HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0 0 0 0 0 0 0				
A# 140371-0001 CNR534 P E 021	140371 PICA			
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (ID#) (Medicare #) (Medicare #) (Medicare #) (Medicare #) (Medicare #) (ID#/DoD#) (Member ID#) (ID#)	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	MB00829154 4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
GRAHAM CAYCE M 11 28 1975 X	GRAHAM CAYCE M			
5. PATIENT'S ADDRESS (No., Street)  6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)			
3482 EVENING LIGHT Self X Spouse Child Other CITY STATE 8 RESERVED FOR NUCC USE	3482 EVENING LIGHT			
BARTLETT TN	BARTLETT TN			
ZIP CODE TELEPHONE (Include Area Code)	ZIP CODE TELEPHONE (Include Area Code)			
38135 901 647 - 1209 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	38135 901 647-1209			
	BARTLETT TN  ZIP CODE TELEPHONE (Include Area Code)  38135 (901) 647-1209  11 INSUREDS POLICY GROUP OR FECA NUMBER  1048800604  a. INSURED'S DATE OF BIRTH  MM DD YY  11 28 1975 M F X			
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?	11 28 1975 b. OTHER CLAIM ID (Designated by NUCC)			
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	c. INSURANCE PLAN NAME OR PROGRAM NAME  EVOCARE  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize			
12. 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.	payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNATURE ON FILE 10/22/20	SIGNATURE ON FILE			
SIGNED DATE  14, DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)   15, OTHER DATE	SIGNED			
MM DD YY QUAL QUAL MM DD YY	FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 1GOTHO00	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM   DD   YY			
DN SAMYA CRUZ MD 17b. NPI 1417056409	FROM TO TO 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 0	22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. R928 B. N6321 C. D.	23. PRIOR AUTHORIZATION NUMBER			
E. L. G. H. L.	23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES E. From To PLACE OF (Explain Unusual Circumstances) DIAGNOSE	F. G. H. I J.  DAYS EPSOT ID. RENDERING S. CHARGES USES FRINNY OLIAL PROVIDER ID #			
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS I MODIFIER POINTER	GMIG THE GOVE THOUSENED IN			
10 22 20 11 76641 LT AB	240 00 1 NPI 1790044147			
AD AD	240 00 1 NPI 1790044147			
	NPI			
	NPI			
	NPI NPI			
	NPI NPI			
	NPI NPI			
	NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT? (For govi. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use			
621116618 X 10195980 X YES NO 31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION	\$ 240 00 \$ 33 BILLING PROVIDER INFO & PH. # (901) 397 3340			
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse DIPC US	DIAGNOSTIC IMAGING PC			
apply to this bill and are made a part thereof.)  6401 POPLAR AVE	PO BOX 1000 DEPT 275			
CASEY S TAYLOR MD MEMPHIS TN 38119-	MEMPHIS, TN 381480275			
SIGNED 10/27/29ATE a b	1699725812 ZZ2085R0202X			



BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (	(NUCC) 02/12 0000000				
	CNR534 P E 021	140371 PICA			
1. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (For Program in Item 1)			
(Medicare #) (Medicald #) (ID#/DoD#)	(Member 1D#) (ID#) (ID#) X (ID#)	MB00829154			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) GRAHAM CAYCE M	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)	11 28 1975 FX	GRAHAM CAYCE M			
3482 EVENING LIGHT		7. INSURED'S ADDRESS (No., Street)			
CITY EVENTING LIGHT		3482 EVENING LIGHT			
BARTLETT	TN	CITY STATE			
ZIP CODE TELEPHONE (Include Area		BARTLETT TN  ZIP CODE TELEPHONE (Include Area Code)			
38135 (901) 647-1	1209				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:		38135 (901) 647-1209  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	11 28 1975 M X			
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE	YES X NO				
O, NESERVED FOR NUCC USE		c INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES X NO	EVOCARE			
Solitan India	10d. CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?			
READ BACK OF FORM BEFORE	COMPLETING & SIGNING THIS FORM.	YES X NO If yes, complete items 9, 9a and 9d.			
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Is to process this claim. I also request payment of government</li> </ol>	COMPLETING & SIGNING THIS FORM. authorize the release of any medical or other information necessary in benefits either to myself or to the party who accepts assignment	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>			
SIGNATURE ON FILE	10/22/20	services described below.			
SIGNED	DATE	SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY	(LMP) 15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM   DD   YY MM   DD   YY			
QUAL	QUAL.	FROM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	1741 100111000	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
DN SAMYA CRUZ MD	17b NPI 1417056409	FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC	C) 2	20 OUTSIDE LAB? \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Rela	ato A L to conside line heles (OAT)	YES X NO			
R928 N6221	ICD Ind. 0	22 RESUBMISSION CODE ORIGINAL REF. NO.			
B NOSZI	C	22 PRIOR AUTHORIZATION AND APPLIA			
F	G H	23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE B. C.	D. PROCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I J.			
