

BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

PROVED BY NATIONAL UNIFOR	M CLAIM COMMITTEE (NUCC) 02/12	00000000

PICA A# 226554-0001 CN	R534 P E 019	226554 PICA	
1. MEDICARE MEDICAID TRICARE	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG	1a. INSURED'S I.D. NUMBER (For Program in Item 1	
(Medicare #) (Medicaid #) (ID#/DoD#)	(Member ID#) (ID#) (ID#) X (ID#)	MB01430656	
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)	
DONALDSON ROGER B 5. PATIENT'S ADDRESS (No., Street)	10 24 1960 X	DONALDSON ROGER B	
1775 PLINE SEPTEMBER MEDITAL STREET STREET	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
338 HARRIS ST	Self X Spouse Child Other	338 HARRIS ST	
CITY	STATE 8. RESERVED FOR NUCC USE	CITY	
COLLIVERVILLE  ZIP CODE TELEPHONE (Include Area Co	TN		$\Gamma N$
/ / /	70-5%	ZIP CODE TELEPHONE (Include Area Code)	
38017 (901) 574-29		38017 (901) 574-2904	1
9 OTHER INSURED'S NAME (Last Name First Name, Middle Init	itial) 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
- OTHER INCHES IN POLICY OF SPORIS AND SEC		1048800701	
a OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX	
L DEOEDIED SOD MUSE ME	YES X NO	10 24 1960 M X	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
DESCRIPTION FOR ALLOS LIST	YES X NO		
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
L NOUTH NOT TO A STATE OF THE S	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 PERSON		YES X NO If yes, complete items 9, 9a and 9d.	
READ BACK OF FORM BEFORE CO  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I auth to process this claim. I also request payment of government be	OMPLETING & SIGNING THIS FORM.  For ize the release of any medical or other information necessary	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier</li> </ol>	for
Delow		services described below.	101
SIGNATURE ON FILE	11/03/20	SIGNATURE ON FILE	
SIGNED	DATE	SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LN MM   DD   YY	MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM , DD , YY	
QUAL.	QUAL.	FROM	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1GOTH000	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
DN SAMYA CRUZ MD  19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17b. NPI 1417056409	FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A	All to service line below (24E)	YES X NO	
R918 J432	ICD Ind.	22 RESUBMISSION CODE ORIGINAL REF. NO.	
В	C J438 D R05	CO. DOUGD AUTHORIZATION AND TOTAL	
E F	G H	23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE B. C.	D. PROCEDURES, SERVICES, OR SUPPLIES E.	F G. H. J. J.	
From To PLACE OF	(Explain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J.  DAYS EPSOT ID. RENDERING	
MM DD YY MM DD YY SERVICE EMG	CPT/HCPCS   MODIFIER POINTER	S CHARGES UNITS Plan QUAL. PROVIDER ID #	
11 03 20 11	71250 ABCD	652 00 1	
	71250 ABCD	652 00 1 NPI 166955376	4
		NPI NPI	
	1 1 1 1 1 1		
		NPI NPI	
	1 1 1 1 1 1		
		NPI NPI	
		NPI	
25. FEDERAL TAX I.D NUMBER SSN EIN 26. PA	TIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGE   29. AMOUNT PAID   30. Rsvd for NUC	· · · ·
	1200E10 (For govt claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUC.	
SIGNATURE OF PHYSICIAN OR SUPPLIER     32. SEI	RVICE FACILITY LOCATION INFORMATION		0
INCLUDING DEGREES OR CREDENTIALS	PC CT	33. BILLING PROVIDER INFO & PH # (901) 387-234 DIAGNOSTIC IMAGING PC	U
apply to this bill and assumed a post throught	01 POPLAR AVE		
	MPHIS TN 38119-	PO BOX 1000 DEPT 275	
11/09/20	TITED IN DOILE	MEMPHIS, TN 381480275	
SIGNED II/ 09/2DATE a.	N F	a1699725812 b ZZ2085R0202X	

