

EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

HEALTH INSURANCE CLAIM FORM							
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 00000000							
A# 226993-0001	CNR534 P E 020 CHAMPVA GROUP FECA OTHER	226993PICA 1					
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#) BLK LUNG (ID#) X(ID#)	MB04111491					
2. PATIENT'S NAME (Last Name, First Name, Middle Initia	al) 3. PATIENT'S BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)					
PAPPAS ANTHONY 10 26 1990 X		PAPPAS ANTHONY					
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)					
1445 DEXTER LAKE DR Self X Spouse Child Other		1445 DEXTER LAKE DR					
COPPOLA	STATE 8. RESERVED FOR NUCC USE	CITY STATE					
CORDOVA ZIP CODE TELEPHONE (Include A	TN Area Code)	CORDOVA TN					
38016 ()		(Include Alea Code)					
OTHER INSURED'S NAME (Last Name, First Name, Michael Name)	ddle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	38016 () 11. INSURED'S POLICY GROUP OR FECA NUMBER					
		STATE OF SELECT STATE OF THE ST					
a OTHER INSURED'S POLICY OR GROUP NUMBER a: EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH SEX					
	YES XNO	10 26 1990 MX					
b RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)					
DEAGE AND ALLES	YES XNO						
c. RESERVED FOR NUCC USE	c OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES XNO 10d. CLAIM CODES (Designated by NUCC)	EVOCARE					
	Toda Servini Sobes (Besignated by 14000)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
READ BACK OF FORM BEFOR	DRE COMPLETING & SIGNING THIS FORM.	YES XNO If yes, complete items 9, 9a and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize					
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of government. 	E I authorize the release of any medical or other information necessary ment 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					
SIGNATURE ON FII		SIGNATURE ON FILE					
SIGNED	DATE	SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANO MM , DD , YY	ICY (LMP) 15 OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
QUAL	QUAL	FROM MM DD YY TO MM DC YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. ZZ207R00000X		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY					
DN DOUGLAS ODEA MD 17b NPI 1316974132 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		FROM TO					
The state of the	500,	20. OUTSIDE LAB? S CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. R	Relate A-L to service line below (24E) ICD Ind. 0	YES XNO 22. RESUBMISSION					
M25551 B M25552	M545	CODE ORIGINAL REF. NO.					
E. L F. L	G.L. H.I	23. PRIOR AUTHORIZATION NUMBER					
J	K						
24. A DATE(S) OF SERVICE B. C From To PLACE OF	D. PROCEDURES, SERVICES, OR SUPPLIES E. (Explain Unusual Circumstances)	F. G. H. I. J.					
MM DD YY MM DD YY SERVICE EM	MG CPT/HCPCS MODIFIER POINTER	\$ CHARGES OR FIRM QUAL PROVIDER ID. #					
11 24 20 11	HIP 73721 RT A	1000 00 1					
11 21 20	HIP A	1023 00 1 NPI 1043258247					
11 24 20 11	73721 LT B	1023 00 1 NP 1043258247					
		1023 00 1 NPI 1043258247					
11 24 20 11	72148 C	1068 00 1 NPI 1043258247					
		Ū					
		NPI NPI					
		NPI 0					
		3					
25. FEDERAL TAX I.D. NUMBER SSN EIN 2	26 PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	NPI					
621116618 X	10228385 XYES NO	s 3114 00 s					
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 MRI SIEMENS		DIAGNOSTIC IMAGING PC					
6401 POPLAR AVE		PO BOX 1000 DEPT 275					
LOI T VU MD MEMPHIS TN 38119-		MEMPHIS TN 381480275					

