

IN THE SUPREME COURT OF THE STATE OF NEVADA

Supreme Court Case No.
District Court Case No. A-19-792978

UnitedHealth Group, Inc., United Healthcare Insurance Company, UnitedHealthcare
Care Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health-Care
Insurance Company, Inc., Sierra Health-Care Options, Inc., Health Plan of Nevada,
Inc.,
Petitioners

Electronically Filed
Aug 25 2020 01:29 p.m.
Elizabeth A. Brown
Clerk of Supreme Court

v.

The Eighth Judicial District Court, State of Nevada, Clark County, and
the Honorable Nancy L. Allf, District Court Judge,
Respondent

and

Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-
Mandavia, P.C., Crum Stefanko and Jones, Ltd.,
Real Parties in Interest.

PETITIONER'S APPENDIX – VOLUME 3

D. LEE ROBERTS, JR., ESQ.
Nevada Bar No. 8877
COLBY L. BALKENBUSH, ESQ.
Nevada Bar No. 13066
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Nevada Bar No. 13527
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Attorneys for Petitioners

CHRONOLOGICAL INDEX

Date Filed	Description	Bates Number	Volume(s)
04/15/2019	Complaint	PA 1-17	1
05/14/2019	Notice of Removal to Federal Court	PA 18-76	1
01/29/2020	Declaration of Sandra Way	PA 77-84	1
02/20/2020	Order Granting Amended Motion to Remand to State Court	PA 85-90	1
05/15/2020	First Amended Complaint	PA 91-139	2
05/26/2020	Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint	PA 140-285	2, 3
	Exhibit 1: UHIC, UHS and UMR Declaration	PA 172-175	2
	Exhibit 2: Oxford Declaration	PA 176-179	2
	Exhibit 3: SHO Declaration	PA 180-183	2
	Exhibit 4: SHL and HPN Declaration	PA 184-187	2
	Exhibit 5: Sample Claim Forms for UMR	PA 188-233	3
	Exhibit 6: Sample Claim Forms for SHO	PA 234-273	3
	Exhibit 7: <i>Hill Country Order</i>	PA 274-285	3
05/26/2020	Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiff's First Amended Complaint Addressing Plaintiff's Eighth Claim for Relief	PA 286-300	4
05/29/2020	Plaintiffs' Opposition to Defendants Motion to Dismiss First Amended Complaint	PA 301-406	4

CHRONOLOGICAL INDEX

	Exhibit 1: Amended Motion to Remand	PA 333-350	4
	Exhibit 1 to Amended Motion to Remand: Transcript of Hearing on Jan 6, 2020	PA 351-355	4
	Exhibit 2 to Amended Motion to Remand: <i>Petition in Hill County Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.</i>	PA 356-372	4
	Exhibit 2: Reply in Support of Amended Motion to Remand	PA 373-389	4
	Exhibit 1 to Reply in Support of Motion to Remand: Amended Complaint filed in Marin Gen. Hosp. v. Modesto & Empire Traction Co.	PA 390-406	4
05/29/2020	Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	PA 407-422	4
06/03/2020	Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint	PA 423-452	4
06/03/2020	Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint	PA 453-462	5
06/08/2020	Hearing Transcript: Friday June 5, 2020	PA 463-497	5
06/09/2020	Minute Order	PA 498-499	5

CHRONOLOGICAL INDEX

06/10/2020	Hearing Transcript: Tuesday June 9, 2020	PA 500-586	5
06/24/2020	Order Denying Defendants' (1) Motion to Dismiss first Amended Complaint; and (2) Supplemental Brief in Support of their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	PA 587-628	5
07/08/2020	Defendants' Answer to Plaintiffs' First Amended Complaint	PA 629-678	5

ALPHABETICAL INDEX

Date Filed	Description	Bates Number	Volume(s)
04/15/2019	Complaint	PA 1-17	1
01/29/2020	Declaration of Sandra Way	PA 77-84	1
07/08/2020	Defendants' Answer to Plaintiffs' First Amended Complaint	PA 629-678	5
05/26/2020	Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint	PA 140-285	2, 3
06/03/2020	Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint	PA 423-452	4
06/03/2020	Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint	PA 453-462	5
05/26/2020	Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiff's First Amended Complaint Addressing Plaintiff's Eighth Claim for Relief	PA 286-300	4
	Exhibit 1 to Amended Motion to Remand: Transcript of Hearing on Jan 6, 2020	PA 351-355	4
	Exhibit 1 to Reply in Support of Motion to Remand: Amended Complaint filed in Marin Gen. Hosp. v. Modesto & Empire Traction Co.	PA 390-406	4
	Exhibit 1: Amended Motion to Remand	PA 333-350	4
	Exhibit 1: UHIC, UHS and UMR Declaration	PA 172-175	2

ALPHABETICAL INDEX

	Exhibit 2 to Amended Motion to Remand: <i>Petition in Hill County Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.</i>	PA 356-372	4
	Exhibit 2: Oxford Declaration	PA 176-179	2
	Exhibit 2: Reply in Support of Amended Motion to Remand	PA 373-389	4
	Exhibit 3: SHO Declaration	PA 180-183	2
	Exhibit 4: SHL and HPN Declaration	PA 184-187	2
	Exhibit 5: Sample Claim Forms for UMR	PA 188-233	3
	Exhibit 6: Sample Claim Forms for SHO	PA 234-273	3
	Exhibit 7: <i>Hill Country Order</i>	PA 274-285	3
05/15/2020	First Amended Complaint	PA 91-139	2
06/08/2020	Hearing Transcript: Friday June 5, 2020	PA 463-497	5
06/10/2020	Hearing Transcript: Tuesday June 9, 2020	PA 500-586	5
06/09/2020	Minute Order	PA 498-499	5
05/14/2019	Notice of Removal to Federal Court	PA 18-76	1
06/24/2020	Order Denying Defendants' (1) Motion to Dismiss first Amended Complaint; and (2) Supplemental Brief in Support of their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	PA 587-628	5

ALPHABETICAL INDEX

02/20/2020	Order Granting Amended Motion to Remand to State Court	PA 85-90	1
05/29/2020	Plaintiffs' Opposition to Defendants Motion to Dismiss First Amended Complaint	PA 301-406	4
05/29/2020	Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	PA 407-422	4

EXHIBIT 5

Sample Claim Forms for UMR

EXHIBIT 5

1500

Claim TPA ID :
Claim Total : \$883.00

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL NOT YET APPROVED BY N.U.C. 02/12

PICA											
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>											
2. RESERVED FOR NUCC USE											
3. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
4. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
5. OTHER INSURED'S POLICY OR GROUP NUMBER											
6. RESERVED FOR NUCC USE											
7. RESERVED FOR NUCC USE											
8. INSURANCE PLAN NAME OR PROGRAM NAME											
9. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.											
10. INSURED'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 the party who accepts assignment below. SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/01/17											
11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED AUTHORIZED SIGNATURE ON FILE											
12. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL 06 28 17 QUAL											
13. OTHER DATE QUAL MM DD YY											
14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
15. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
16. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
17. RESUBMISSION CODE 1 ORIGINAL REF. NO.											
18. PRIOR AUTHORIZATION NUMBER											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#											
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. S161XXA B. M5412 C. R030 D. X58XXXA E. F. G. H. I. J. K. L.											
21. DATES OF SERVICE From MM DD YY To MM DD YY 07 01 17 07 01 17											
22. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 99284											
23. DIAGNOSIS POINTER A, B, C, D											
24. \$ CHARGES 883 00											
25. DAYS OF UNITS 1											
26. I.D. QUAL											
27. RENDERING PROVIDER I.D. # 1063778611											
28. FEDERAL TAX I.D. NUMBER 880262438 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>											
29. PATIENT ACCOUNT NO. 1457306359											
30. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
31. TOTAL CHARGE \$ 883 00											
32. AMOUNT PAID \$											
33. Rsvd for NUCC Use											
34. 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.) RIVAS, JULIE 1063778611 207P00000X SIGNED DATE											
35. SERVICE FACILITY LOCATION INFORMATION SOUTHERN HILLS HOSPITAL AND ME 9300 W SUNSET RD LAS VEGAS, NV 89148-4844 a. 1457306359 b.											
36. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1679550149 b.											

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

PA000189

1500

Claim TPA ID :
Claim Total : \$1,295.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

<input type="checkbox"/> PICA											
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>											
8. RESERVED FOR NUCC USE											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO											
b. OTHER CLAIM ID(Designated by NUCC)											
c. INSURANCE PLAN NAME OR PROGRAM NAME											
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.											
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 <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>07/02/17</u>											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL 07 02 17 QUAL											
15. OTHER DATE QUAL. MM DD YY											
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.											
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#											
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. <u>S098XXA</u> B. <u>S0083XA</u> C. <u>F10129</u> D. <u>W228XXA</u> E. F. G. H. I. J. K. L.											
22. RESUBMISSION CODE 1 ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER											
24 A. DATES 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. EPSPDT Family Plan I. L.D. QUAL J. RENDERING PROVIDER I.D. #											
1 07 02 17 07 02 17 23 99285 A,B,C,D 1,295 00 1 1063462364											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/> X											
26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
28. TOTAL CHARGE \$ 1,295 00 29. AMOUNT PAID \$ 30. Rvd 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.) LOVINGER, AARON 1063462364 207P00000X SIGNED DATE											
32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.											
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.											

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 752297429-10036 (UHC 837 MEDICAL)

PA000190

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID :
 Claim Total : \$505.00

Patient's Acct# :
 Batch Number :
 CCN# :
 HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIALNOT YET APPROVED BY N.U.C. 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>			
8. RESERVED FOR NUCC USE			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES(Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING 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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>07/03/17</u>		c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d. 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 <u>AUTHORIZED SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. 17c. 17d. 17e. 17f. 17g. 17h. 17i. 17j. 17k. 17l. 17m. 17n. 17o. 17p. 17q. 17r. 17s. 17t. 17u. 17v. 17w. 17x. 17y. 17z.	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. M109 B. C. D. E. F. G. H. I. J. K. L.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
24 A. DATES 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		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.	
26. PATIENT ACCOUNT NO.		23. PRIOR AUTHORIZATION NUMBER	
27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24 F. \$ CHARGES G. DAYS OR UNITS H. EPBDT Family Plan I. L.D. QUAL J. RENDERING. PROVIDER I.D. #	
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.) LEONG, JOEANN 1104011527 207P00000X SIGNED DATE		28. TOTAL CHARGE \$ 505 00 29. AMOUNT PAID \$ 30. Rcvd for NUCC Use	
32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LASVEGAS, NV 89128-0436		33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772	
a. b.		a. 1366429821 b.	

1500

Claim TPA ID :
Claim Total : \$1,787.00

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA	
1. MEDICARE (Medicare#)		MEDICAID (Medicaid#)	
TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)	
GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	
OTHER (ID#)		<input checked="" type="checkbox"/>	
8. RESERVED FOR NUCC USE			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10d. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME	
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 the party who accepts assignment below.		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 <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>07/06/17</u>		SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
MM DD YY		MM DD YY	
QUAL		QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b.	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
Referral# REF# HL#		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		23. PRIOR AUTHORIZATION NUMBER	
A. R42 B. R55 C. E860 D. I959			
E. F. G. H. I. J. K. L.			
24 A. DATES OF SERVICE		F. \$ CHARGES	
From To		G. DAYS OF UNITS	
MM DD YY MM DD YY		H. EP800 Family Plan	
B. PLACE OF SERVICE		I. I.D. QUAL	
C. EMG		J. RENDERING PROVIDER I.D. #	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			
CPT/HCPCS MODIFIER			
E. DIAGNOSIS POINTER			
1 07 06 17 07 06 17 23 99291 A, B, C, D		1,681 00 1 1568656213	
2 07 06 17 07 06 17 23 93010 A		64 00 1 1568656213	
3 07 06 17 07 06 17 23 99053 A, B, C, D		42 00 1 1568656213	
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER		26. PATIENT ACCOUNT NO.	
880262438		27. ACCEPT ASSIGNMENT	
SSN EIN		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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.)		28. TOTAL CHARGE	
HIKSON, MICHAEL		29. AMOUNT PAID	
1568656213		30. Rcvd for NUCC Use	
207P00000X			
SIGNED DATE		a. 1770626426 b. 1689013161	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #	
ST ROSE DOMINICAN HOSPITALS-SI		FREMONT EMERGENCY SERVICES MAN	
3001 ST ROSE PKWY		PO BOX 638972	
HENDERSON, NV 89052-3839		CINCINNATI, OH 45263-8972	
		(888) 952-6772	

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Page: 1 of 1

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

UNOFFICIAL NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

PA000192

1500

Submitter : 752297429-10036 (UHC 837 MEDICAL)
Claim TPA ID :
Claim Total : \$1,295.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIALNOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<div>10d. CLAIM CODES(Designated by NUCC)</div>						
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/>		
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>07/09/17</u>				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 <u>AUTHORIZED SIGNATURE ON FILE</u>		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Releats A-L to service line below(24E) ICD Ind. 0 A. <u>R1031</u> B. <u>N200</u> C. <u>N3001</u> D. <u>R112</u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>				22. RESUBMISSION CODE 1 ORIGINAL REF. NO.		
23. PRIOR AUTHORIZATION NUMBER						
24 A. DATES OF SERVICE From To MM DD YY 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. EPSON Family Plan I. L.D. QUAL J. RENDERING PROVIDER I.D. #		
1 07 09 17 07 09 17 23 99285 A,B,C,D				1,295 00 1 1558317354		
2						
3						
4						
5						
6						
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT ACCOUNT NO.		27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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.) SLAUGHTER, KEVIN 1558317354 207P00000X SIGNED DATE				32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 102 E LAKE MEAD PKWY HENDERSON, NV 89015-5575 a. b.		33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIALNOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 752297429-10036 (UHC 837 MEDICAL)