BIRMINGHAM AL 35243

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12  00000000			
A# 144206-0001 CNR53	1a INSURED'S LD NUMBER	144206 PICA	
	1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER (Medicare #) (Me		(For Program in Item 1)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	MB04616354  4. INSURED'S NAME (Last Name, First Na	nme, Middle Initial)
HALFORD CHARLES  5. PATIENT'S ADDRESS (No., Street)	12 14 1962 X F	HALFORD CHARLE:	S
11787 PATRICK ST	Self X Spouse Child Other	11787 PATRICK	СT
CITY STA	TE 8 RESERVED FOR NUCC USE	CITY	STATE
	ΓN	ARLINGTON	TN
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPH	HONE (Include Area Code)
38002   901 825-0752 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	38002 :	901 825-0752
3	to to the total of		ANOMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	1048800103 a INSURED'S DATE OF BIRTH	SEX
	YES XNO	12 14 1962	M X F
b RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC	
PEOPENTE FOR MILES LICE	YES XNO		
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRA	AM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME	YES XNO  10d. CLAIM CODES (Designated by NUCC)	EVOCARE  d. IS THERE ANOTHER HEALTH BENEFI	T PLAN2
	(2009)	The same of the sa	nplete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLET		13. INSURED'S OR AUTHORIZED PERSO	N'S SIGNATURE Lauthorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize it to process this claim. I also request payment of government benefits below</li> </ol>	ne release of any medical or other information necessary either to myself or to the party who accepts assignment	payment of medical benefits to the unde services described below.	ersigned physician or supplier for
SIGNATURE ON FILE	11/05/20	SIGNATURE	ON FILE
SIGNED	DATE	SIGNED	
MM DD YY	DUAL MM DD YY	16 DATES PATIENT UNABLE TO WORK I	MM DD YY
QUAL.	17a. 1GOTH000	FROM  18 HOSPITALIZATION DATES RELATED	TO CURRENT SERVICES
	17b. NPI 1417056409	FROM DD YY	MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	111,030109	20 OUTSIDE LAB?	\$ CHARGES
		YES X NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate A-L to s	ervice line below (24E) ICD Ind. 0	22 RESUBMISSION CODE ORIGINA	L REF. NO
A M47814 B M546 C	D. L	CO. DRIOR AUTHORIZATION NUMBER	
E.L	Н	23 PRIOR AUTHORIZATION NUMBER	
	OCEDURES, SERVICES, OR SUPPLIES E.	F. G. H. I	J,
1.500.01	Explain Unusual Circumstances)  DIAGNOSIS  HOPCS   MODIFIER POINTER	\$ CHARGES DAYS EPSDT OR Family QU	
			770710517105.9
11 05 20 11 720	70 AB	83 00 1 N	1649220120
		N	PI
		N	PI
	1 1 1 1 1		
		N N	PI
			PI
	S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28 TOTAL CHARGE 29 AMOUN	
Land Land Control of the Control of	8890 X YES NO	s 83 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.)	R&F POPLAR AVE	DIAGNOSTIC IMAG	COUNTY AND AND MAKEN
	IIS TN 38119-	PO BOX 1000 DEPT MEMPHIS, TN 3814	
SIGNED 11/09/20TE	b.	a1699725812 DZZ20	
, DOLL			00102021