ZZ2085R0202X

a1699725812 b



EVOCARE C/O ACCOUNTS PAYABLE 4735 MELISSA WAY

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 0 0 0 0 0 0 0						
PICA A# 226602-0001 CNR534 P E 019 22660						
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) MB05656344					
PATIENT'S NAME (Last Name, First Name, Middle Initial) PATIENT'S BIRTH DATE SEX MM DD	INSURED'S NAME (Last Name, First Name, Middle Initial)					
HENRIQUEZ ANNA L 01 27 1973 F X 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	HENRIQUEZ WILFREDO 7. INSURED'S ADDRESS (No., Street)					
2153 WOODFIELD PARK RD Self Spouse X Child Other	2153 WOODFIELD PARK RD					
MEMPHIS STATE 8. RESERVED FOR NUCC USE	CITY					
ZIP CODE TELEPHONE (Include Area Code)	MEMPHIS TN ZIP CODE TELEPHONE (Include Area Code)					
38134 (901) 267 - 6167 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO	38134 (90) 267-6167					
10. IS PATIENTS CONDITION RECATED TO	1048800604					
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 YES XNO	11 05 1968 M X F					
YES XNO						
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? YES XNO	C. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	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 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.	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 11/24/20	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 TO TO					
77. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178. 1GOTH000 DN SAMYA CRUZ MD 176. NPI 1417056409	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY					
DN SAMYA CRUZ MD 17b NPI 1417056409 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	PROM TO 20. OUTSIDE LAB? \$ CHARGES					
ACTUAL INVOICE COST 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate A-L to service line below (24E)	YES XNO					
A R930 B J341 C G9389	22. RESUBMISSION CODE ORIGINAL REF. NO.					
E. L G. L H. L	23. PRIOR AUTHORIZATION NUMBER					
L	F. G. H I J.					
From To FLACE OF PLACE OF PLACE OF MM DD (Explain Unusual Circumstances) DIAGNOSIS MM DD YY MM DD YY SERVICE EMG CPT/HCPCS I MODIFIER POINTER	DAYS EPSOT ID. RENDERING S CHARGES UNITS PAID PAID QUAL PROVIDER ID. #					
11 24 20 11 70553 ABC	1455 00 1 NPI 1669553764					
11 24 20 11 A9575 ABC	26 25 15 NPI 1669553764					
	NPI					
	NPI					
	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) X 10228179 X VES NO.	28 TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFORMATION	\$ 1481 25 s 33 BILLING PROVIDER INFO & PH. # (901 387-2340					
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereot.) DIPC MRI SIEMENS	DIAGNOSTIC IMAGING PC					
SAMUEL P BILYEU MD MEMPHIS TN 38119-	PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275					
SIGNED 12/01/20TE a. MEMPHIS IN 38119-	a1699725812 b 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# 226976-0001 CNR534 P E 019 226976						
(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) BLK LUNG (ID#) Y(ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) MB02227439					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
VAUGHAN JOSEPH F 09 26 1979 X F 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED	VAUGHAN JESSICA					
3468 EVENING LIGHT Self Spouse X Child Other	7. INSURED'S ADDRESS (No., Street)					
CITY STATE 8. RESERVED FOR NUCC USE	3468 EVENING LIGHT					
BARTLETT TN ZIP CODE TELEPHONE (Include Area Code)	BARTLETT TN					
38135 (901) 485-4682	ZIP CODE TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:	38135 (901) 485-4682 11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Provious)	1048800604					
Tourist of Hevita's	a. INSURED'S DATE OF BIRTH MM DD YY OO 1 10 10 11 M F F F					
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State)	09 18 1981 M F X					
YES XNO	(-505/1055)					
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT?	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?					
	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 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.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for					
SIGNATURE ON FILE 11/24/20	services described below,					
SIGNED DATE	SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
QUAL. QUAL	FROM					
DN JAY M SAENZ MD 176 NPI 1235140211	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY					