PA000193

1500

Submitter : COBA (MEDICARE COBA MEDICAL)
Claim TPA ID :
Claim Total : \$1,681.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number :

HEALTH INSURANCE CLAIM FORM

UNOFFICIALNOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)</div> <div>11. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.</div> <div>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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>07/10/17</u></div> <div>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 <u>AUTHORIZED SIGNATURE ON FILE</u></div> <div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL</div> <div>15. OTHER DATE MM DD YY QUAL</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#</div> <div>20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Releats A-L to service line below (24E) ICD Ind. 0 A. J189 B. A419 C. R0902 D. I10 E. F. G. H. I. J. K. L.</div> <div>22. RESUBMISSION CODE ORIGINAL REF. NO. 1</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <div>24 A. DATES 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. EPBDT Family Plan I. LD. QUAL J. RENDERING PROVIDER I.D. #</div> <div>1 07 10 17 07 10 17 23 99291 DESC: CRITICAL CARE FIRST HOUR - 99291 1,681 00 1 1023391026</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 X</div> <div>26. PATIENT ACCOUNT NO.</div> <div>27. ACCEPT ASSIGNMENT X YES NO</div> <div>28. TOTAL CHARGE \$ 1,681 00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rvd for NUCC Use</div> <div>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.) ALBEKORD, ARASH 1023391026 SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION SOUTHERN HILLS HOSPITAL AND ME 9300 W SUNSET RD LAS VEGAS, NV 89148-4844 a. 1457306359 b.</div> <div>33. BILLING PROVIDER INFO & PH# FREMOT EMER SVCMANDAVIA LTD PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1679550149 b.</div>						

1500

Claim TPA ID :
Claim Total : \$1,295.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL NOT YET APPROVED BY N.U.C. 02/12

PICA										PICA											
1. MEDICARE										MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BLK LUNG		OTHER	
(Medicare#)										(Medicaid#)		(ID#/DoD#)		(Member ID#)		(ID#)		(ID#)		(ID#)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:											
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous)											
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO											
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO											
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)											
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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>07/12/17</u>										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 <u>AUTHORIZED SIGNATURE ON FILE</u>											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>R0789</u> B. <u>R0600</u> C. <u>R042</u> D. <u>R918</u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>										22. RESUBMISSION CODE <u>1</u> ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER																					
24 A. DATES OF SERVICE From To MM DD YY 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. EPSED Family Plan I. I.D. QUAL J. RENDERING. PROVIDER I.D. #											
1 07 12 17 07 12 17 23 99285 A,B,C,D 1,295 00 1 1114286077																					
2																					
3																					
4																					
5																					
6																					
25. FEDERAL TAX ID. NUMBER 880262438 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
28. TOTAL CHARGE \$ 1,295 00										29. AMOUNT PAID \$											
30. Rvd 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.) MACEDO, MARK 1114286077 207P00000X SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LASVEGAS, NV 89128-0436 a. b.											
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1366429821 b.																					

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 752297429-10036 (UHC 837 MEDICAL)

PA000195

1500

Claim TPA ID :
Claim Total : \$1,295.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
10. IS PATIENT'S CONDITION RELATED TO:						
a. EMPLOYMENT? (Current or Previous)						
b. AUTO ACCIDENT? PLACE (State)						
c. OTHER ACCIDENT?						
10d. CLAIM CODES (Designated by NUCC)						
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
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 AUTHORIZED SIGNATURE ON FILE DATE 07/15/17						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)						
15. OTHER DATE						
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
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 (24E) ICD Ind. 0						
22. RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER						
24. A. DATES OF SERVICE						
B. PLACE OF SERVICE						
C. EMG						
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)						
E. DIAGNOSIS POINTER						
F. \$ CHARGES						
G. DAYS OR UNITS						
H. EPST Family Plan						
I. I.D. QUAL						
J. RENDERING PROVIDER I.D. #						
25. FEDERAL TAX I.D. NUMBER SSN EIN						
26. PATIENT ACCOUNT NO.						
27. ACCEPT ASSIGNMENT						
28. TOTAL CHARGE						
29. AMOUNT PAID						
30. Rvd 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.)						
32. SERVICE FACILITY LOCATION INFORMATION						
33. BILLING PROVIDER INFO & PH #						

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

PA000196

1500

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)
Claim TPA ID :
Claim Total : \$1,295.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
10. IS PATIENT'S CONDITION RELATED TO:						
a. EMPLOYMENT? (Current or Previous)						
b. AUTO ACCIDENT? PLACE (State)						
c. OTHER ACCIDENT?						
c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
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 the party who accepts assignment below.						
SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>07/17/17</u>						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP)						
15. OTHER DATE						
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
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(24E) ICD Ind. 0						
22. RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER						
24. A. DATES OF SERVICE						
B. PLACE OF SERVICE						
C. EMG						
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)						
E. DIAGNOSIS POINTER						
F. \$ CHARGES						
G. DAYS OR UNITS						
H. EPSON Family Plan						
I. I.D. QUAL						
J. RENDERING PROVIDER I.D. #						
25. FEDERAL TAX I.D. NUMBER SSN EIN						
26. PATIENT ACCOUNT NO.						
27. ACCEPT ASSIGNMENT						
28. TOTAL CHARGE						
29. AMOUNT PAID						
30. Rvd 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.)						
32. SERVICE FACILITY LOCATION INFORMATION						
33. BILLING PROVIDER INFO & PH #						

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

PA000197

1500

Claim TPA ID :
Claim Total : \$463.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
10. IS PATIENT'S CONDITION RELATED TO:						
a. EMPLOYMENT? (Current or Previous)						
b. AUTO ACCIDENT? PLACE (State)						
c. OTHER ACCIDENT?						
c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
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 the party who accepts assignment below.						
SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/29/17						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP)						
15. OTHER DATE						
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
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(24E) ICD Ind. 0						
22. RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER						
24 A. DATES OF SERVICE						
B. PLACE OF SERVICE						
C. EMG						
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)						
E. DIAGNOSIS POINTER						
F. \$ CHARGES						
G. DAYS OR UNITS						
H. EP/SDT Family Plan						
I. I.D. QUAL						
J. RENDERING PROVIDER I.D. #						
25. FEDERAL TAX I.D. NUMBER SSN EIN						
26. PATIENT ACCOUNT NO.						
27. ACCEPT ASSIGNMENT						
28. TOTAL CHARGE						
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.)						
32. SERVICE FACILITY LOCATION INFORMATION						
33. BILLING PROVIDER INFO & PH #						

NUCC Instruction Manual at: www.nucc.org

UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

Page: 1 of 1

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

PA000198

1500

Claim TPA ID :
Claim Total : \$463.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE (Medicare#)		MEDICAID (Medicaid#)	
TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)	
GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	
OTHER (ID#)		<input checked="" type="checkbox"/> (ID#)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
10. IS PATIENT'S CONDITION RELATED TO:			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10d. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME	
13. INSURED'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 the party who accepts assignment below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
SIGNED AUTHORIZED SIGNATURE ON FILE DATE 08/14/17		SIGNED AUTHORIZED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER DATE MM DD YY	
QUAL		QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
Referral# REF# HL#		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Releate A-L to service line below (24E) ICD Ind. 0		23. PRIOR AUTHORIZATION NUMBER	
A. M5412 B. R030 C. F419 D. I. E. F. G. H. I. J. K. L.		F. \$ CHARGES G. DAYS OR UNITS H. EPSTOT Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #	
24 A. DATES 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. EPSTOT Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #	
1 08 14 17 08 14 17 23 99283 A, B, C 463 00 1 1619979028			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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.) ANDERSON, ERIC 1619979028 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 9300 W SUNSET RD LASVEGAS, NV 89148-4844 a. b.	
		33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1679550149 b.	

1500

Claim TPA ID :
Claim Total : \$64.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)</div> <div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.</div> <div>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 AUTHORIZED SIGNATURE ON FILE DATE 08/26/17</div> <div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL</div> <div>15. OTHER DATE MM DD YY QUAL</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#</div> <div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Releate A-L to service line below (24E) ICD Ind. 0 A. R4182 B. I509 C. R7989 D. N289 E. F. G. H. I. J. K. L.</div> <div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <div>24 A. DATES 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 OF UNITS H. EPST Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #</div> <div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO.</div> <div>27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE \$ 64.00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rcvd for NUCC Use</div> <div>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.) MCBRIDE, DANIEL 1629049945 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3001 ST ROSE PKWY HENDERSON, NV 89052-3839 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1689013161 b.</div>						

1500

Claim TPA ID :
Claim Total : \$883.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL NOT YET APPROVED BY N.U.C. 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>11/10/17</u>		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 <u>AUTHORIZED SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE QUAL. MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. <input type="checkbox"/> 17b. <input type="checkbox"/>	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>O200</u> B. <u>R030</u> C. <u>Z3A01</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. DATES OF SERVICE	
24 A. From YY To YY MM DD YY 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 OF UNITS	
H. SPOT Family Plan		I. I.D. QUAL.	
J. RENDERING PROVIDER I.D. #			
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT ACCOUNT NO.	
27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 883.00	
29. AMOUNT PAID \$		30. Rvd 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.) LI, TERRY 1336566579 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 102 E LAKE MEAD PKWY HENDERSON, NV 89015-5575 a. b.	
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1689013161 b.			

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

PA000201

1500

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)
Claim TPA ID :
Claim Total : \$1,295.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>		
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		
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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>11/11/17</u>				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 <u>AUTHORIZED SIGNATURE ON FILE</u>		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Releate A-L to service line below (24E) ICD Ind. 0 A. <u>E860</u> B. <u>R1110</u> C. <u>N289</u> D. <u>R197</u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>				22. RESUBMISSION CODE 1 ORIGINAL REF. NO.		
23. PRIOR AUTHORIZATION NUMBER				24. A. DATES 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 E. DIAGNOSIS POINTER		
25. FEDERAL TAX I.D. NUMBER 880262438 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT ACCOUNT NO. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
27. ACCEPT ASSIGNMENT				28. TOTAL CHARGE \$ 1,295.00		
29. AMOUNT PAID \$				30. Rvd 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.) CRAVEN, IAN 1285898049 207P00000X SIGNED DATE				32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 a. b.		
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.						

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

PA000202

1500

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)
Claim TPA ID :
Claim Total : \$883.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIALNOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<div>ZIP CODE: 79119</div> <div>TELEPHONE (Include Area Code):</div> <div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER:</div> <div>b. RESERVED FOR NUCC USE:</div> <div>c. RESERVED FOR NUCC USE:</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME:</div> <div>10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State): c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES(Designated by NUCC):</div> <div>c. INSURANCE PLAN NAME OR PROGRAM NAME:</div> <div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.</div> <div>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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>12/08/17</u></div> <div>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 <u>AUTHORIZED SIGNATURE ON FILE</u></div> <div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.</div> <div>15. OTHER DATE QUAL. MM DD YY</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# HL#</div> <div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. Q200 B. Q2341 C. R102 D. Z3A01 E. F. G. H. I. J. K. L.</div> <div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <div>24 A. DATES 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 OF UNITS H. EP807 Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #</div> <div>25. FEDERAL TAX I.D. NUMBER 880262438 SSN EIN <input type="checkbox"/> X</div> <div>26. PATIENT ACCOUNT NO.</div> <div>27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE \$ 883 00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rcvd for NUCC Use</div> <div>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.) KATZ, JASON 1720375322 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS, NV 89109-2317 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.</div>						

NUCC Instruction Manual at: www.nucc.org

Page: 1 of 1

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

UNOFFICIALNOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

PA000203

1500

Claim TPA ID :
Claim Total : \$463.00

Submitter : 841162764UFE (OPTUMINSIGHT FKA ICS/INGENIX UFE 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>01/01/18</u>						
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 <u>AUTHORIZED SIGNATURE ON FILE</u>						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.						
15. OTHER DATE MM DD YY QUAL.						
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.						
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#						
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>N390</u> B. <u>R030</u> C. <u></u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>						
22. RESUBMISSION CODE 1 ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER						
24 A. DATES 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 Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #						
1 01 01 18 01 01 18 23 99283 A, B 463 00 1 1578786877						
2						
3						
4						
5						
6						
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>						
26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
28. TOTAL CHARGE \$ 463 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.) ZAHAROFF, NATALIE 1578786877 207P00000X SIGNED DATE						
32. SERVICE FACILITY LOCATION INFORMATION ER AT THE LAKES 3325 SOUTH FORT APACHE LAS VEGAS, NV 89117-6360 a. 9999999995 b.						
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1679550149 b.						

