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

5689

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

00000000

PICA

A# 227387-0001 CNR534 P E 001

227387 PICA

CARRIER

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#) X (ID#)	MB00296623
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) TODD ANGELA	3. PATIENT'S BIRTH DATE MM DD YY SEX 02 04 1971 F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial) TODD ANGELA	
5. PATIENT'S ADDRESS (No., Street) 3215 YUKON DR	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) 3215 YUKON DR	
CITY LAKELAND	STATE TN
8. RESERVED FOR NUCC USE	
CITY LAKELAND	STATE TN
ZIP CODE 38002	TELEPHONE (Include Area Code) (901) 382-3190
ZIP CODE 38002	TELEPHONE (Include Area Code) (901) 382-3190
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 NUMBER 1048800403	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX 02 04 1971 M F X	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES X NO
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? 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? YES X NO *If yes,* complete items 9, 9a and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.
SIGNATURE ON FILE SIGNED 12/17/20 DATE

13. 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 SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN DAN OTTEN MD	17a. ZZ207RC0000X 17b. NPI 1508088162	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		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 A. I517 B. I361 C. I340 D. I10 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 17 20	11		93306	ABCD	660 00	1		NPI	1740247485
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								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. AMOUNT PAID	30. Rsvd for NUCC use
621116618 X	10248037	X YES NO	$ 660 00	$	

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 LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (901) 387-2340
LOUIS S PARVEY MD SIGNED 12/23/20 DATE	DIPC US 6401 POPLAR AVE MEMPHIS TN 38119- a. b.	DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 a 1699725812 b ZZ2085R0202X

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF 16 ENV WHCF 16 ENV SS

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

5689

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

A# 126613-0001 CNR534 00000000 P E 003

126613 PICA

CARRIER

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER: X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): MB03447814
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): GARRISON JAMIE L	4. INSURED'S NAME (Last Name, First Name, Middle Initial): GAMSON EDWARD
3. PATIENT'S BIRTH DATE MM DD YY: 10 09 1982 SEX F: X	7. INSURED'S ADDRESS (No., Street): 12311 LONGHORN DR
5. PATIENT'S ADDRESS (No., Street): 12311 LONGHORN DR	CITY: ARLINGTON STATE: TN
6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse: X / Child / Other	ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 517-8119
CITY: ARLINGTON STATE: TN	11. INSURED'S POLICY GROUP OR FECA NUMBER: 1048800702
8. RESERVED FOR NUCC USE	a. INSURED'S DATE OF BIRTH MM DD YY: 12 19 1977 SEX M: X F:
ZIP CODE: 38002 TELEPHONE (Include Area Code): (901) 517-8119	b. OTHER CLAIM ID (Designated by NUCC):
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	c. INSURANCE PLAN NAME OR PROGRAM NAME: EVOCARE
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO: X — *If yes,* complete items 9, 9a and 9d.
b. RESERVED FOR NUCC USE:	
c. RESERVED FOR NUCC USE:	
d. INSURANCE PLAN NAME OR PROGRAM NAME:	

SECOND FOLD

PATIENT AND INSURED INFORMATION

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES / NO: X
b. AUTO ACCIDENT? YES / NO: X PLACE (State):
c. OTHER ACCIDENT? YES / NO: X
10d. CLAIM CODES (Designated by NUCC):

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.
SIGNED: SIGNATURE ON FILE DATE: 12/04/20

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SAMYA CRUZ MD	17a. 1GOTH000 17b. NPI 1417056409
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES / NO: X $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. R2232 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1 12 04 20	11		76882		A	92 00	1		NPI	1649220120
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 621116618 X	26. PATIENT'S ACCOUNT NO.: 10235562	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES: X / NO	28. TOTAL CHARGE: $ 92 00	29. AMOUNT PAID: $	30. Rsvd for NUCC use
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.) ROBERT A DUKE MD SIGNED 12/08/20 DATE	32. SERVICE FACILITY LOCATION INFORMATION DIPC US 6401 POPLAR AVE MEMPHIS TN 38119- a. NPI b.		33. BILLING PROVIDER INFO & PH. # (901) 387-2340 DIAGNOSTIC IMAGING PC PO BOX 1000 DEPT 275 MEMPHIS, TN 381480275 a. 1699725812 b. ZZ2085R0202X		