19 ADDITIONAL CLAIM INFORMATION (Pagingated by MUCC)	20. OUTSIDE LAB? \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	YES XNO					
A M48061 B M5126 C M5416	22. RESUBMISSION CODE ORIGINAL REF. NO.					
	23. PRIOR AUTHORIZATION NUMBER					
I. J. K. L. 24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES. SERVICES, OR SUPPLIES E.						
From To PLACE OF (Explain Unusual Circumstances) DIAGNOSIS	F G. H. J. J. DAYS EPSOT ID. RENDERING					
TO A COLUMN TO THE POINTER	\$ CHARGES OR Family QUAL PROVIDER ID #					
11 24 20 11 72148 ABC	1068 00 1 NPI 1669553764 NPI NPI					
	NPI U					
	NPI NPI					
	NPI NPI					
	IND					
	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use					
621116618 X 10229193 X YES NO \$	1068 00 8					
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse DTPC MRT STEMENC	BILLING PROVIDER INFO & PH # (901 387-2340					
6401 POPLAR AVE	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275					
MEMPHIS TN 38119- MEMPHIS, TN 381480275						
SIGNED 12/01/20TE a b. a	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		2270E O PIGA					
PICA A# 227050-0001 CNR534	1a INSURED'S I.D. NUMBER (For Program in Item 1)						
1. MEDICARE MEDICAID TRICARE CHAMPV (Medicare #) (Medicaid #) (ID#/DoD#) (Member	- HEALTH PLAN - BLK LUNG	MB03270310	(1 of 1 togram in them 1)				
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		INSURED'S NAME (Last Name, First Name, Middle Initial)					
RINGOLD AMBER	10 13 1983 FX	RINGOLD AMBER					
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)					
2452 W GEMINI CV	Self X Spouse Child Other	2452 W GEMINI CV					
CITY	o. Heachtes Forthers and	BARTLETT	STATE				
BARTLETT TN ZIP CODE TELEPHONE (Include Area Code)	-	ZIP CODE TELEPHONE (Include Area Code)					
38134 (901) 485-2861		38134 (901) 485-2861					
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 NUM	IBER				
		1048800504					
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH	SEX F 🔻				
	b. AUTO ACCIDENT?	10 13 1983	FX				
b. RESERVED FOR NUCC USE	PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	1				
c. RESERVED FOR NUCC USE	c OTHER ACCIDENT?	c INSURANCE PLAN NAME OR PROGRAM NA	ME				
c. RESERVED FOR NOCC USE	YES X NO	EVOCARE					
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN	N?				
		YES XNO If yes, complete items 9, 9a and 9d.					
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits eit	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for						
nelow		services described below. SIGNATURE ON	ק.ודק ז				
SIGNATURE ON FILE	11/30/20	SIGNED	, ribb				
SIGNED	OTHER DATE	16 DATES PATIENT UNABLE TO WORK IN CUI					
MM DD YY QUAL QUAL		FROM YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 1GOTH000		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY					
DN DAVID COHEN MD 175. NPI 1891912556		FROM TO					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? \$ CHARGES					
ACTUAL INVOICE COST 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to se	rvice line below (24E)	22 RESUBMISSION					
D259 B N920 C	ICD Ind.	CODE ORIGINAL REF	F. NO.				
A B C.	H.L	23. PRIOR AUTHORIZATION NUMBER					
↓ J. L. K.	L.						
24. A. DATE(S) OF SERVICE B. C. D. PRO From To PLACE OF (E:	OCEDURES, SERVICES, OR SUPPLIES E. CARDINIO DIAGNOSIS	F. G. H. I. DAYS EPSOT ID	J. RENDERING				
MM DD YY MM DD YY SERVICE EMG CPT/HC		\$ CHARGES DAYS EPSOT OR Family QUAL	PROVIDER ID. #				
1 11 30 20 11 721	95 AB	1068 00 1 NPI	1669553764				
11 30 20 11 72							
2 11 30 20 11 A95	75 AB	35 00 20 NPI	1669553764				
3							
9		I NPI					
4		NPI					
	i i i	NI-1					
5		NPI					
6							
6	A ACCOUNT ACCOUNT ACCOUNTS	NPI 28. TOTAL CHARGE 29. AMOUNT PAI	ID 30. Rsvd for NUCC use				
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S 1023	27 ACCEPT ASSIGNMENT? (For govt claims, see back) X YES NO	28. TOTAL CHARGE 29. AMOUNT PAI	So, restu for NOCC use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE	FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # / 9	01 387-2340				
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse DIPC	DIAGNOSTIC IMAGING PC						
apply to this bill and are made a part thereof.) 6401 POPLAR AVE		PO BOX 1000 DEPT 275					
CAMILET D BILVEII MD MEMPHIS TN 38119-		MEMPHIS, TN 381480275					

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