NUCC Instruction Manual at: www.nucc.org

Page: 1 of 1

Submitter : 841162764UFE (OPTUMINSIGHT FKA ICS/INGENIX UFE 837 MEDICAL)

UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

PA000204

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)
ZIP CODE 89108						
TELEPHONE (Include Area Code)						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
a. INSURED'S DATE OF BIRTH MM DD YY 08 27 74 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>						
b. OTHER CLAIM ID(Designated by NUCC)						
c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>01/04/18</u>						
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 <u>AUTHORIZED SIGNATURE ON FILE</u>						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.						
15. OTHER DATE MM DD YY QUAL.						
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO MM DD YY MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.						
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO MM DD YY MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#						
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R102 B. N83201 C. R030 D. E. F. G. H. I. J. K. L.						
22. RESUBMISSION CODE ORIGINAL REF. NO. 1						
23. PRIOR AUTHORIZATION NUMBER						
24 A. DATES OF SERVICE From To MM DD YY MM DD YY 01 04 18 01 04 18 B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 99285 E. DIAGNOSIS POINTER A, B, C F. \$ CHARGES 1,360 00 G. DAYS OF TREATMENT UNITS 1 H. EP501 Family Plan I. I.D. QUAL. J. RENDERING PROVIDER I.D. # 1720375322						
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>						
26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
28. TOTAL CHARGE \$ 1,360 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.) KATZ, JASON 1720375322 207P00000X SIGNED DATE						
32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LASVEGAS, NV 89128-0436 a. b.						
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1366429821 b.						

1500

Submitter : 133068979 (MULTIPLAN 837 MEDICAL)
Claim TPA ID :
Claim Total : \$927.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/>		
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		
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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>01/08/18</u>				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>K625</u> B. <u>K8590</u> C. <u>I10</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>				22. RESUBMISSION CODE 1 ORIGINAL REF. NO.		
23. PRIOR AUTHORIZATION NUMBER						
24 A. DATES 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 POINTNER	F. \$ CHARGES
1 01 08 18 01 08 18		23		99284	A, B, C	927 00
2						1
3						
4						
5						
6						
25. FEDERAL TAX I.D. NUMBER 880262438		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT ACCOUNT NO. <u></u>	27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 927 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.) TANG, MICHAEL 1073933057 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS, NV 89109-2317 a. b.		33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.		

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 133068979 (MULTIPLAN 837 MEDICAL)

PA000206

Submitter : 383384800 (HOVS MEDICAL)

1500

Claim TPA ID :
 Claim Total : \$1,360.00

Patient's Acct# :
 Batch Number :
 CCN# :
 HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA	
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)
GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES NO PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES(Designated by NUCC)	
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 the party who accepts assignment below.		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 <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>01/19/18</u>		SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY 01 19 18 QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF= H/L=		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. <u>R531</u> B. <u>R001</u> C. <u>I452</u> D. <u>I10</u> E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24 A. DATES OF SERVICE From To MM DD YY MM DD YY 01 19 18 01 19 18		B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 99285 E. DIAGNOSIS POINTER A, B, C, D	
F. \$ CHARGES 1,360 00		G. DAYS OR UNITS 1 H. EPSCY I. I.D. QUAL J. RENDERING PROVIDER I.D. # 1518387885	
25. FEDERAL TAX I.D. NUMBER 880262438		26. PATIENT ACCOUNT NO.	
SSN EIN [X]		27. ACCEPT ASSIGNMENT YES NO [X]	
28. TOTAL CHARGE \$ 1,360 00		29. AMOUNT PAID \$ 1,324 87	
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.) NUSSBAUM, CHRISTIN 1518387885 SIGNED DATE	
32. SERVICE FACILITY LOCATION INFORMATION MOUNTAINVIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS, NV 89128-0436 a. 1104870187 b.		33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 a. 1366429821 b.	

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : 752297429-10144 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA

1. MEDICARE (Medicare#) 2. MEDICAID (Medicaid#) 3. TRICARE (ID#/DoD#) 4. CHAMPVA (Member ID#) 5. GROUP HEALTH PLAN (ID#) 6. FECA BLK LUNG (ID#) 7. OTHER (ID#) X

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

YES NO

b. AUTO ACCIDENT? PLACE (State)

YES NO

c. OTHER ACCIDENT?

YES NO

10d. CLAIM CODES (Designated by NUCC)

a. INSURED'S DATE OF BIRTH SEX

MM DD YY M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

YES NO 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 the party who accepts assignment below.

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 01/24/18

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 AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)

MM DD YY

QUAL.

15. OTHER DATE

MM DD YY

QUAL.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM TO MM DD YY MM DD YY

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

FROM TO MM DD YY MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#

REF#

H/L#

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

ICD Ind. 0

A. R0789

B. I10

C. R05

D. I

E. I

F. I

G. I

H. I

I. I

J. I

K. I

L. I

20. OUTSIDE LAB? \$ CHARGES

YES NO

22. RESUBMISSION CODE

1

ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE

From To MM DD YY 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. ESD/ PLAN

I. I.D. QUAL

J. RENDERING PROVIDER I.D. #

1 01 24 18 01 24 18 23

99285

A, B, C

1,360 00

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1548425259

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NUCC Instruction Manual at: www.nucc.org

Page: 1 of 1

Submitter : 752297429-10144 (UHC 837 MEDICAL)

UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

PA000209

PA000210

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/>		
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		
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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>02/22/18</u>					
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 <u>AUTHORIZED SIGNATURE ON FILE</u>					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.			15. OTHER DATE MM DD YY QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# = REF = HL =			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>R1011</u> B. <u>K8050</u> C. <u>E6601</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>			22. RESUBMISSION CODE 1 ORIGINAL REF. NO.		
24 A. DATES OF SERVICE From To MM DD YY MM DD YY 1 02 22 18 02 22 18 2 3 4 5 6			24 B. PLACE OF SERVICE EMG 23		
24 C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 99285			24 D. MODIFIER A, B, C		
24 E. DIAGNOSIS POINTER			24 F. \$ CHARGES 1,360 00		
24 G. DAYS OR UNITS 1			24 H. EPST Family Plan		
24 I. ID. QUAL			24 J. RENDERING PROVIDER I.D. # 1558317354		
25. FEDERAL TAX I.D. NUMBER 880262438		26. PATIENT ACCOUNT NO. [REDACTED]	27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1,360 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.) SLAUGHTER, KEVIN 1558317354 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 9300 W SUNSET RD LASVEGAS, NV 89148-4844 a. b.		33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1679550149 b.	

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : COBA (MEDICARE COBA MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number :

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)</div> <div>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 <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/23/18</u></div> <div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.</div> <div>15. OTHER DATE MM DD YY QUAL.</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#</div> <div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>R0789</u> B. <u>I2510</u> C. <u>E876</u> D. <u>R000</u> E. F. G. H. I. J. K. L.</div> <div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <div>24 A. DATES 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. DAY'S OR UNITS H. EPSDT Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #</div> <div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE \$ 1,360 00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rsvd for NUCC Use</div> <div>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.) WRIGHT, BROOKS E 1336574250 SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS, NV 89128-0436 a. 1104870187 b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMOT EMER SVC MANDAVIA LTD PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1366429821 b.</div>						

1500

Claim TPA ID :
Claim Total : \$1,404.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)	
TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)	
GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)	
OTHER <input checked="" type="checkbox"/> (ID#)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
10. IS PATIENT'S CONDITION RELATED TO			
a. EMPLOYMENT? (Current or Previous)			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>			
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/31/18</u>			
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 <u>AUTHORIZED SIGNATURE ON FILE</u>			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. <input type="checkbox"/> 17b. <input type="checkbox"/>	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. <u>F10129</u> B. <u>R4182</u> C. <u>R739</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>			
24 A. DATES OF SERVICE From To MM DD YY 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. EPSTDY Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #	
1 03 31 18 03 31 18 23 99285 A, B, C 1,360 00 1 1063462364			
2 03 31 18 03 31 18 23 99053 A, B, C 44 00 1 1063462364			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER 880262438		26. PATIENT ACCOUNT NO. [REDACTED]	
SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 1,404 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.) LOVINGER, AARON 1063462364 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS, NV 89109-2317 a. b.	
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.			

1500

Claim TPA ID :
Claim Total : \$1,956.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div>						
<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/></div> <div>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>10d. CLAIM CODES (Designated by NUCC)</div>						
<div>11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>04/26/18</u></div>						
<div>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 the party who accepts assignment below.</div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>04/26/18</u></div>						
<div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u></div>						
<div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.</div> <div>15. OTHER DATE QUAL. MM DD YY</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#</div> <div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>K0889</u> B. <u>K047</u> C. <u>L03211</u> D. <u>R030</u> E. F. G. H. I. J. K. L.</div> <div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <div>24 A. DATES 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. I.D. QUAL J. RENDERING PROVIDER I.D. #</div> <div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO.</div> <div>27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE \$ 1,956 00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rsvd for NUCC Use</div> <div>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.) TRANCHELL, NATHAN 1558599050 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3001 ST ROSE PKWY HENDERSON, NV 89052-3839 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1689013161 b.</div>						

PA000214

1500

Claim TPA ID :
Claim Total : \$927.00

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
I. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)	
TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)	
GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)	
OTHER <input checked="" type="checkbox"/> (ID#)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>05/16/18</u>			
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 <u>AUTHORIZED SIGNATURE ON FILE</u>			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY 05 16 18 QUAL.		15. OTHER DATE QUAL. MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. <u>S32511A</u> B. <u>R262</u> C. <u>W0110XA</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24 A. DATES OF SERVICE From To MM DD YY MM DD YY 05 16 18 05 16 18		B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 99284 E. DIAGNOSIS POINTER A, B, C	
F. \$ CHARGES 927 00		G. DAYS OR UNITS 1 H. EPST Family Plan I. ID QUAL J. RENDERING PROVIDER I.D. # 1194131854	
25. FEDERAL TAX I.D. NUMBER 880262438		26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 927 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.) LIN, CHARLES 1194131854 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 a. b.	
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.			

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID :
 Claim Total : \$927.00

Patient's Acct# :
 Batch Number :
 CCN# :
 HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA	
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)
GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	OTHER (ID#)
<div style="background-color: black; height: 100px; width: 100%;"></div>			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10d. CLAIM CODES (Designated by NUCC)		a. INSURED'S DATE OF BIRTH <input type="checkbox"/> MM <input type="checkbox"/> DD <input type="checkbox"/> YY	
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 the party who accepts assignment below.		b. OTHER CLAIM ID (Designated by NUCC)	
SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>06/07/18</u>		c. INSURANCE PLAN NAME OR PROGRAM NAME	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u>		<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
MM DD YY 06 07 18 QUAL.		MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
17a. 17b.		FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
Referral# REF# H/L#		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		23. PRIOR AUTHORIZATION NUMBER	
A. <u>S80211A</u> B. <u>S80212A</u> C. <u>M542</u> D. <u>R1011</u>			
E. F. G. H. I. J. K. L.			
24 A. DATES OF SERVICE		D. PROCEDURES, SERVICES, OR SUPPLIES	
From To PLACE OF SERVICE		(Explain Unusual Circumstances)	
MM DD YY MM DD YY		CPT/HCPCS MODIFIER	
1 06 07 18 06 07 18 23		99284 SA A, B, C, D	
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT ACCOUNT NO.	
880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>			
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.)		27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
SONDRUP, LOGAN 1255799227 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION	
		FREMONT EMERGENCY SERVICES MAN 8280 W WARM SPRINGS RD LAS VEGAS, NV 89113-3612	
33. BILLING PROVIDER INFO & PH #		28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use	
FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772		\$ 927 00 \$	
a. 1689013161 b.			

1500

Claim TPA ID :
Claim Total : \$1,803.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA	
1. MEDICARE (Medicare#)		2. MEDICAID (Medicaid#)	
3. TRICARE (ID#/DoD#)		4. CHAMPVA (Member ID#)	
5. GROUP HEALTH PLAN (ID#)		6. FECA BLK LUNG (ID#)	
7. OTHER (ID#)		8. PICA	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? (Current or Previous)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? (Current or Previous)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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 the party who accepts assignment below.		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: AUTHORIZED SIGNATURE ON FILE DATE 07/15/18		SIGNED: AUTHORIZED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
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 (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24 A. DATES OF SERVICE		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT ACCOUNT NO.	
27. ACCEPT ASSIGNMENT		28. TOTAL CHARGE	
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.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH #		34. FREMONT EMERGENCY SERVICES MAN	
35. CINCINNATI, OH 45263-8972		36. (888) 952-6772	
37. 1518120971		38. 1518120971	

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 752297429-10036 (UHC 837 MEDICAL)

PA000217

1500

Claim TPA ID :
Claim Total : \$927.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)

☐ YES ☐ NO

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)

☐ YES ☐ NO

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?

☐ YES ☐ NO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

a. INSURED'S DATE OF BIRTH SEX

MM DD YY M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

☐ YES ☐ NO 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 the party who accepts assignment below.

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/25/18

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 AUTHORIZED SIGNATURE ON FILE14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
MM DD YY
QUAL.15. OTHER DATE
MM DD YY
QUAL.16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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17zo.
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17zs.
17zt.
17zu.
17zv.
17zw.
17zx.
17zy.
17zz.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral# REF= H/L=

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

A. R1031 B. E860 C. N390 D.
E. F. G. H.
I. J. K. L. 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY20. OUTSIDE LAB? \$ CHARGES
☐ YES ☐ NO22. RESUBMISSION CODE ORIGINAL REF. NO.
1

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER

From MM DD YY	To MM DD YY	Place of Service	EMG	CPT/HCPCS	Modifier	Diagnosis Pointer
07 25 18	07 25 18	23		99284		A, B, C

F. \$ CHARGES G. DAYS OR UNITS H. EPBDT Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #

\$ CHARGES	DAYS OR UNITS	EPBDT Family Plan	I.D. QUAL	RENDERING PROVIDER I.D. #
927 00	1			1013357102

25. FEDERAL TAX I.D. NUMBER SSN EIN
880262438 ☐ ☒26. PATIENT ACCOUNT NO.
27. ACCEPT ASSIGNMENT
☒ YES ☐ NO28. TOTAL CHARGE
\$ 927 0029. 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.)