EVOCARE
C/O ACCOUNTS PAYABLE
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BIRMINGHAM AL 35243

5689

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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PICA

A# 227265-0001 CNR534 P E 019

227265 PICA

CARRIER

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X (ID#)	ME03058721
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX
WINKLER AMBER	03 24 1983 F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
WINKLER AMBER	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
7950 OAK PEBBLE CV	Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
7950 OAK PEBBLE CV	
CITY / STATE	8. RESERVED FOR NUCC USE
MILLINGTON TN	
CITY / STATE	
MILLINGTON TN	
ZIP CODE / TELEPHONE (Include Area Code)	
38053 (901) 647-8933	
ZIP CODE / TELEPHONE (Include Area Code)	
38053 (901) 647-8933	
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 NUMBER	
1048800103	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
	03 24 1983 M F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES X NO
	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? 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? YES X NO *If yes,* complete items 9, 9a and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 12/10/20

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ZZ363L00000X	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN LAURA ERICKSON-BLY NP	17b NPI 1659674208	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO $ CHARGES
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 R079 B R0602 C D E F G H I J K L		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 12 10 20	11		71046		AB	81 00	1		NPI	1669553764
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									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. AMOUNT PAID	30. Rsvd for NUCC use
621116618 X	10242899D	X YES NO	$ 81 00	$	

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 LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (901) 387-2340
SAMUEL P BILYEU MD	DIPC R&F	DIAGNOSTIC IMAGING PC
SIGNED 12/15/20 DATE	6401 POPLAR AVE	PO BOX 1000 DEPT 275
	MEMPHIS TN 38119-	MEMPHIS, TN 381480275
	a	a 1699725812 b ZZ2085R0202X

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF 10-ENV / WHCF 10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

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

5689

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

00000000

PICA

A# 227290-0001 CNR534 P E 003

227290 PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MB03549704

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RICE NANCY J

3. PATIENT'S BIRTH DATE MM DD YY: 11 19 1959 SEX F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): RICE TIMOTHY

5. PATIENT'S ADDRESS (No., Street): 4405 HWY 76

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse X Child Other

7. INSURED'S ADDRESS (No., Street): 4405 HWY 76

CITY: MOSCOW STATE: TN

8. RESERVED FOR NUCC USE

CITY: MOSCOW STATE: TN

ZIP CODE: 38057 TELEPHONE (Include Area Code): (901) 331-1981

ZIP CODE: 38057 TELEPHONE (Include Area Code): (901) 331-1981

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 NUMBER: 1048800702

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 07 23 1960 SEX M X F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO X

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? YES NO X *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.
SIGNED: SIGNATURE ON FILE DATE: 12/11/20

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN BARTON THRASHER MD

17a. ZZ207Q00000X

17b NPI 1740223460

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A M810 B Z13820 C D
E F G H
I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL	J RENDERING PROVIDER ID. #
1 12 11 20		11		77078		AB	291 00	1		NPI	1649220120
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 621116618 X

26. PATIENT'S ACCOUNT NO.: 10242295D

27. ACCEPT ASSIGNMENT? (For govt. claims, see back.) X YES NO

28. TOTAL CHARGE: $ 291 00

29. AMOUNT PAID: $

30. Rsvd for NUCC use

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.)
ROBERT A DUKE MD
SIGNED 12/15/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION
DIPC CT
6401 POPLAR AVE
MEMPHIS TN 38119-
a. b.

33. BILLING PROVIDER INFO & PH. # (901) 387-2340
DIAGNOSTIC IMAGING PC
PO BOX 1000 DEPT 275
MEMPHIS, TN 381480275
a 1699725812 b ZZ2085R0202X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV WHCF-10-ENV-SS

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