a and 9d. PERSON'S SIGNATURE I authorize	
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATU to process this claim. I also request payment of gover below.			payment of medical benefits to I services described below	the undersigned physician or supplier for	
SIGNATURE ON FI	DATE	12/11/20	SIGNATU	JRE ON FILE	
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNA MM DD YY  OUAL	NCY (LMP) 15 OTHER DATE	MM DD YY	16. DATES PATIENT UNABLE TO YY	WORK IN CURRENT OCCUPATION MM DD YY	
17 NAME OF REFERRING PROVIDER OR OTHER SOL		Q00000X	18. HOSPITALIZATION DATES REI	ATED TO CURRENT SERVICES	
DN BARTON THRASHER MD  19 ADDITIONAL CLAIM INFORMATION (Designated by	17b NPI 174		FROM DD YY	TO DD YY	
			20. OUTSIDE LAB?  YES X NO	\$ CHARGES	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		IE) ICD Ind. 0	22 RESUBMISSION	RIGINAL REF. NO	
M810 B Z13820	0	D.	23. PRIOR AUTHORIZATION NUMB		
I J	G	H	23. PRIOR AUTHORIZATION NUMB	SER	
24 A DATE(S) OF SERVICE B From To PLACE OF	C. D. PROCEDURES, SERVI (Explain Unusual Circu			H. I J. Seri ID. RENDERING	
MM DD YY MM DD YY SERVICE I	EMG CPT/HCPCS	MODIFIER POINTER	\$ CHARGES OR UNITS	QUAL PROVIDER ID. #	
12 11 20 11	77078	AB	291 00 1	NPI 1649220120	
				NPI	
	1			ND	
				NPI	
				NPI	
			1 1 1	NPI	
25. FEDERAL TAX I D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29 A	MOUNT PAID 30 Rsvd for NUCC use	
621116618 X 31. SIGNATURE OF PHYSICIAN OR SUPPLIER	10242295D 32 SERVICE FACILITY LOCATIO	X YES NO	\$ 291 00 \$		
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	DIPC CT	The second secon	DIAGNOSTIC IM	301-2340	
apply to this bill and are made a part thereof )	6401 POPLAR A		PO BOX 1000 D		
ROBERT A DUKE MD MEMPHIS TN 38119-		MEMPHIS, TN 3	MEMPHIS, TN 381480275		
SIGNED 12/15/20TE	D.		1699725812 D	Z2085R0202X	