KUO, TIM
1013357102
207P00000X
SIGNED DATE32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3001 ST ROSE PKWY
HENDERSON, NV 89052-3839a. b. 33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI, OH 45263-8972
(888) 952-6772a. 1689013161 b.

1500

Claim TPA ID :
Claim Total : \$1,353.00

Submitter : 841162764UFE (OPTUMINSIGHT FKA ICS/INGENIX UFE 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA	
I. MEDICARE (Medicare#)		MEDICAID (Medicaid#)	
TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)	
GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	
OTHER (ID#)		X (ID#)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
10. IS PATIENT'S CONDITION RELATED TO			
a. EMPLOYMENT? (Current or Previous)			
b. AUTO ACCIDENT? PLACE (State)			
c. OTHER ACCIDENT?			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP)			
15. OTHER DATE			
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
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(24E) ICD Ind. 0			
22. RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER			
24 A. DATES OF SERVICE			
B. PLACE OF SERVICE			
C. EMG			
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			
E. DIAGNOSIS POINTER			
F. \$ CHARGES			
G. DAYS OR UNITS			
H. EPSDT Family Plan			
I. I.D. QUAL			
J. RENDERING PROVIDER I.D. #			
25. FEDERAL TAX I.D. NUMBER SSN EIN			
26. PATIENT ACCOUNT NO.			
27. ACCEPT ASSIGNMENT			
28. TOTAL CHARGE			
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.)			
32. SERVICE FACILITY LOCATION INFORMATION			
33. BILLING PROVIDER INFO & PH #			

PA000219

1500

Claim TPA ID :
Claim Total : \$530.00

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA	
1. MEDICARE (Medicare#)		MEDICAID (Medicaid#)	
TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)	
GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	
OTHER (ID#)		<input checked="" type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER CLAIM ID (Designated by NUCC)			
c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>01/02/19</u>			
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 <u>AUTHORIZED SIGNATURE ON FILE</u>			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. <u>J069</u> B. <u>R05</u> C. <u></u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>		22. RESUBMISSION CODE <u>1</u> ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. DATES OF SERVICE From To MM DD YY MM DD YY	
B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E. DIAGNOSIS POINTER		F. \$ CHARGES	
G. DAYS OR UNITS		H. EPICD Family Plan	
I. I.D. QUAL		J. RENDERING PROVIDER I.D. #	
1 01 02 19 01 02 19 23 99283 A, B 486 00 1 1336574250			
2 01 02 19 01 02 19 23 99053 A, B 44 00 1 1336574250			
3			
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5			
6			
25. FEDERAL TAX I.D. NUMBER 880262438		26. PATIENT ACCOUNT NO. <u></u>	
SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 530 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.) WRIGHT, BROOKS 1336574250 207P00000X SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS, NV 89128-0436 a. 1104870187 b.	
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1366429821 b.			

1500

Claim TPA ID :
Claim Total : \$927.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA																																																																																				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)																																																																																
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div>																																																																																						
<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State):</div> <div>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>10d. CLAIM CODES (Designated by NUCC)</div>																																																																																						
<div>11. READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.</div> <div>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 the party who accepts assignment below.</div> <div>SIGNED: <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>01/12/19</u></div>																																																																																						
<div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div> <div>SIGNED: <u>AUTHORIZED SIGNATURE ON FILE</u></div>																																																																																						
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<div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div>																																																																																						
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<div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>R509</u> B. <u>J09X2</u> C. <u>J3489</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u></div>																																																																																						
<div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div>																																																																																						
<table border="1"><thead><tr><th>24 A. DATES OF SERVICE</th><th>B. PLACE OF SERVICE</th><th>C. EMG</th><th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th><th>E. DIAGNOSIS POINTER</th><th>F. \$ CHARGES</th><th>G. DAYS OR UNITS</th><th>H. EPSDT Family Plan</th><th>I. I.D. QUAL</th><th>J. RENDERING PROVIDER I.D. #</th></tr></thead><tbody><tr><td>From MM DD YY To MM DD YY</td><td></td><td></td><td>CPT/HCPCS MODIFIER</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>01 12 19 01 12 19</td><td>23</td><td></td><td>99284</td><td>A, B, C</td><td>927 00</td><td>1</td><td></td><td></td><td>1508055765</td></tr><tr><td colspan="10">2</td></tr><tr><td colspan="10">3</td></tr><tr><td colspan="10">4</td></tr><tr><td colspan="10">5</td></tr><tr><td colspan="10">6</td></tr></tbody></table>							24 A. DATES OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #	From MM DD YY To MM DD YY			CPT/HCPCS MODIFIER							01 12 19 01 12 19	23		99284	A, B, C	927 00	1			1508055765	2										3										4										5										6									
24 A. DATES OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #																																																																													
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<div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>27. ACCEPT ASSIGNMENT</div> <div>28. TOTAL CHARGE \$ 927 00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rsvd for NUCC Use</div>																																																																																						
<div>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.) RUSHTON, JOHN 1508055765 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LAS VEGAS, NV 89128-0436 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1366429821 b.</div>																																																																																						

PA000221

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : COBA (MEDICARE COBA MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number :

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>10. IS PATIENT'S CONDITION RELATED TO</div> <div>a. EMPLOYMENT? (Current or Previous)</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>b. AUTO ACCIDENT? PLACE (State)</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>c. OTHER ACCIDENT?</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>10d. CLAIM CODES (Designated by NUCC)</div> <div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.</div> <div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>01/14/19</u></div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u></div> <div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)</div> <div>MM DD YY QUAL.</div> <div>15. OTHER DATE</div> <div>MM DD YY QUAL.</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div> <div>17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div>FROM MM DD YY TO MM DD YY</div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</div> <div>Referral# REF# H/L#</div> <div>20. OUTSIDE LAB? \$ CHARGES</div> <div><input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0</div> <div>A. <u>I2699</u> B. <u>E1165</u> C. <u>J90</u> D. <u></u></div> <div>E. <u></u> F. <u></u> G. <u></u> H. <u></u></div> <div>I. <u></u> J. <u></u> K. <u></u> L. <u></u></div> <div>22. RESUBMISSION CODE ORIGINAL REF. NO.</div> <div>1</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <div>24 A. DATES OF SERVICE</div> <div>From MM DD YY To MM DD YY</div> <div>B. PLACE OF SERVICE</div> <div>C. EMG</div> <div>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</div> <div>CPT/HCPCS MODIFIER</div> <div>E. DIAGNOSIS POINTER</div> <div>F. \$ CHARGES</div> <div>G. DAYS OR UNITS</div> <div>H. EPSDT Family Plan</div> <div>I. I.D. QUAL</div> <div>J. RENDERING PROVIDER I.D. #</div> <div>1 01 14 19 01 14 19 23 99285 DESC: EMERGENCY DEPT VISIT A,B,C 99285 1,360 00 1 1811395718</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>25. FEDERAL TAX I.D. NUMBER SSN EIN</div> <div>880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO.</div> <div>27. ACCEPT ASSIGNMENT</div> <div><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE</div> <div>\$ 1,360 00</div> <div>29. AMOUNT PAID</div> <div>\$</div> <div>30. Rsvd for NUCC Use</div> <div>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.)</div> <div>FORSMAN, ROBYN R 1811395718</div> <div>32. SERVICE FACILITY LOCATION INFORMATION</div> <div>SUNRISE HOSPITAL AND MEDICAL C 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317</div> <div>33. BILLING PROVIDER INFO & PH #</div> <div>FREMONT EMERGENCY SERVICES PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772</div> <div>a. 1861439952 b.</div> <div>a. 1518120971 b.</div>						

PA000222

1500

Submitter : 752297429-10036 (UHC 837 MEDICAL)
Claim TPA ID :
Claim Total : \$1,360.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA																																																																																				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)																																																																																
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<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/></div> <div>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>10d. CLAIM CODES (Designated by NUCC)</div>																																																																																						
<div>11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></div> <div>b. OTHER CLAIM ID (Designated by NUCC)</div> <div>c. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.</div>																																																																																						
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<div>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 <u>AUTHORIZED SIGNATURE ON FILE</u></div>																																																																																						
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<div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div>																																																																																						
<div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#</div> <div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div>																																																																																						
<div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>R569</u> B. <u>R4182</u> C. <u></u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u></div> <div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div>																																																																																						
<table border="1"><thead><tr><th>24 A. DATES OF SERVICE</th><th>B. PLACE OF SERVICE</th><th>C. EMG</th><th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th><th>E. DIAGNOSIS POINTER</th><th>F. \$ CHARGES</th><th>G. DAYS OR UNITS</th><th>H. EPSTI Family Plan</th><th>I. I.D. QUAL</th><th>J. RENDERING PROVIDER I.D. #</th></tr><tr><th>From MM DD YY</th><th>To MM DD YY</th><th></th><th>CPT/HCPCS MODIFIER</th><th></th><th></th><th></th><th></th><th></th><th></th></tr></thead><tbody><tr><td>02 25 19</td><td>02 25 19</td><td>23</td><td>99285</td><td>A, B</td><td>1,360 00</td><td>1</td><td></td><td></td><td>1104087287</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table>							24 A. DATES OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSTI Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #	From MM DD YY	To MM DD YY		CPT/HCPCS MODIFIER							02 25 19	02 25 19	23	99285	A, B	1,360 00	1			1104087287																																																		
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02 25 19	02 25 19	23	99285	A, B	1,360 00	1			1104087287																																																																													
<div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE \$ 1,360 00 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use</div>																																																																																						
<div>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.) FLORES, PATRICK 1104087287 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.</div>																																																																																						

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 752297429-10036 (UHC 837 MEDICAL)

PA000223

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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 the party who accepts assignment below.		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 <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/04/19</u>		SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)		22. RESUBMISSION CODE	
A. <u>R0602</u> B. <u>R1900</u> C. <u>D649</u> D. <u></u>		1	
E. <u></u> F. <u></u> G. <u></u> H. <u></u>		23. PRIOR AUTHORIZATION NUMBER	
I. <u></u> J. <u></u> K. <u></u> L. <u></u>			
24 A. DATES OF SERVICE		B. PLACE OF SERVICE	
C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES	
E. DIAGNOSIS POINTER		F. \$ CHARGES	
G. DAYS OR UNITS		H. EPSON Family Plan	
I. I.D. QUAL		J. RENDERING PROVIDER I.D. #	
1 03 04 19 03 04 19 23		99285 A, B, C 1,360 00 1 1235431388	
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER		26. PATIENT ACCOUNT NO.	
880262438		27. ACCEPT ASSIGNMENT	
SSN EIN		28. TOTAL CHARGE	
<input type="checkbox"/> <input checked="" type="checkbox"/>		\$ 1,360 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		29. AMOUNT PAID	
INCLUDING DEGREES OR CREDENTIALS		30. Rsvd for NUCC Use	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)			
GOMEZ, ADRIAN		32. SERVICE FACILITY LOCATION INFORMATION	
1235431388		FREMONT EMERGENCY SERVICES MAN	
207P00000X		3100 N TENAYA WAY	
SIGNED		LAS VEGAS, NV 89128-0436	
DATE		33. BILLING PROVIDER INFO & PH #	
		FREMONT EMERGENCY SERVICES MAN	
		PO BOX 638972	
		CINCINNATI, OH 45263-8972	
		(888) 952-6772	
		a. 1366429821 b.	

