## EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243

BICA	00000 E 003	2	26425 PICA
1. MEDICARE         MEDICAID         TRICARE         CHAMPVA         GRC           (Medicare #)         (Medicaid #)         (ID#/DoD#)         (Member ID#)         (ID#/DoD#)	ALTH PLAN  BLK LUNG  (ID#)  X (ID#)	MB01493386	r Program in Item 1)
HEATH JOY 12	T'S BIRTH DATE DD   YY 09 1991 F X T RELATIONSHIP TO INSURED	INSURED'S NAME (Last Name, First Name, Middle     HEATH JOY     INSURED'S ADDRESS (No., Street)	e Initial)
2459 FLOWERING TREE DR	Spouse Child Other  VED FOR NUCC USE	2459 FLOWERING TRE	E DR
BARTLETT ZIP CODE TELEPHONE (Include Area Code)	VED FOR NOOD OSE	BARTLETT ZIP CODE TELEPHONE (Incl	TN
38134 (901) 219-1093	FIENT'S CONDITION RELATED TO:	/ \	219-1093
S. OTTELL HOOFE STATE (LEGS TRAINS)	YMENT? (Current or Previous)	1048800203 a. INSURED'S DATE OF BIRTH	SEX
AND	YES X NO ACCIDENT? PLACE (State)	12 09 1991 b. OTHER CLAIM ID (Designated by NUCC)	FX
c. RESERVED FOR NUCC USE c. OTHER	YES X NO ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
d INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAII	YES X NO M CODES (Designated by NUCC)	EVOCARE d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
READ BACK OF FORM BEFORE COMPLETING & SIGNING  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of an to process this claim. I also request payment of government benefits either to myself.	G THIS FORM. y medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGN payment of medical benefits to the undersigned p	ATURE I authorize
SIGNATURE ON FILE	10/28/20	services described below.  SIGNATURE ON	FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OT	DATETE MM DD YY	SIGNED  16. DATES PATIENT UNABLE TO WORK IN CURRE  MM   DD   YY   MN  FROM   TO	NT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 1GO	ГН000 417056409	18. HOSPITALIZATION DATES RELATED TO CURR FROM DD   YY MN FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	117030109	20. OUTSIDE LAB? \$ CHARC	GES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line belo  A   N6310 B   C.	W (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. N	0.
E. L G. L K. L	H. L.	23. PRIOR AUTHORIZATION NUMBER	
24. A.         DATE(S) OF SERVICE         B. PLACE OF From         C. PLACE OF TO TO PLACE OF TO	SERVICES, OR SUPPLIES I Circumstances)  MODIFIER  E DIAGNOSIS POINTER	F. G. H. I. DAYS EPSOT ID OR Family QUAL	RENDERING PROVIDER ID. #
10 28 20 11 76642 R	Т	198 00 1 NPI 1	649220120
		NPI	
		NPI	
		NPI NPI	
		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIENT'S ACCOUNT N 621116618 X 10200822	NO. 27 ACCEPT ASSIGNMENT? (For govt. claims, see back)  X YES NO	28. TOTAL CHARGE 29. AMOUNT PAID \$ 198 00 \$	30. Rsvd for NUCC us
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  32. SERVICE FACILITY LOG DIPC US 6401 POPLA.	CATION INFORMATION  R AVE	DIAGNOSTIC IMAGING PO BOX 1000 DEPT 27	5
ROBERT A DUKE MD MEMPHIS TN  SIGNED 11/02/2QATE a	38119-	MEMPHIS, TN 3814802 41699725812 ZZ2085R	The state of the s