From	(Explain Unusual Circumstances) DIAGNOSIS CPT/HCPCS   MODIFIER POINTER	DAYS EPSDT ID. RENDERING			
	CPT/HCPCS   MODIFIER POINTER	\$ CHARGES ON PROVIDER ID. #			
10 22 20 11	77065 LT AB	330 00 1 NPI 1790044147			
10 22 20		1/3001111/			
10 22 20 11	G0279 AB	143 00 1 NPI 1790044147			
		NPI -			
		NPI			
		NPI			
		NEW COLUMN			
Social property and the second	PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 2	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use			
	10195972   X YES   NO   \$	473 00 s			
INCLUDING DEGREES OF CREDENTIALS	SERVICE FACILITY LOCATION INFORMATION 3:	3. BILLING PROVIDER INFO & PH. # (901) 387-2340			
(I certify that the statements on the reverse		DIAGNOSTIC IMAGING PC			
6401 POPLAR AVE		PO BOX 1000 DEPT 275			
MEMPHIS TN 38119-		MEMPHIS, TN 381480275			
SIGNED 10/27/20ATE a.	109850	1699725812 ZZ2085R0202X			

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0 0 0 0 0	000				
PICA A# 226247-0001 CNR534 P E			226247 PICA		
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUI  (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#/	FECA OTHER BLK LUNG (ID#)  X (ID#)	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S	MB00674951 4. INSURED'S NAME (Last Name, Fire	st Name Middle Initial)			
HART JARED C 07 0	5 1977 X	HART JARED C	or reality, (modific limital)		
	ELATIONSHIP TO INSURED	TART JARED C  7. INSURED'S ADDRESS (No., Street)			
The second secon	pouse Child Other	588 FELLOWSHIP BAPTIST CH RD			
CITY STATE 8 RESERVED	FOR NUCC USE	CITY	STATE		
MILLINGTON TN ZIP CODE TELEPHONE (Include Area Code)		MILLINGTON ZIP CODE TEL	TN		
38053 (901) 848-9093		Files Societies	LEPHONE (Include Area Code)		
	IT'S CONDITION RELATED TO:	38053	901 848-9093 FECA NUMBER		
		1048800303	. ESTITIONISE!		
YES X NO		a. INSURED'S DATE OF BIRTH SEX			
		07 05 1977 MX			
b. RESERVED FOR NUCC USE b. AUTO ACC	PLACE (State)	b. OTHER CLAIM ID (Designated by N	IUCC)		
c. RESERVED FOR NUCC USE c. OTHER AC	YES X NO L	c. INSURANCE PLAN NAME OR PRO	OCDAN NAME		
C SILLIAG	YES X NO		JGHAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM C	ODES (Designated by NUCC)	EVOCARE  d. IS THERE ANOTHER HEALTH BEY	NEFIT PLAN?		
		YES X NO If yes	c, complete items 9, 9a and 9d.		
READ BACK OF FORM BEFORE COMPLETING & SIGNING TO 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any more signature.	edical or other information necessary	13. INSURED'S OR AUTHORIZED PE	RSON'S SIGNATURE I authorize undersigned physician or supplier for		
to process this claim. I also request payment of government benefits either to myself or to below.	the party who accepts assignment	services described below	andereigned physician or supplier for		
SIGNATURE ON FILE	10/26/20		E ON FILE		
SIGNED DAT  14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)   15. OTHER DATE		SIGNED	ADV IN CURRENT OCCURATION		
MM DD YY QUAL QUAL	MM DD YY	FROM DD YY	MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 1GOTH	000	18. HOSPITALIZATION DATES RELAT	TED TO CURRENT SERVICES		
DN SAMYA CRUZ MD 176. NPI 141	7056409	FROM DD YY	TO 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 (2	4E)	YES X NO			
A   R0789 B   R062 C   R05	ICD Ind.	CODE ORIO	GINAL REF. NO.		
F G	D. L	23. PRIOR AUTHORIZATION NUMBER	3		
J. L. K. L.	L	10,000,000,000,000,000,000,000,000,000,			
24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERV (Explain Unusual Circ	(umotonooo)	F G H	I J J		
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS I	MODIFIER DIAGNOSIS POINTER	\$ CHARGES DAYS EPSDI OR Family Plan	D. RENDERING OUAL. PROVIDER ID. #		
10 20 20 11 71046 06	220				
10 20 20 11 71046 Q6	ABC	81 00 1	NPI 1649220120		
			NPI I		
			NPI		
			NPI		
			NPI		
			NPI		
			NPI .		