PA000224

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE (Medicare#)		MEDICAID (Medicaid#)	
TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)	
GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	
OTHER (ID#)		<input checked="" type="checkbox"/> (ID#)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
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 the party who accepts assignment below.		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 <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/05/19</u>		SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
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 (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24 A. DATES OF SERVICE		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT ACCOUNT NO.	
27. ACCEPT ASSIGNMENT		28. TOTAL CHARGE	
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.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH #		34. BILLING PROVIDER INFO & PH #	

1500

Claim TPA ID :
Claim Total : \$1,360.00

Submitter : 841162764 (OPTUMINSIGHT FKA ICS/INGENIX 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
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 the party who accepts assignment below.		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: <u>AUTHORIZED SIGNATURE ON FILE</u> DATE: <u>03/06/19</u>		SIGNED: <u>AUTHORIZED SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
MM DD YY QUAL.		MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
17a. 17b.		FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
Referral# REF# H/L#		<input type="checkbox"/> YES <input type="checkbox"/> 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. <u>R1011</u> B. <u>R1013</u> C. D. E. F. G. H. I. J. K. L.		1	
24 A. DATES OF SERVICE		F. \$ CHARGES	
From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. DIAGNOSIS POINTER		G. DAYS OF UNITS H. EPST Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #	
1 03 06 19 03 06 19 23 99285 A, B		1,360 00 1 1972505675	
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT ACCOUNT NO.	
880262438 X		X YES <input type="checkbox"/> NO	
27. ACCEPT ASSIGNMENT		28. TOTAL CHARGE	
X YES <input type="checkbox"/> NO		\$ 1,360 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.)		32. SERVICE FACILITY LOCATION INFORMATION	
DUNAGAN, CLARENCE 1972505675 207P00000X		MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS, NV 89128-0436	
SIGNED DATE		a. 1104870187 b. 1366429821	
		33. BILLING PROVIDER INFO & PH #	
		FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772	

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 841162764 (OPTUMINSIGHT FKA ICS/INGENIX 837 MEDICAL)

PA000226

1500

Claim TPA ID :
Claim Total : \$1,337.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA																																																																																				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FICA BLK LUNG (ID#)	OTHER (ID#)																																																																																
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div>																																																																																						
<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)</div> <div>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>10d. CLAIM CODES (Designated by NUCC)</div>																																																																																						
<div>11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></div> <div>b. OTHER CLAIM ID (Designated by NUCC)</div> <div>c. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a and 9d.</div>																																																																																						
<div>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 the party who accepts assignment below.</div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/09/19</u></div>																																																																																						
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<div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0</div> <div>A. <u>R1013</u> B. <u>K529</u> C. <u>L</u> D. <u>L</u> E. <u>L</u> F. <u>L</u> G. <u>L</u> H. <u>L</u> I. <u>L</u> J. <u>L</u> K. <u>L</u> L. <u>L</u></div>																																																																																						
<div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div>																																																																																						
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24 A. DATES OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #																																																																													
From MM DD YY To MM DD YY			CPT/HCPCS MODIFIER																																																																																			
03 09 19 03 09 19	23		99285	A, B	1,295 00	1			1366865206																																																																													
03 09 19 03 09 19	23		99053	A, B	42 00	1			1366865206																																																																													
<div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE \$ 1,337 00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rsvd for NUCC Use</div>																																																																																						
<div>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.) LUNDBERG, MICHAEL 1366865206 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3325 SOUTH FORT APACHE LAS VEGAS, NV 89117-6360 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1679550149 b.</div>																																																																																						

PA000227

1500

Claim TPA ID :
Claim Total : \$484.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input checked="" type="checkbox"/> (ID#)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
10. IS PATIENT'S CONDITION RELATED TO:						
a. EMPLOYMENT? (Current or Previous)						
<input type="checkbox"/> YES <input type="checkbox"/> NO						
b. AUTO ACCIDENT? PLACE (State)						
<input type="checkbox"/> YES <input type="checkbox"/> NO						
c. OTHER ACCIDENT?						
<input type="checkbox"/> YES <input type="checkbox"/> NO						
c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
<input type="checkbox"/> YES <input type="checkbox"/> NO 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 the party who accepts assignment below.						
SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/11/19</u>						
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 <u>AUTHORIZED SIGNATURE ON FILE</u>						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP)						
MM DD YY QUAL.						
15. OTHER DATE						
MM DD YY QUAL.						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						
17a. 17b.						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						
Referral# REF# H/L#						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0						
A. <u>M25562</u> B. <u>M25462</u> C. <u>L</u> D. <u>L</u>						
E. <u>L</u> F. <u>L</u> G. <u>L</u> H. <u>L</u>						
I. <u>L</u> J. <u>L</u> K. <u>L</u> L. <u>L</u>						
22. RESUBMISSION CODE 1 ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER						
24 A. DATES OF SERVICE						
From To PLACE OF SERVICE						
MM DD YY MM DD YY EMG						
24 B. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER						
E. DIAGNOSIS POINTER						
F. \$ CHARGES						
G. DAYS OF UNITS						
H. EPST? Family Plan						
I. I.D. QUAL						
J. RENDERING PROVIDER I.D. #						
1 03 11 19 03 11 19 23 99283 A,B 484 00 1 1114286077						
2						
3						
4						
5						
6						
25. FEDERAL TAX I.D. NUMBER SSN EIN						
880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>						
26. PATIENT ACCOUNT NO.						
27. ACCEPT ASSIGNMENT						
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
28. TOTAL CHARGE						
\$ 484 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.)						
MACEDO, MARK						
1114286077						
207P00000X						
SIGNED DATE						
32. SERVICE FACILITY LOCATION INFORMATION						
FREMONT EMERGENCY SERVICES MAN						
7207 ALIANTE PKWY						
NORTH LAS VEGAS, NV 89084-2373						
33. BILLING PROVIDER INFO & PH #						
FREMONT EMERGENCY SERVICES MAN						
PO BOX 638972						
CINCINNATI, OH 45263-8972						
(888) 952-6772						
a. 1316488141 b.						

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 752297429-10036 (UHC 837 MEDICAL)

PA000228

1500

Submitter : 133068979 (PHCS ROUTED 837 MEDICAL)
Claim TPA ID :
Claim Total : \$1,428.00Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHE (ID#)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)		
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES(Designated by NUCC)		
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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/18/19</u>				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 <u>AUTHORIZED SIGNATURE ON FILE</u>		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. <u>J189</u> B. <u>R0600</u> C. <u>R05</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>				22. RESUBMISSION CODE 1 ORIGINAL REF. NO.		
24 A. DATES OF SERVICE From To MM DD YY MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. DIAGNOSIS POINT F. \$ CHARGES G. DAYS CR H. EP&DT Family Plan I. I.D. QUAL J. RENDERING PROVIDER I.D. #				23. PRIOR AUTHORIZATION NUMBER		
1 03 18 19 03 18 19 23 99285 A,B,C 1,428 00 1 1194131854				23. PRIOR AUTHORIZATION NUMBER		
2				23. PRIOR AUTHORIZATION NUMBER		
3				23. PRIOR AUTHORIZATION NUMBER		
4				23. PRIOR AUTHORIZATION NUMBER		
5				23. PRIOR AUTHORIZATION NUMBER		
6				23. PRIOR AUTHORIZATION NUMBER		
25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT ACCOUNT NO. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
27. ACCEPT ASSIGNMENT (For all dates of service) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 1,428 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.) LIN, CHARLES 1194131854 207P00000X SIGNED DATE				32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS,NV 89109-2317 a. b.		
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.						

NUCC Instruction Manual at: www.nucc.org
Page: 1 of 1UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)
Submitter : 133068979 (PHCS ROUTED 837 MEDICAL)

PA000229

1500

Claim TPA ID :
Claim Total : \$1,474.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA																																																																																				
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)																																																																																
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div>																																																																																						
<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/></div> <div>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>10d. CLAIM CODES (Designated by NUCC)</div> <div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.</div>																																																																																						
<div>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 the party who accepts assignment below.</div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/19/19</u></div>																																																																																						
<div>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</div> <div>SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u></div>																																																																																						
<div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.</div> <div>15. OTHER DATE MM DD YY QUAL.</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div>																																																																																						
<div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div> <div>17a. <input type="checkbox"/> 17b. <input type="checkbox"/></div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div>																																																																																						
<div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF= H/L=</div> <div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div>																																																																																						
<div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0</div> <div>A. <u>IJ189</u> B. <u>R0902</u> C. <u>J45901</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u></div> <div>22. RESUBMISSION CODE <u>1</u> ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div>																																																																																						
<table border="1"><thead><tr><th>24 A. DATES OF SERVICE</th><th>B. PLACE OF SERVICE</th><th>C. EMG</th><th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th><th>E. DIAGNOSIS POINTER</th><th>F. \$ CHARGES</th><th>G. DAYS OR UNITS</th><th>H. EP/SDT Family Plan</th><th>I. I.D. QUAL</th><th>J. RENDERING PROVIDER I.D. #</th></tr><tr><th>From MM DD YY To MM DD YY</th><th></th><th></th><th>CPT/HCPCS MODIFIER</th><th></th><th></th><th></th><th></th><th></th><th></th></tr></thead><tbody><tr><td>03 19 19 03 19 19</td><td>23</td><td></td><td>99285</td><td>A, B, C</td><td>1,428 00</td><td>1</td><td></td><td></td><td>1851592497</td></tr><tr><td>03 19 19 03 19 19</td><td>23</td><td></td><td>99053</td><td>A, B, C</td><td>46 00</td><td>1</td><td></td><td></td><td>1851592497</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table>							24 A. DATES OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/SDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #	From MM DD YY To MM DD YY			CPT/HCPCS MODIFIER							03 19 19 03 19 19	23		99285	A, B, C	1,428 00	1			1851592497	03 19 19 03 19 19	23		99053	A, B, C	46 00	1			1851592497																																								
24 A. DATES OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/SDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #																																																																													
From MM DD YY To MM DD YY			CPT/HCPCS MODIFIER																																																																																			
03 19 19 03 19 19	23		99285	A, B, C	1,428 00	1			1851592497																																																																													
03 19 19 03 19 19	23		99053	A, B, C	46 00	1			1851592497																																																																													
<div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>27. ACCEPT ASSIGNMENT</div> <div>28. TOTAL CHARGE \$ 1,474 00</div> <div>29. AMOUNT PAID \$</div> <div>30. Rsvd for NUCC Use</div>																																																																																						
<div>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.) WALKER, JAMES 1851592497 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1518120971 b.</div>																																																																																						

PA000230

1500

Claim TPA ID :
Claim Total : \$964.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA	
I. MEDICARE (Medicare#)		MEDICAID (Medicaid#)	
TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)	
GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)	
OTHER (ID#)		<input checked="" type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
10. IS PATIENT'S CONDITION RELATED TO			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. RESERVED FOR NUCC USE		<input type="checkbox"/> YES <input type="checkbox"/> NO	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		<input type="checkbox"/> YES <input type="checkbox"/> NO	
10d. CLAIM CODES (Designated by NUCC)		c. OTHER ACCIDENT?	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		SIGNED: AUTHORIZED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
MM DD YY QUAL		MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
17a. 17b.		FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
Referral# REF# H/L#		<input type="checkbox"/> YES <input type="checkbox"/> 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. H6691 B. B974 C. L D. L		1	
E. L F. L G. L H. L		23. PRIOR AUTHORIZATION NUMBER	
I. L J. L K. L L. L			
24 A. DATES OF SERVICE		B. PLACE OF SERVICE	
From To MM DD YY MM DD YY		EMG	
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	
CPT/HCPCS MODIFIER			
F. \$ CHARGES		G. DAYS OF UNITS	
H. EPST Family Plan		I. I.D. QUAL	
J. RENDERING PROVIDER I.D. #			
1 03 24 19 03 24 19 23 99284 A, B 964 00 1 1578786877			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT ACCOUNT NO.	
880262438 <input type="checkbox"/> <input checked="" type="checkbox"/>		27. ACCEPT ASSIGNMENT	
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.) ZAHAROFF, NATALIE 1578786877 207P00000X SIGNED DATE		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 7207 ALIANTE PKWY NORTH LAS VEGAS, NV 89084-2373 a. b.		28. TOTAL CHARGE \$ 964 00	
33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1316488141 b.		29. AMOUNT PAID \$	
30. Rsvd for NUCC Use			

PA000231

1500

Claim TPA ID :
Claim Total : \$1,853.00

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Patient's Acct# :
Batch Number :
CCN# :
HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA																																																																										
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)																																																																						
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>b. RESERVED FOR NUCC USE</div> <div>c. RESERVED FOR NUCC USE</div> <div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>10. IS PATIENT'S CONDITION RELATED TO</div> <div>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State):</div> <div>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>10d. CLAIM CODES (Designated by NUCC)</div> <div>c. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.</div> <div>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 the party who accepts assignment below. SIGNED <u>AUTHORIZED SIGNATURE ON FILE</u> DATE <u>03/28/19</u></div> <div>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 <u>AUTHORIZED SIGNATURE ON FILE</u></div> <div>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.</div> <div>15. OTHER DATE MM DD YY QUAL.</div> <div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.</div> <div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</div> <div>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral# REF# H/L#</div> <div>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</div> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. <u>K5900</u> B. <u>E860</u> C. <u>N451</u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u></div> <div>22. RESUBMISSION CODE 1 ORIGINAL REF. NO.</div> <div>23. PRIOR AUTHORIZATION NUMBER</div> <table border="1"><thead><tr><th>24 A. DATES OF SERVICE From MM DD YY To MM DD YY</th><th>B. PLACE OF SERVICE</th><th>C. EMG</th><th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th><th>E. DIAGNOSIS POINTER</th><th>F. \$ CHARGES</th><th>G. DAYS OR UNITS</th><th>H. EP501 Family Plan</th><th>I. I.D. QUAL</th><th>J. RENDERING PROVIDER I.D. #</th></tr></thead><tbody><tr><td>03 28 19 03 28 19</td><td>23</td><td></td><td>99291</td><td>A, B, C</td><td>1,853 00</td><td>1</td><td></td><td></td><td>1609253103</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table> <div>25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>26. PATIENT ACCOUNT NO. 27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</div> <div>28. TOTAL CHARGE \$ 1,853 00 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use</div> <div>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.) CHANG, WILLIS 1609253103 207P00000X SIGNED DATE</div> <div>32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LAS VEGAS, NV 89128-0436 a. b.</div> <div>33. BILLING PROVIDER INFO & PH # FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI, OH 45263-8972 (888) 952-6772 a. 1366429821 b.</div>							24 A. DATES 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. EP501 Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #	03 28 19 03 28 19	23		99291	A, B, C	1,853 00	1			1609253103																																																		
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Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID :
 Claim Total : \$927.00

Patient's Acct# :
 Batch Number :
 CCN# :
 HIC Number : n/a

HEALTH INSURANCE CLAIM FORM

UNOFFICIAL/NOT YET APPROVED BY N.U.C. 02/12

PICA		PICA																																																																							
1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)																																																																						
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EXHIBIT 6

Sample Claim Forms for SHO

EXHIBIT 6



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

SPONSORED BY: [REDACTED] 8/1/13

MEDICARE [] MEDICAID [] TRICARE [] CHAMPVA [] GROUP HEALTH PLAN [] FECA BLK LUNG [] OTH []