BIRMINGHAM AL 35243 HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 00000000					
PICA A# 84974-0001 CNR534 P E 003 84974 PICA					
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (ID#) (ID#) (ID#) X (ID#)			MB04098396	5	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initia	MM I		4. INSURED'S NAME (Last N		Middle Initial)
PATTERSON RONALD P 5. PATIENT'S ADDRESS (No., Street)		16 1958 X F	PATTERSON 7. INSURED'S ADDRESS (N		
4152 SUNNY MEADOWS	Self	Spouse X Child Other	4152 SUNN	MEADO	WS
CITY	STATE 8 RESERVE	D FOR NUCC USE	CITY	i iidiido	STATE
BARTLETT	TN		BARTLETT		TN
ZIP CODE TELEPHONE (Include A	Area Code)		ZIP CODE	TELEPHON	E (Include Area Code)
	-5981	VITA COMPLETON OF ATTR TO	38135	(90	
9. OTHER INSURED'S NAME (Last Name, First Name, Min	ddle Initial) 10. IS PATIE	NT'S CONDITION RELATED TO	11. INSURED'S POLICY GRO		UMBEH
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYM	MENT? (Current or Previous)	1048800203 a. INSURED'S DATE OF BIR		SEX
		YES X NO	03 06 19	M.	FX
b. RESERVED FOR NUCC USE	b AUTO AC		L OTHER OF MINIB (D		21
		YES X NO			
c. RESERVED FOR NUCC USE	c OTHER A	300000000000000000000000000000000000000	c. INSURANCE PLAN NAME	OR PROGRAM N	NAME
- INCURANCE DI ANNIANE OR PROCEDANIANE	101 01 101	YES X NO	EVOCARE	I THE DESIGNATION OF THE PARTY	ANIO
d. INSURANCE PLAN NAME OR PROGRAM NAME	Tod. CLAIM	CODES (Designated by NUCC)	d. IS THERE ANOTHER HEA		
READ BACK OF FORM BEFO	RE COMPLETING & SIGNING 1	THIS FORM.	YES XNO	102,853-3611 CCT0,8030	te items 9, 9a and 9d. SIGNATURE Lauthorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of govern</li> </ol>	E I authorize the release of any rement benefits either to myself or	nedical or other information necessary to the party who accepts assignment	payment of medical benef services described below.	ts to the undersig	ned physician or supplier for
SIGNATURE ON FII		11/04/20		ATURE O	N FILE
SIGNED	DA	the state of the s	SIGNED		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNAN		MM , DD , YY	16 DATES PATIENT UNABL	E TO WORK IN C	URRENT OCCUPATION MM , DD , YY
QUAL   17. NAME OF REFERRING PROVIDER OR OTHER SOUR	QUAL	7000	FROM   18 HOSPITALIZATION DATE	TC	
DN SAMYA CRUZ MD	1001	17056409	FROM DD	YY TO	MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by N		17030403	20 OUTSIDE LAB?		CHARGES
			YES X NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.	Relate A-L to service line below	ICD Ind.	22 RESUBMISSION CODE	ORIGINAL R	EF NO
M5136 B. I2510	c M545	M25559			
E_M25511 F_Z96611	<sub>G</sub> M2551:	2 н	23 PRIOR AUTHORIZATION	NUMBER	
1. J. J. 24. A. DATE(S) OF SERVICE B.	K. L C. D. PROCEDURES, SER	RVICES, OR SUPPLIES E.	F. G.	H. I.	J,
From To PLACE OF MM DD YY MM DD YY SERVICE E	(Explain Unusual C MG CPT/HCPCS I	ircumstances) DIAGNOS MODIFIER POINTE		S EPSOT ID. Family Plan QUAL.	RENDERING PROVIDER ID. #
	me   CFIMOPOS	MODIFIER	Unit	o residentes	PHO PIDELLI ID.
11 04 20   11	72100	ABC	85 00	L NPI	1649220120
11 04 20   11	72170		66 00	1	1649220120
11 04 20 11	/21/0	D	00 00 .	L NPI	1649220120
11 04 20   11	73030 RT	EF	72 00	L NPI	1649220120
	Section Section Section 1				
11 04 20   11	73030 LT	G	72 00 3	L NPI	1649220120
		2 1 1			
				NPI	
		1 1 1 1		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 P.	AID 30. Rsvd for NUCC use
621116618 X	10209690	X YES NO	295 00	s	
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	32. SERVICE FACILITY LOCA	TION INFORMATION	33. BILLING PROVIDER INF	( -	01) 387-2340
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	DIPC R&F	7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7	DIAGNOSTIC		
ROBERT A DUKE MD	6401 POPLAR MEMPHIS TN		PO BOX 1000 MEMPHIS, TI		
11/00/20	MEMPHIS IN .	30113-	a1699725812		
SIGNED II/ 09/2 DATE	1000		100012	22200	51.020211



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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	0000000		CA
PICA A# 226682-0001 CNR534 P E 019		2:	26682 <sup>PICA</sup>
1. MEDICARE MEDICAID TRICARE CHAMPVA	- HEALTH PLAN - BLK LUNG -		Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID  2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	MB04626050  4. INSURED'S NAME (Last Name, First Name, Middle	e Initial)
SMITH TERRY	03 09 1985 X	SMITH TERRY	
	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
6793 SEVEN VALLEY DR	Self X Spouse Child Other  8. RESERVED FOR NUCC USE	6793 SEVEN VALLEY	DR STATE
CITY STATE	8. RESERVED FOR NUCC USE	MEMPHIS	TN
MEMPHIS TN  ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Inclu	
38141 (901) 568-2916			568-2916
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)	1048800303 a INSURED'S DATE OF BIRTH	SEX
	YES XNO	03 09 1985 X	F
b. RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)	9
a DECEDIED FOR NUCC HOS	YES XNO	c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	EVOCARE	
d. INSURANCE PLAN NAME OR PROGRAM NAME.	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
		YES XNO If yes, complete item	
READ BACK OF FORM BEFORE COMPLETING  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the re to process this claim. I also request payment of government benefits eithe	lease of any medical or other information necessary	13 INSURED'S OR AUTHORIZED PERSON'S SIGN, payment of medical benefits to the undersigned pl services described below.	
to process this claim. Taiso request payment or government benefits eline	11/09/20		FILE
SIGNATORE ON FIDE	DATE	SIGNED	1 1 1 1 1 1 1
MM DD YY	OTHER DATE MM   DD   YY		NT OCCUPATION AND AND AND AND AND AND AND AND AND AN
QUAL		FROM TO  18. HOSPITALIZATION DATES RELATED TO CURR	ENT SERVICES
	1GOTH000 NPI 1417056409	FROM DD YY MM	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	1 2 2 2 3 3 3 3 3 3	20. OUTSIDE LAB? \$ CHARG	iES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to servi	no line below (24E)	YES X NO 22 RESUBMISSION	
MOFF12	ICD Ind	CODE ORIGINAL REF N	0.
A M25512 B C C	D. L.	23. PRIOR AUTHORIZATION NUMBER	
J. L. K. L	L. L.		
	EDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS	F. G. H. I.  DAYS EPSDT ID.  OR Family CHAP	J. RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/HCP	CS   MODIFIER POINTER	\$ CHARGES OR Family QUAL.	PROVIDER ID. #
11 09 20   11   7303	O LT A	72 00 1 NPI 1	669553764
		NPI	
3		NPI	
		NPI	
5		NPI	
		110	
		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	(For govt claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID	30. Rsvd for NUCC use
621116618 X 10212 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FA	686D X YES NO	\$ 72 00 \$ 33. BILLING PROVIDER INFO & PH. # ( 901)	387-2340
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse DIPC R	&F	DIAGNOSTIC IMAGING	The state of the s
apply to this bill and are made a part thereof.) 6401 P	OPLAR AVE	PO BOX 1000 DEPT 27	
	S TN 38119-	MEMPHIS, TN 3814802	
SIGNED 11/13/2 <sub>Q</sub> <sub>TE</sub> a.	b.	1699725812 □ ZZ2085R	.0202X