25. FEDERAL TAX I.D NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOTAL CHARGE 29 AMO	OUNT PAID 30. Rsvd for NUCC use		
621116618 X 10195584	X YES NO	\$ 81 00 \$			
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 apply to this bill and are made a part thereof.)  DIPC R&F 6401 POPLAR AVE		DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275			
ROBERT A DUKE MD MEMPHIS TN 38					
7.0./0.0./0.0		MEMPHIS, TN 381480275 1699725812 ZZ2085R0202X			

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMM	ITTEE (NUCC) 02/12 000	00000					
A# 226247-000	1 01	E 003				22624	PICA TIT
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER				1a. INSURED'S I.D. NUMBER (For Program in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle	(Member ID#) (IE	(ID#)	X (ID#)	MB00674			
HART JARED C	MM	NT'S BIRTH DATE	SEX	4 INSURED'S NAME	(Last Name, Fi	irst Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	0.7	05 1977 X	F	HART JA	ARED C		
588 FELLOWSHIP BAPT	The state of the s		Other	7. INSURED'S ADDRESS (No., Street)			
CITY		RVED FOR NUCC USE	Omer	588 FELLOWSHIP BAPTIST CH RD			
MILLINGTON	TN			141141111111111111111111111111111111111	TITONI		STATE
ZIP CODE TELEPHONE (Inclu	ensual poet ( poetal)			MILLING ZIP CODE		LEPHONE (Include Area	TN Code)
38053 (901) 84	8-9093			38053		(901) 848-	
9. OTHER INSURED'S NAME (Last Name, First Name	, Middle Initial) 10. IS PA	TIENT'S CONDITION REL	ATED TO:	11. INSURED'S POLI	CY GROUP OR	FECA NUMBER	9093
a. OTHER INSURED'S POLICY OR GROUP NUMBER	P. FUDIO	W.F.		1048800	303		
S S S S S S S S S S S S S S S S S S S	a EMPLO	YMENT? (Current or Prev		a. INSURED'S DATE		SEX	9
b. RESERVED FOR NUCC USE	b. AUTO A	YES X NO		07 05	1977	MX	F
		YES X NO	PLACE (State)	b. OTHER CLAIM ID (	Designated by N	NUCC)	9
c. RESERVED FOR NUCC USE	c. OTHER	ACCIDENT?		c INSURANCE PLAN	NAME OF PRO	OCDAM NAME	4
		YES X NO		EVOCARE		JGHAW NAME	1
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAII	M CODES (Designated by		d. IS THERE ANOTHE	R HEALTH BEI	NEFIT PLAN?	F
DEAD DACK OF FORM OF				YES X	NO If yes	complete items 9, 9a and	1 9d
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNAT to process this claim. I also request payment of gov below.	EFORE COMPLETING & SIGNING URE I authorize the release of any	THIS FORM.  medical or other informat	ion necessary	13. INSURED'S OR AU	ITHORIZED PE	RSON'S SIGNATURE I au undersigned physician or	Alle and a second
SIGNATURE ON F	TT D			services described	helow.	undersigned physician or	supplier for
SIGNED		10/26/:	20	CONTRACTOR OF THE PROPERTY OF	GNATUR	E ON FILE	
14 DATE OF CURRENT ILLNESS, INJURY, or PREGN	NANCY (LMP) 15. OTHER DAT			SIGNED	MARIE TO WO	PRK IN CURRENT OCCUP	<u> </u>
QUAL	QUAL	MM DD	YY	FROM DE	YY YY	TO MM   DD	PATION
17. NAME OF REFERRING PROVIDER OR OTHER SO	DURCE 17a. 1GOT	H000		18 HOSPITALIZATION	DATES RELAT	ED TO CURRENT SERVI	CES
DN SAMYA CRUZ MD	17b. NPI 14	17056409		FROM MM   DE	) YY	MM DD	YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20 OUTSIDE LAB? \$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJUR	Y Relate A-L to service line below	(245)		YES X	NO		
R0781 B S2231X	77	ICD Ind. 0		22. RESUBMISSION CODE	ORIG	GINAL REF. NO.	
E. L	C. L.	D		23. PRIOR AUTHORIZA	TION NUMBER		
I	К. L	H		20. THIOTI NOTHONIZA	TION NUMBER		
24. A. DATE(S) OF SERVICE B. From To PLACE OF	C. D. PROCEDURES, SE (Explain Unusual (	RVICES, OR SUPPLIES	E.	F.	G. H.	L J.	
AMA DD	EMG CPT/HCPCS I	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS ERSDT Family	TICHOL	1000 0000
10 26 20 11					UNITO Pan	QUAL PROVIDE	H ID.#
10 26 20 11	71101		AB	91 00	1	NPI 164922	0120 5
	1	1 1 1	Y				Z
						NPI	SUPPLER INFORMA
		1-1-1-				ND	
						NPI	
						NPI	
	1	1 1 1					
						NPI	
	1	1 1 1					PHYSICIAN
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASS	IGNMENT?	28. TOTAL CHARGE	20 44401	NPI	
621116618 X	10198216	X YES	see back) NO	\$ 91 0	29. AMOL	UNI PAID 30 Rsvd	for NUCC use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. SERVICE FACILITY LOCAT	ION INFORMATION		33. BILLING PROVIDER		(901) 207	2240
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		DIAGNOSTIC IMAGING PC			2340		
			PO BOX 1000 DEPT 275				
DODEDT A DITTE ME	6401 POPLAR			PO BOX 10	00 DEP	T 275	
ROBERT A DUKE MD SIGNED 10/28/20ATF	6401 POPLAR MEMPHIS TN 3			PO BOX 10 MEMPHIS,	00 DEP	T 275	