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary for payment of medical benefits either to myself or to the party who accepts assignment) SIGNATURE ON FILE DATE: 12/28/17										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 (MM/DD/YY) 08/26/17 QUAL: 431										15. OTHER DATE (MM/DD/YY) QUAL: _____									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: _____ TO: _____										17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. _____ 17b. NPI: _____									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: 08/26/17 TO: 08/26/17										19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES: _____									
20. DIAGNOSIS OF INJURY OR ILLNESS OR INJURY (Specify A-E to service line below (24E)) R03.0										21. RESUBMISSION CODE _____ ORIGINAL REF NO: _____									
22. PRIOR AUTHORIZATION NUMBER _____										23. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances) DATE: _____ TIME: _____ PLACE: _____ CPT/HCPCS: _____ MODIFIER: _____ DIAGNOSIS POINTER: _____									
24. TOTAL CHARGE \$ CHARGES: _____										25. AMOUNT PAID \$ CHARGES: _____									
26. TOTAL CHARGE \$ CHARGES: 1295.00										27. AMOUNT PAID \$ CHARGES: 0.00									
28. BILLING PROVIDER INFO & PH # (800)-562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972										29. BILLING PROVIDER INFO & PH # (800)-562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972									
30. BILLING PROVIDER INFO & PH # 1518120971										31. BILLING PROVIDER INFO & PH # 72207P00000X									
32. BILLING PROVIDER INFO & PH # 44 OUTSOURCED BILLING										33. BILLING PROVIDER INFO & PH # 44 OUTSOURCED BILLING									

SIERRA HEALTHCARE OPTIONS\



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS, NV 89114-5392



<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>1. I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT. I AGREE TO HOLD THE PROVIDER, SUPPLIER, OR OTHER PARTY RESPONSIBLE FOR ANY MEDICAL OR OTHER INFORMATION NEEDED BY THE INSURANCE COMPANY, AND TO HOLD THEM HARMLESS FROM ANY AND ALL CLAIMS, DAMAGES, LOSSES, AND EXPENSES, INCLUDING REASONABLE ATTORNEY'S FEES, THAT MAY BE ASSERTED AGAINST THEM BY THE INSURANCE COMPANY OR ITS SUCCESSORS, ASSIGNS, OR AGENTS.</p>										<p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If not, complete below:</p> <p>13. PROVIDER'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE: _____</p> <p>DATE: _____</p>																			
<p>SIGNATURE ON FILE DATE 01/02/18</p> <p>14. DATE OF BIRTH (MM/DD/YY) 01/14/17</p> <p>15. OTHER DATE (MM/DD/YY) 01/14/17</p> <p>16. DATE OF PATIENT'S BIRTH (MM/DD/YY) 01/14/17</p> <p>17. FROM (MM/DD/YY) 01/14/17 TO (MM/DD/YY) 01/14/17</p> <p>18. HOSPITALIZATION DATES (MM/DD/YY) 01/14/17 TO 01/14/17</p> <p>19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>20. REIMBURSEMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>21. PRINT AUTHORIZED REPRESENTATIVE'S NAME: _____</p>										<p>22. PRINT AUTHORIZED REPRESENTATIVE'S NAME: _____</p> <p>23. PRINT AUTHORIZED REPRESENTATIVE'S ADDRESS: _____</p> <p>24. PRINT AUTHORIZED REPRESENTATIVE'S CITY/STATE/ZIP: _____</p> <p>25. PRINT AUTHORIZED REPRESENTATIVE'S PHONE: _____</p> <p>26. PRINT AUTHORIZED REPRESENTATIVE'S FAX: _____</p> <p>27. PRINT AUTHORIZED REPRESENTATIVE'S EMAIL: _____</p>																			
<p>28. PROVIDER'S ACCOUNT NO. 88-0262438</p> <p>29. ACCT. ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>30. TOTAL CHARGE 1601.00</p> <p>31. PATIENT'S PORTION 0.00</p> <p>32. INSURANCE PORTION 1601.00</p> <p>33. PATIENT'S PORTION 0.00</p> <p>34. INSURANCE PORTION 1601.00</p> <p>35. PATIENT'S PORTION 0.00</p> <p>36. INSURANCE PORTION 1601.00</p> <p>37. PATIENT'S PORTION 0.00</p> <p>38. INSURANCE PORTION 1601.00</p> <p>39. PATIENT'S PORTION 0.00</p> <p>40. INSURANCE PORTION 1601.00</p> <p>41. PATIENT'S PORTION 0.00</p> <p>42. INSURANCE PORTION 1601.00</p> <p>43. PATIENT'S PORTION 0.00</p> <p>44. INSURANCE PORTION 1601.00</p> <p>45. PATIENT'S PORTION 0.00</p> <p>46. INSURANCE PORTION 1601.00</p> <p>47. PATIENT'S PORTION 0.00</p> <p>48. INSURANCE PORTION 1601.00</p> <p>49. PATIENT'S PORTION 0.00</p> <p>50. INSURANCE PORTION 1601.00</p> <p>51. PATIENT'S PORTION 0.00</p> <p>52. INSURANCE PORTION 1601.00</p> <p>53. PATIENT'S PORTION 0.00</p> <p>54. INSURANCE PORTION 1601.00</p> <p>55. PATIENT'S PORTION 0.00</p> <p>56. INSURANCE PORTION 1601.00</p> <p>57. PATIENT'S PORTION 0.00</p> <p>58. INSURANCE PORTION 1601.00</p> <p>59. PATIENT'S PORTION 0.00</p> <p>60. INSURANCE PORTION 1601.00</p> <p>61. PATIENT'S PORTION 0.00</p> <p>62. INSURANCE PORTION 1601.00</p> <p>63. PATIENT'S PORTION 0.00</p> <p>64. INSURANCE PORTION 1601.00</p> <p>65. PATIENT'S PORTION 0.00</p> <p>66. INSURANCE PORTION 1601.00</p> <p>67. PATIENT'S PORTION 0.00</p> <p>68. INSURANCE PORTION 1601.00</p> <p>69. PATIENT'S PORTION 0.00</p> <p>70. INSURANCE PORTION 1601.00</p> <p>71. PATIENT'S PORTION 0.00</p> <p>72. INSURANCE PORTION 1601.00</p> <p>73. PATIENT'S PORTION 0.00</p> <p>74. INSURANCE PORTION 1601.00</p> <p>75. PATIENT'S PORTION 0.00</p> <p>76. INSURANCE PORTION 1601.00</p> <p>77. PATIENT'S PORTION 0.00</p> <p>78. INSURANCE PORTION 1601.00</p> <p>79. PATIENT'S PORTION 0.00</p> <p>80. INSURANCE PORTION 1601.00</p> <p>81. PATIENT'S PORTION 0.00</p> <p>82. INSURANCE PORTION 1601.00</p> <p>83. PATIENT'S PORTION 0.00</p> <p>84. INSURANCE PORTION 1601.00</p> <p>85. PATIENT'S PORTION 0.00</p> <p>86. INSURANCE PORTION 1601.00</p> <p>87. PATIENT'S PORTION 0.00</p> <p>88. INSURANCE PORTION 1601.00</p> <p>89. PATIENT'S PORTION 0.00</p> <p>90. INSURANCE PORTION 1601.00</p> <p>91. PATIENT'S PORTION 0.00</p> <p>92. INSURANCE PORTION 1601.00</p> <p>93. PATIENT'S PORTION 0.00</p> <p>94. INSURANCE PORTION 1601.00</p> <p>95. PATIENT'S PORTION 0.00</p> <p>96. INSURANCE PORTION 1601.00</p> <p>97. PATIENT'S PORTION 0.00</p> <p>98. INSURANCE PORTION 1601.00</p> <p>99. PATIENT'S PORTION 0.00</p> <p>100. INSURANCE PORTION 1601.00</p>																													
<p>BAILEY MD, JAMES</p> <p>SIGNATURE ON FILE 01/02/18</p> <p>1104870187</p>										<p>MOUNTAIN VIEW HOSPITAL</p> <p>3100 N TENAYA WAY</p> <p>LAS VEGAS, NV 89128-0436</p>										<p>FREMONT EMERGENCY SERVICES M</p> <p>PO BOX 638972</p> <p>CINCINNATI, OH 45263-8972</p> <p>1366429821 77207P000000X</p>									



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

CARRIER
PATIENT AND INSURED INFORMATION

1. PATIENT 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.) SIGNATURE ON FILE DATE 01/08/18		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 DATE	
2. DATE OF CURRENT SERVICE (MM/DD/YYYY) 05/14/17 TIME 431		3. DATE OF SERVICE (MM/DD/YYYY) FROM 05/14/17 TO 05/14/17	
4. NAME OF PHYSICIAN PROVIDER (OTHER SERVICE) K56.69		5. OUTSIDE LAB CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
6. ADDITIONAL CLARIFICATION (Assigned to RUC) K56.69		7. RESUBMISSION CODE 0 ORIGINAL REF NO.	
8. PRIOR AUTHORIZATION NUMBER		9. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
10. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		11. CHARGES	
12. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. TOTAL CHARGE 1273.00	
14. SERVICE FACILITY LOCATION INFORMATION ST ROSE DOMINICAN HOSPI 3001 ST ROSE PKWY HENDERSON, NV 89052-3839 1770626426		15. BILLING PROVIDER INFO FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1689013161 ZZ207P00000X	
16. SIGNATURE OF TRUAX DO, GREG FERMIN SIGNATURE ON FILE 01/08/18		17. AMOUNT PAID 0.00	

PHYSICIAN OR SUPPLIER INFORMATION



HEALTH DISBURDANCE CLAIM FORM

[illegible]

SRD Inst 52600 must be available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED FOR RELEASE BY NSA ON 02-12-2012

WOMEN LEADS BY

PA000238



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES												21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. R55 B. N93.9 C. R00.0 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 To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD ID. QUAL J. RENDERING PROVIDER ID. #																																			
1 08 19 17 08 19 17 23 X 99291 222.00 ABC 1681.00 NPI 1740625946												2 08 19 17 08 19 17 23 X 99291 222.00 ABC 1681.00 NPI 1740625946												3 08 19 17 08 19 17 23 X 99291 222.00 ABC 1681.00 NPI 1740625946																							
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25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438 <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO. _____												27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE 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.) BRIA MD, CARLEY SIGNATURE ON FILE SIGNED 01/19/18												32. SERVICE FACILITY LOCATION INFORMATION SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 1861439952												33. BILLING PROVIDER INFO & PH. # (800-562-2945) FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1518120971 ZZ207P00000X																							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CLAIMS FOR PAYMENT (02-12)

WCMS-1500CS-12

PA000239



SIERRA HEALTH OPTIONS
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

FIRST FOLD WHCF-10-EN / WHCF-10-EN-S3

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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 _____ DATE 01/25/18										SIGNED _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)										15. OTHER DATE									
MM DD YY QUAL 07 18 17 431										MM DD YY QUAL 07 18 17 439									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
17a. _____ 17b. NPI _____										FROM MM DD YY TO MM DD YY 07 18 17 07 18 17									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. S72.121A B. R03.0 C. Y93.89 D. _____																			
E. _____ F. _____ G. _____ H. _____																			
I. _____ J. _____ K. _____ L. _____																			
24. A. DATE(S) OF SERVICE										23. PRIOR AUTHORIZATION NUMBER									
From To PLACE OF SERVICE EMG CPT/HCPCS MODIFIER DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. gross bill per I. ID. QUAL J. RENDERING PROVIDER ID. #																			
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2										NPI									
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6										NPI									
25. FEDERAL TAX ID. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
88-0262438																			
<input type="checkbox"/> <input checked="" type="checkbox"/>										27. ACCEPT ASSIGNMENT? (For govt. claims, see back)									
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																			
28. TOTAL CHARGE										29. AMOUNT PAID									
\$ 1295 00										\$ 0 00									
30. Signature of Physician or Supplier INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made in good faith.)										31. BILLING PROVIDER INFO & PH. #									
FLORES DO, PATRICK H										(800) 562-2945									
SIGNATURE ON FILE										FREMONT EMERGENCY SERVICES MA									
SIGNED 01/25/18 DATE										PO BOX 638972									
a. 1861439952 b.										CINCINNATI, OH 45263-8972									
										a. 1518120971 b. VWCHDG207P00000X									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0326-1972 FORM 1380 (02-12)

WCMS-1500CS-12

PA000240



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

APPROVED BY NAACCM: UNIFORM CLAIM FORM (02/05) (10/05) (12/10)

PATIENT AND INSURED INFORMATION

12. PATIENT 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 01/26/18

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: DATE:

SIGNED:

14. DATE OF CURRENT ILLNESS OR INJURY, OR PREGNANCY (MM/DD/YY)
11/22/17 QUAL 431

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

15. OTHER DATE (MM/DD/YY)
QUAL

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY)
FROM 11/22/17 TO 11/22/17

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a. 17b. NPI

19. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES

17c. ADDITIONAL CLERK INFORMATION (designated by NUCC)

20. RESUBMISSION CODE ORIGINAL REF. NO.

17. (A) THOSE ORIGINATOR OF ILLNESS OR INJURY, (B) ICD-9-CM, (C) ICD-10, (D) F17.200
A. I48.3 B. I50.9 C. R79.89 D. F17.200

21. PRIOR AUTHORIZATION NUMBER

17. (E) (F) (G) (H)

22. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

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37. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

PHYSICIAN OR SUPPLIER INFORMATION

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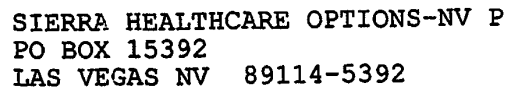
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HEALTH INSURANCE CLAIM FORM

APP. 1000 BY SA JAMES JOHNSON (LAW ENFORCEMENT PROC.) (P.12)

[illegible]



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 10-12

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

02/22/18

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) FROM MM DD YY TO MM DD YY QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 09 29 17 TO 09 29 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB

20a

20b

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Rule by A-L to service line below (24E)

ICD 10

A. I21.3

D. I10

C.