BIRMINGHAM AL 35243
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NU	<sup>(CC) 02/12</sup> 00000000 JR534 P E 001	226602 PICA 1115
A# 226602-0001 CN  1. MEDICARE MEDICAID TRICARE		OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (ID#/DoD#)  2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	(Member ID#) (ID#) (ID#) (ID#) X	MB05656344  4. INSURED'S NAME (Last Name, First Name, Middle Initial)
HENRIQUEZ ANNA L	MM   DD   YY	HENRIQUEZ WILFREDO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
2153 WOODFIELD PARK RD	Self Spouse X Child Othe	ZIJJ WOODIIIDD IAKK KD
MEMPHIS	TN	MEMPHIS TN
ZIP CODE TELEPHONE (Include Area C	1	MEMPHIS TN  ZIP CODE TELEPHONE (Include Area Code)  38134 (901) 267 - 6167  11. INSURED'S POLICY GROUP OR FECA NUMBER  1048800604  a INSURED'S DATE OF BIRTH  MM DD TY  11 05 1968 M X  E (State)  b. OTHER CLAIM ID (Designated by NUCC)
38134 (901) 267 - 61		38134 (901) 267 - 6167  TO: 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  MM   DD   YY
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE	11 05 1968 M X  E (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
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES X NO  10d CLAIM CODES (Designated by NUCC)	EVOCARE  d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES X NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE C  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I au to process this claim. I also request payment of government I	COMPLETING & SIGNING THIS FORM.  Ithorize the release of any medical or other information ned benefits either to myself or to the party who accents assign	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	11/05/20	SIGNATURE ON FILE
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (L	LMP) 15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO TO
QUAL   17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a ZZ363L00000X	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM   DD   YY   MM   DD   YY
DN LAURA ERICKSON-BLY NE		FROM TO 20. OUTSIDE LAB? S CHARGES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, Relate A-L to service line below (24E)		22. RESUBMISSION ORIGINAL REF. NO.
A G9389 B J341	c. R519 D.	23. PRIOR AUTHORIZATION NUMBER
E F	G. L H. L	ES. THOS AS HORIZATION NONDES
24. A. DATE(S) OF SERVICE B. C. From To PLACE OF	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. F. G. H. I. J. AGNOSIS DAYS EPROT ID. RENDERING
MM DD YY MM DD YY SERVICE EMG		OINTER S CHARGES UNITS Frank QUAL PROVIDER ID. #
11 05 20   11	70450	ABC 511 00 1 NPI 1740247485
		NPI
3		NPI NPI
4		NPI
		i (VF)
		NPI
6		NPI NPI
	PATIENT'S ACCOUNT NO. 27 ACCEPT ASSIGNM (For govi. claims, see	MENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC use
	10209534 X YES NO SERVICE FACILITY LOCATION INFORMATION	o s 511 00 s
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse	IPC CT	DIAGNOSTIC IMAGING PC
apply to this bill and are made a part thereof.)	401 POPLAR AVE	PO BOX 1000 DEPT 275
11/00/20	EMPHIS TN 38119-	MEMPHIS, TN 381480275
SIGNED 11/09/20ATE a	0,	TOJJIZJOIZ ZZZZZZZZZZZZZZZZZ