# 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 000000	00		
A# 226442-000	1 CNR534 P E	020		226442 PICA
1. MEDICARE MEDICAID TRICARE  (Medicare #) (Medicaid #) (ID#/DoD#)	CHAMPVA GROUP HEALTH PL	AN FECA OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle II	(Member ID#) (ID#)  nitial) 3. PATIENT'S BIRT	(ID#) X (ID#)	MB04778289  4. INSURED'S NAME (Last Name,	Plant No. of the Control of the Cont
PATTERSON SALBETHA	MM I DD I	1985 F X		
5. PATIENT'S ADDRESS (No., Street)		TIONSHIP TO INSURED	PATTERSON SA 7. INSURED'S ADDRESS (No., Str	ALBETHA
650 MURRELL ST	Self X Spous		650 MURRELL	ST
	STATE 8. RESERVED FOR	R NUCC USE	CITY	STATE
OAKLAND ZIP CODE TELEPHONE (Include	le Area Code)		OAKLAND ZIP CODE	TN
38060 (662) 429	5-3492		38060	TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name,		CONDITION RELATED TO	11. INSURED'S POLICY GROUP (	662 425-3492 DR FECA NUMBER
OTHER MOURES POLICY OF COMMISSION			1048800303	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		(Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDEN	T? NO	05 27 1985 b. OTHER CLAIM ID (Designated by	
	Y	PLACE (State)	b. OTHER CLAIM ID (Designated b	y NUCC)
c: RESERVED FOR NUCC USE	c. OTHER ACCIDE	24	c. INSURANCE PLAN NAME OR P	ROGRAM NAME
- INCURANCE SUMMAN OF SECOND		ES XNO	EVOCARE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES	S (Designated by NUCC)	d. IS THERE ANOTHER HEALTH E	BENEFIT PLAN?
READ BACK OF FORM BE	FORE COMPLETING & SIGNING THIS FO	ORM		res, 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 government of govern	JRE I authorize the release of any medical rnment benefits either to myself or to the p	or other information necessary party who accepts assignment	payment of medical benefits to t services described below.	he undersigned physician or supplier for
SIGNATURE ON F		10/28/20	A MARKETS AND	JRE ON FILE
SIGNED	DATE	/ - × / ×===	SIGNED	ALL ON TILL
14. DATE OF CURRENT ILLNESS, INJURY, or PREGN		MM   DD   YY	16. DATES PATIENT UNABLE TO V	VORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SO	URCE 17a 1GOTH00	0	FROM  18. HOSPITALIZATION DATES REL	TO
DN SAMYA CRUZ MD	17b NPI 14170		MM   DD   YY	MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	\$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Doloto A.I. to sension line but. (ALE)		YES X NO	
N02201 D100		ICD Ind. 0	22 RESUBMISSION CODE O	RIGINAL REF. NO.
A N832UI B RIUZ	_ R109	D. L	23. PRIOR AUTHORIZATION NUMB	ITD.
1	G	H [	23. PHION ACTHONIZATION NUMB	ER
24. A. DATE(S) OF SERVICE B. From To PLACE OF	C. D. PROCEDURES, SERVICES, (Explain Unusual Circumsta	mone)		t. L. J.
	E110	DIFIER DIAGNOSIS POINTER	S CHARGES OF THE	SDT ID. RENDERING Mily QUAL PROVIDER ID. #
10 28 20 11	76830	ABC	262 20 1	
	70030	ABC	263 00 1	NPI 1043258247
				NPI
		, , , , , , , , , , , , , , , , , , , ,		NPI S
				NPI
				NPI
				NPI 3
25. FEDERAL TAX I.D NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29 A	NPI
621116618 X	10201093	X YES NO	\$ 263 00 \$	MOUNT PAID 30. Rsvd for NUCC use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. SERVICE FACILITY LOCATION INF		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.)		DIAGNOSTIC IMAGING PC		
6401 POPLAR AVE OI T VU MD MEMPHIS TN 38119-		PO BOX 1000 D		
SIGNED 11/02/2 <sub>1</sub> Q <sub>TE</sub>	MEMPHIS TN 38119-		MEMPHIS, TN 3	81480275
NHCC Instruction Manual and India			1699725812 Z	42085R0202X

## EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243 HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITT	0000000	74850 PICA
1 MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OT	THER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#) (ID#) X (IL	MB04311737  4. INSURED'S NAME (Last Name, First Name, Middle Initial)
2. PATIENT'S NAME (Last Name, First Name, Middle Ini	MM   DD   YY	
POWELL SANDRA J 5. PATIENT'S ADDRESS (No., Street)	07 14 1965 F	X POWELL SANDRA J 7 INSURED'S ADDRESS (No., Street)
	Self X Spouse Child Other	5856 EDGEWATER CV
5856 EDGEWATER CV	STATE 8. RESERVED FOR NUCC USE	CITY STATE
MEMPHIS	TN	MEMPHIS T
ZIP CODE TELEPHONE (Includ		ZIP CODE TELEPHONE (Include Area Code)
38134 (901) 381	-4062	38134 (901) 381-4062
9. OTHER INSURED'S NAME (Last Name, First Name,		11. INSURED'S POLICY GROUP OR FECA NUMBER
		1048800604
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
	YES X NO	07 14 1965 M
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (\$	State) b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	EVOCARE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
DEAD DADY OF FORM DE	FORE COMPLETING & CICNING THIS FORM	YES XNO If yes, complete items 9, 9a and 9d.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATU	FORE COMPLETING & SIGNING THIS FORM. JRE I authorize the release of any medical or other information necess rnment 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.
below.	and 20 pt 20	SIGNATURE ON FILE
SIGNATURE ON F		SIGNATURE ON FILE
SIGNED	DATEANCY (LMP) 15, OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY QUAL	QUAL. MM DD YY	FROM   DD   YY MM   DD   YY
17. NAME OF REFERRING PROVIDER OR OTHER SC		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN SAMYA CRUZ MD	17b NPI 1417056409	FROM DD YY MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by	(NUCC)	20. OUTSIDE LAB? \$ CHARGES
		YES X NO
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.
M79645		
E. L. F. L.	G. L. H. L.	23. PRIOR AUTHORIZATION NUMBER
1.	C D PROCEDURES, SERVICES, OR SUPPLIES E	E. F. G. H. I. J.
From To PLACE OF	(Explain Unusual Circumstances) DIAGI	NOSIS DAYS EPSDT ID RENDERING
MM DD YY MM DD YY SERVICE	EMG CPT/HCPCS   MODIFIER POIN	NTER S CHARGES UNITS Family QUAL PROVIDER ID #
10 28 20 11	73130 LT A	69 00 1 NPI 174024748
		NPI
		NPI NPI
		, NPI
		NPI NPI
		INF!
		NPI NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT ACCEPT ACCEPT ASSIGNMENT ACCEPT ACCEPT ACCEPT ACCEPT ACCEPT ACCEPT ASSIGNMENT ACCEPT	NT? 28 TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUC
621116618 X	10201135 (For govt claims, see bac	\$ 69 00 \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER	32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH. # (901) 387-234
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		DIAGNOSTIC IMAGING PC
apply to this bill and are made a part thereof.) 6401 POPLAR AVE		PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275
LOUIS S PARVEY MD		
11/02/2,Q <sub>TF</sub>		1699725812 ZZ2085R0202X