D.

E.

F.

G.

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24. A. DATE(S) OF SERVICE

From To

B. PLACE OF SERVICE

C. EMG

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)

OPT HCPCS

MODIFIER

E. DIAGNOSIS POINTER

F. CHARGES

G. CPT

H. ICD

I. TOTAL

J. PAYING PROVIDER ID #

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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DESIGNS OR CREDENTIALS I certify that the statements on this invoice are true and correct to the best of my knowledge and belief.

32. SERVICE FACILITY LOCATION INFORMATION

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33. BILLING TYPE USER INFORMATION

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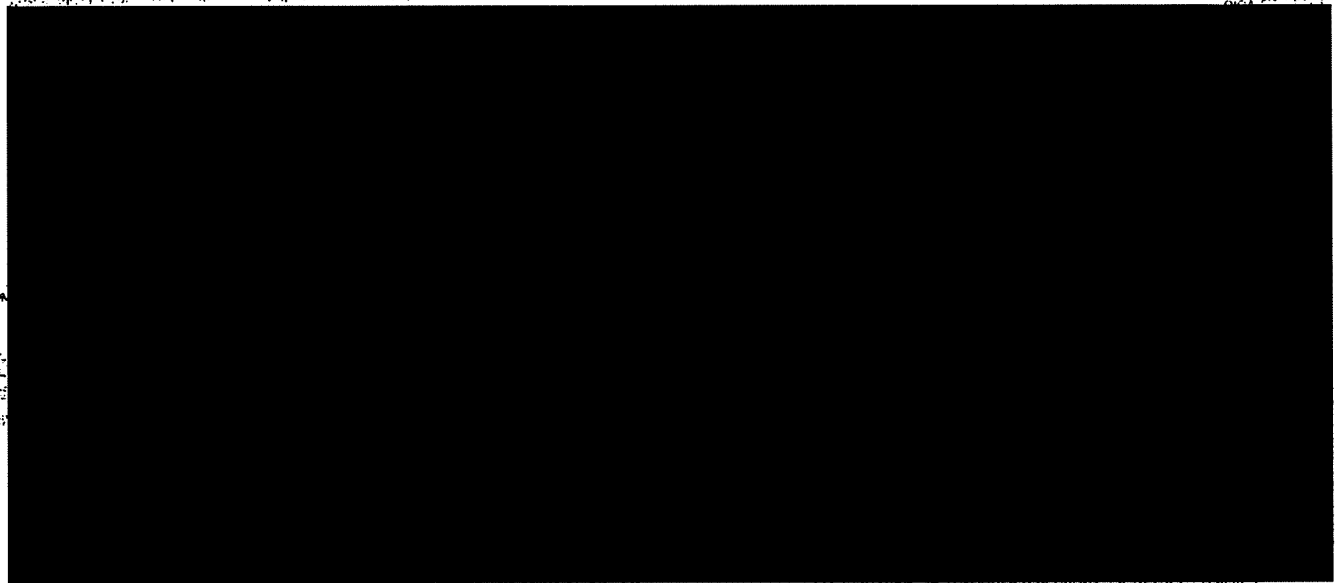
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SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

CARRIER

HEALTH INSURANCE CLAIM FORM



READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE DATE 02/26/18		SIGNATURE ON FILE	
12 28 17 431		GATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 12 28 17 TO 12 28 17	
R07.89 R51 R94.31		HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 12 28 17 TO 12 28 17	
0		OUTSIDE LAB CHARGES <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
0		RESUBMISSION CODE	
ORIGINAL REC NO		AUTHORIZING NUMBER	
12 28 17 12 28 17 23 X 99284 ABC 927 001		NPI 1649569583	
12 28 17 12 28 17 23 X 99053 ABC 44 001		NPI 1649569583	
88-0262438 X		TOTAL CHARGE 971 00 AMOUNT PAID 0 00	
MARTIN DO, JARED T		FREMONT EMERGENCY SERVICES MA	
SIGNATURE ON FILE		PO BOX 638972	
02/26/18		CINCINNATI, OH 45263-8972	
1861439952		1518120971 ZZ207P00000X	

PHYSICIAN OR SUPPLIER INFORMATION



HEALTH INSURANCE CLAIM FORM

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

KAISER
PO BOX 15392
ATTN:SIERRA HEALTH KP CLMS
LAS VEGAS,NV 89114

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

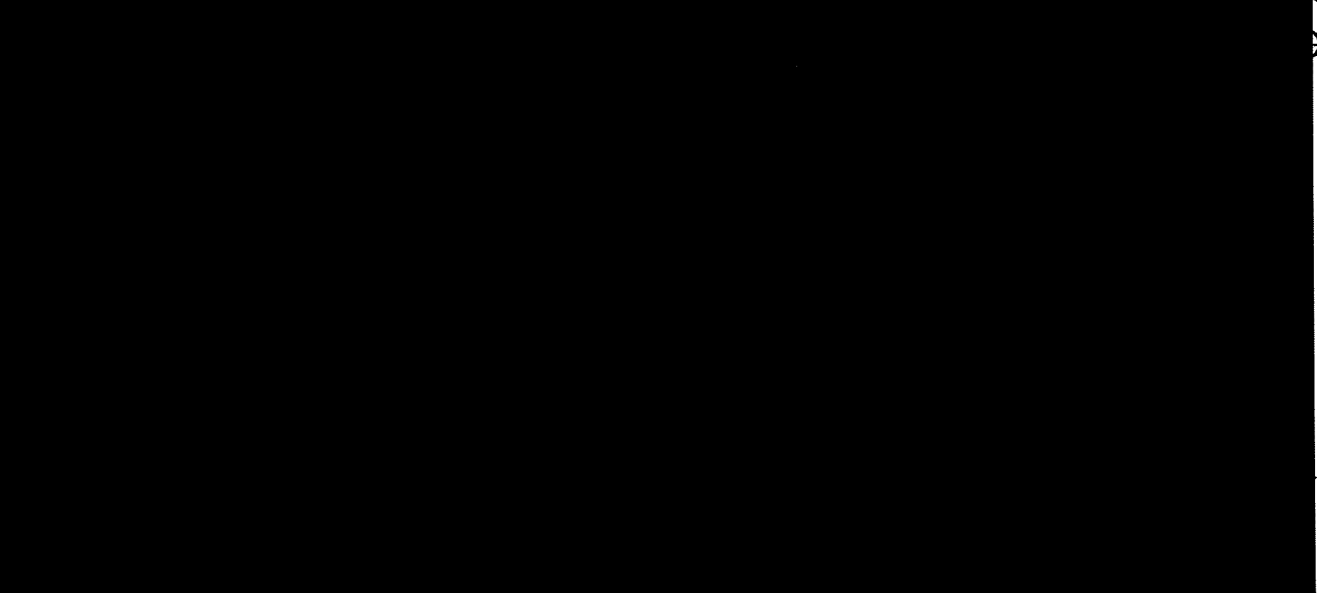
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment or government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 03/06/18 SIGNED _____ DATE _____												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: 431 12 16 17												15. OTHER DATE QUAL: MM DD YY												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 12 16 17																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 12 16 17												19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (2+E) ICD Ind: 0 A. R53.1 B. I63.9 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												22. RESUBMISSION CODE ORIGINAL REF NO. 23. PRIOR AUTHORIZATION NUMBER																							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DAYS OF VISITS H. POSIT. TESTS I. ID. QUAL. J. RENDERING PROVIDER ID #												12 16 17 12 16 17 23 X 99285 AB 1360 001 NPI 1003869504												12 16 17 12 16 17 23 X 93010 A 67 001 NPI 1003869504																							
25. FEDERAL TAX ID, NUMBER SSN EIN 88-0262438 <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO. _____												27. ACCEPT ASSIGNMENT? (For prev. claims, use each) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ 1427.00 29. AMOUNT PAID \$ 0.00 30. Allow 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) KARKAVANDIAN DO, HABI SIGNATURE ON FILE SIGNED 03/06/18												32. SERVICE FACILITY LOCATION INFORMATION ST ROSE DOMINICAN HOSPI 3001 ST ROSE PKWY HENDERSON, NV 89052-3839 a. 1770626426 b. _____												33. BILLING PROVIDER INFO & PH. # (800-562-2945) FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 a. 1689013161 b. ZZ207P00000X																							



KAISER PPO
PO BOX 14392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/01/2000



CARRIER
PATIENT AND INSURED INFORMATION

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 04/30/18 SIGNED _____ 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 _____ DATE _____																																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 04/13/18 QUAL 431												15. OTHER DATE 04/23/18 QUAL 439												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 04/23/18 TO 04/23/18																											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. _____												17b. NPI _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 04/23/18 TO 04/23/18															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																								20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. S06.6X0A B. S06.5X0A C. R20.2 D. F10.129 E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____																								22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																											
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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 PAY PER				I. ID. QUAL				J. RENDERING PROVIDER ID #			
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true and correct to the best of my knowledge thereof.) SIGNATURE ON FILE 04/30/18 SIGNED _____ DATE _____												32. SERVICE FACILITY LOCATION INFORMATION SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 a. 1861439952 b. _____												33. BILLING PROVIDER INFO & PH. # FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 a. 1518120971 b. ZZ207F00000X																											

PHYSICIAN OR SUPPLIER INFORMATION



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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



READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																					
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																																																															
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<table border="1"><thead><tr><th>24. A. DATE(S) OF SERVICE</th><th>B. PLACE OF SERVICE</th><th>C. EMG</th><th>D. PROCEDURES, SERVICES, OR SUPPLIES</th><th>E. DIAGNOSIS</th><th>F. \$ CHARGES</th><th>G. DAYS OR UNITS</th><th>H. ICD-9-CM</th><th>I. ID. QUAL</th><th>J. RENDERING PROVIDER ID. #</th></tr><tr><th>From MM DD YY</th><th>To MM DD YY</th><th></th><th>CPT/HCPCS MODIFIER</th><th>POINTER</th><th></th><th></th><th></th><th></th><th></th></tr></thead><tbody><tr><td>06 17 17</td><td>06 17 17</td><td>23</td><td>X 99291</td><td>AB</td><td>1681.00</td><td></td><td></td><td>NPI</td><td>1205940756</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td><td></td></tr></tbody></table>												24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM	I. ID. QUAL	J. RENDERING PROVIDER ID. #	From MM DD YY	To MM DD YY		CPT/HCPCS MODIFIER	POINTER						06 17 17	06 17 17	23	X 99291	AB	1681.00			NPI	1205940756									NPI										NPI										NPI										NPI										NPI										NPI	
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25. FEDERAL TAX I.D. NUMBER 88-0262438			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1681.00		29. AMOUNT PAID \$ 0.00		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.) LASRY MD, JASON SIGNATURE ON FILE SIGNED 06/05/18			32. SERVICE FACILITY LOCATION INFORMATION ST ROSE DOMINICAN HOSPI 3001 ST ROSE PKWY HENDERSON, NV 89052-3839 1770626426				33. BILLING PROVIDER INFO & PH. # (800)-562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1689013161 ZZ207E00000X																																																																																														

NUCC Instructions Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

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PA000248



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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.												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												SIGNATURE ON FILE											
SIGNED _____ DATE 06/12/18												SIGNED _____											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 11 19 17 431												15. OTHER DATE MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 19 17 TO 11 19 17											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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. I46.9 B. C. D. E. F. G. H. I. J. K. L.												23. PRIOR AUTHORIZATION NUMBER											
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11 19 17 11 19 17 23 X 31500 A 1022 00h NP 1508055765																							
25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438												26. PATIENT'S ACCOUNT NO.											
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ 2703.00 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC use											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made a part hereof.) RUSHTON MD, JOHN MATT SIGNATURE ON FILE												32. SERVICE PROVIDER LOCATION INFORMATION SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 1861439952											
SIGNED 06/12/18												33. BILLING PROVIDER INFO & PH. # (800)-562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1518120971 ZZ207P00000X											



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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 _____ DATE 07/30/18						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 (UMP) MM DD YY 06 05 18 QUAL 431				15. OTHER DATE QUAL _____ MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY FROM 06 05 18 TO 06 05 18					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 06 05 18 TO 06 05 18				19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. J96.90 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ ICD Ind. 0													
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. EXPIRY DATE	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
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											NPI		
											NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438 <input type="checkbox"/> <input checked="" type="checkbox"/>													
26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 1765.00		29. AMOUNT PAID \$ 0.00		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.) LIN MD, CHARLES SIGNATURE ON FILE SIGNED 07/30/18				32. BILLING PROVIDER INFO & PH. # SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 *1861439952				33. BILLING PROVIDER INFO & PH. # FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 *1518120971 ZZ207P00000X					



KAISER
POB 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

READ BACK TO FORM BEFORE COMPLETING AND SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) 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 #										34. BILLING PROVIDER INFO & PH #										35. BILLING PROVIDER INFO & PH #										36. BILLING PROVIDER INFO & PH #										37. BILLING PROVIDER INFO & PH #										38. BILLING PROVIDER INFO & PH #										39. BILLING PROVIDER INFO & PH #										40. BILLING PROVIDER INFO & PH #										41. BILLING PROVIDER INFO & PH #										42. BILLING PROVIDER INFO & PH #										43. BILLING PROVIDER INFO & PH #										44. BILLING PROVIDER INFO & PH #										45. BILLING PROVIDER INFO & PH #										46. BILLING PROVIDER INFO & PH #										47. BILLING PROVIDER INFO & PH #										48. BILLING PROVIDER INFO & PH #										49. BILLING PROVIDER INFO & PH #										50. BILLING PROVIDER INFO & PH #										51. BILLING PROVIDER INFO & PH #										52. BILLING PROVIDER INFO & PH #										53. BILLING PROVIDER INFO & PH #										54. BILLING PROVIDER INFO & PH #										55. BILLING PROVIDER INFO & PH #										56. BILLING PROVIDER INFO & PH #										57. BILLING PROVIDER INFO & PH #										58. BILLING PROVIDER INFO & PH #										59. BILLING PROVIDER INFO & PH #										60. BILLING PROVIDER INFO & PH #										61. BILLING PROVIDER INFO & PH #										62. BILLING PROVIDER INFO & PH #										63. BILLING PROVIDER INFO & PH #										64. BILLING PROVIDER INFO & PH #										65. BILLING PROVIDER INFO & PH #										66. BILLING PROVIDER INFO & PH #										67. BILLING PROVIDER INFO & PH #										68. BILLING PROVIDER INFO & PH #										69. BILLING PROVIDER INFO & PH #										70. BILLING PROVIDER INFO & PH #										71. BILLING PROVIDER INFO & PH #										72. BILLING PROVIDER INFO & PH #										73. BILLING PROVIDER INFO & PH #										74. BILLING PROVIDER INFO & PH #										75. BILLING PROVIDER INFO & PH #										76. BILLING PROVIDER INFO & PH #										77. BILLING PROVIDER INFO & PH #										78. BILLING PROVIDER INFO & PH #										79. BILLING PROVIDER INFO & PH #										80. BILLING PROVIDER INFO & PH #										81. BILLING PROVIDER INFO & PH #										82. BILLING PROVIDER INFO & PH #										83. BILLING PROVIDER INFO & PH #										84. BILLING PROVIDER INFO & PH #										85. BILLING PROVIDER INFO & PH #										86. BILLING PROVIDER INFO & PH #										87. BILLING PROVIDER INFO & PH #										88. BILLING PROVIDER INFO & PH #										89. BILLING PROVIDER INFO & PH #										90. BILLING PROVIDER INFO & PH #										91. BILLING PROVIDER INFO & PH #										92. BILLING PROVIDER INFO & PH #										93. BILLING PROVIDER INFO & PH #										94. BILLING PROVIDER INFO & PH #										95. BILLING PROVIDER INFO & PH #										96. BILLING PROVIDER INFO & PH #										97. BILLING PROVIDER INFO & PH #										98. BILLING PROVIDER INFO & PH #										99. BILLING PROVIDER INFO & PH #										100. BILLING PROVIDER INFO & PH #									

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APPROVED SOURCE ID 97 B D R L I N C (02-12)

WCMS-1500CS-12

PA000251



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PATIENT AND INSURED INFORMATION

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 herein.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the insurance carrier or supplier as services described below.				
SIGNATURE ON FILE					SIGNATURE ON FILE				
SIGNED					SIGNED				
DATE					DATE				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)					15. OTHER DATE				
MM DD YY					MM DD YY				
11 17 17 QUAL 431					11 17 17 QUAL 439				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI				
17b. NPI					18. HOSPITALIZATION DATE RELATE TO DATE OF SERVICE				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)					22. RESUBMISSION CODE				
A. S09.8XXA B. S03.2XXA C. S00.83XA D. Y93.89					23. PRIOR AUTHORIZATION NUMBER				
E. F. G. H. I. J. K. L.					24. A. DATE(S) OF SERVICE				
From To					B. PLACES				
MM DD YY MM DD YY					C. SERVICE				
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					E. DIAGNOSIS				
CPT/HCPCS					POINTERS				
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ABCD					1295 001				
1285898049									
25. FEDERAL TAX ID NUMBER					26. PATIENT'S ACCOUNT NO.				
88-0262438					27. ACCEPT ASSIGNMENT?				
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					29. TOTAL CHARGE				
CRAVEN MD, IAN ANDREW					30. SERVICE FACILITY LOCATION INFORMATION				
SIGNATURE ON FILE					31. BILLING PROVIDER NAME & PHONE				
SIGNED 08/16/18					32. AMOUNT PAID				
1861439952					33. BILLING PROVIDER NAME & PHONE				
1518120971					34. AMOUNT PAID				
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1518120971					98. AMOUNT PAID				
22207P00000X					99. BILLING PROVIDER NAME & PHONE				
1518120971					100. AMOUNT PAID				

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NOT SOURCED BILL IN

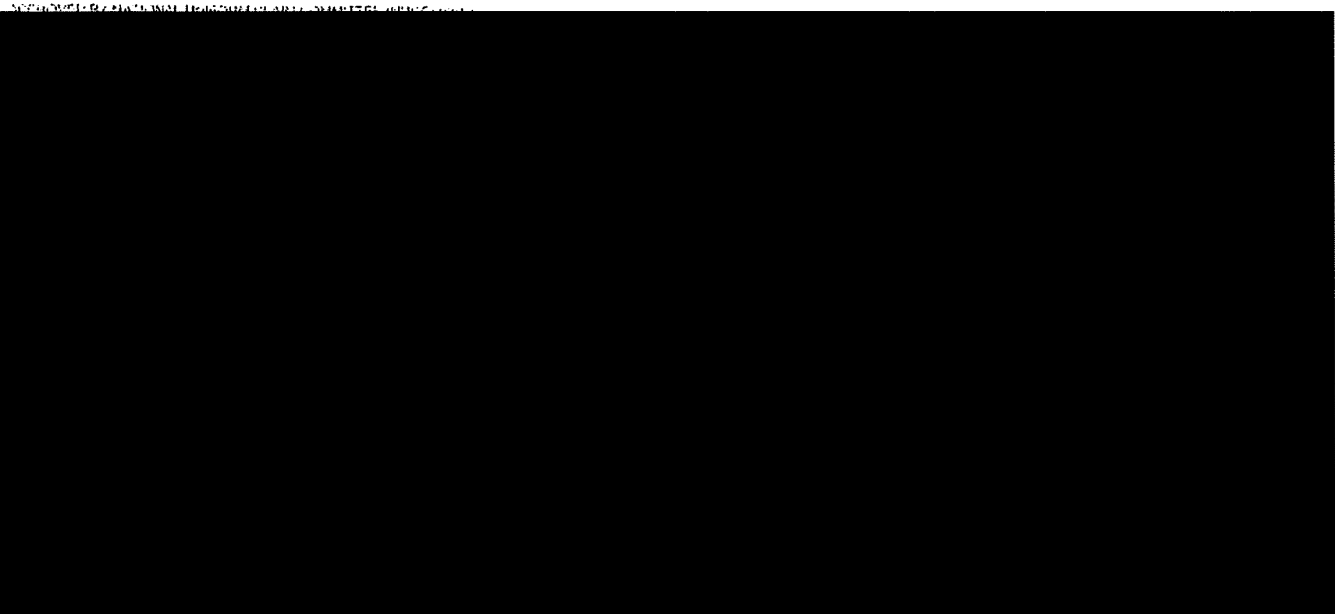
WCMS-1500CS-12

PA000252



KAISER-CA MEDICARE POB 7004 DO
PO BOX 7004
ATTN: CLAIMS DEPT
DOWNEY, CA 90242-7004

HEALTH INSURANCE CLAIM FORM



PATIENT'S SIGNATURE (PRINT NAME AND SIGNATURE) [Redacted Signature] DATE 09/25/18				PATIENT'S SIGNATURE (PRINT NAME AND SIGNATURE) [Redacted Signature] DATE 09/25/18			
DATE OF CURRENT RESIDENCY (MM/DD/YYYY) 02/17/18 CITY 431				DATE OF CURRENT RESIDENCY (MM/DD/YYYY) 02/17/18 CITY 431			
DATE OF BIRTH (MM/DD/YYYY) 02/17/18 CITY 431				DATE OF BIRTH (MM/DD/YYYY) 02/17/18 CITY 431			
R06.00 J18.1 E87.2				R06.00 J18.1 E87.2			
02/17/18 02/17/18 23 X 99285 ABC 1360 001 1437398476				02/17/18 02/17/18 23 X 99285 ABC 1360 001 1437398476			
88-0262438				88-0262438			
LO DO, JOSEPH				LO DO, JOSEPH			
SIGNATURE ON FILE 09/25/18				SIGNATURE ON FILE 09/25/18			
ST ROSE DOMINICAN HOSPI 8280 W WARM SPRINGS RD LAS VEGAS, NV 89113-3612 1528101284				ST ROSE DOMINICAN HOSPI 8280 W WARM SPRINGS RD LAS VEGAS, NV 89113-3612 1528101284			
FREMONT EMERGENCY SERVICES M PO BOX 638972 CINCINNATI, OH 45263-8972 1689013161 77207P00000X				FREMONT EMERGENCY SERVICES M PO BOX 638972 CINCINNATI, OH 45263-8972 1689013161 77207P00000X			



KAISER
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

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

10/04/18

SIGNED

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
08 11 18 QUAL 431

15. OTHER DATE
QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. NPI
17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY
08 11 18 TO 08 11 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
CORRECTED CLAIM

20. OUTSIDE LAB? \$ CHARGES
☐ YES ☒ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)
A. R17 B. E87.1 C. R74.0 D. D72.829
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 To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER

F. \$ CHARGES G. DAYS OR UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID. #

1	08	11	18	08	11	18	23	X	99285			ABCD	1360	001		NPI	1437398476
2	08	11	18	08	11	18	23	X	93010			B	67	001		NPI	1437398476
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
88-0262438 ☐ ☒

26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
☒ YES ☐ NO

28. TOTAL CHARGE 29. AMOUNT PAID
\$ 1427.00 \$ 0.00

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.)
LO DO, JOSEPH

ST ROSE DOMINICAN HOSPI
8280 W WARM SPRINGS RD
LAS VEGAS, NV 89113-3612

33. BILLING PROVIDER INFO & PH. # (800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972

SIGNATURE ON FILE
10/04/18

1528101284

1689013161 b. ZZ207P00000X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED GMS 0998-1997 FORM 1300 (02-12)

WCMS-1500CS-12

PA000254



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

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

10/09/18

SIGNED

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
04 22 18 QUAL: 431

15. OTHER DATE
QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES

☐ YES ☒ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)
A. K57.92 B. R03.0 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 To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER

F. \$ CHARGES G. DAYS OF UNITS H. EPICOT I. ID. QUAL J. RENDERING PROVIDER ID. #

1	04	22	18	04	22	18	23	X	99285				AB	1360	00	1	NPI	1619979028
2																	NPI	
3																	NPI	
4																	NPI	
5																	NPI	
6																	NPI	

25. FEDERAL TAX I.D. NUMBER
88-0262438

SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back)
☒ YES ☐ NO

28. TOTAL CHARGE
\$ 1360.00

29. AMOUNT PAID
\$ 0.00

30. Rev'd 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.)
ANDERSON MD, ERIC JOH
SIGNATURE ON FILE

SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS, NV 89148-4844

33. BILLING PROVIDER INFO & PH. # (800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972

SIGNED 10/09/18

1457306359

1679550149 ZZ207P00000X

NUCC Instructions Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

PA000255



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

PRINT FOLD WKCF-10-BW / WKCF-10-BW-S

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

DATE 10/26/18

SIGNED

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)
07/13/18 QUAL 431

15. OTHER DATE
QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM 07/13/18 TO 07/13/18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES

☐ YES ☒ NO

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

ICD Ind. 0

A. J44.1

B. J96.00

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 To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER

F. \$ CHARGES G. DAYS OF UNITS H. EP801 PAY PERIOD I. ID. QUAL J. RENDERING PROVIDER ID. #

1	07	13	18	07	13	18	23	X	99285			AB	1360	001		NPI	1619979028
2																NPI	
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX ID. NUMBER
88-0262438

SSN EIN ☐ ☒

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE
\$ 1360 00

29. AMOUNT PAID
\$ 0 00

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)
ANDERSON MD, ERIC JOH
SIGNATURE ON FILE

32. SERVICE FACILITY LOCATION INFORMATION
SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS, NV 89109-2317

33. BILLING PROVIDER INFO & PH. # (800) 562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972

SIGNED

DATE

10/26/18

1861439952

518120971

22207000000X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED FOR FILING 10/26/18 FORM 1300 (02-12)

WCMS-1500CS-12

PA000256



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

SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

PATIENT AND INSURED INFORMATION

[illegible]

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 SIGNED _____ DATE _____												SIGNATURE ON FILE SIGNED _____											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: 11 10 16 431												15. OTHER DATE QUAL: MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI: _____												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. I20.8 B. R00.2 C. E11.65 D. I99.8 E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____											
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. ICD Ind. 10 MM DD YY MM DD YY EMG CPT/HCPCS MODIFIER DIAGNOSIS POINTER												F. \$ CHARGES G. DAYS OR UNITS H. (PSUT only) I. ID. QUAL J. RENDERING PROVIDER ID. #											
1 11 10 16 11 10 16 23 X 99285 ABCD 1233 001 NPI 1760458053												1 11 10 16 11 10 16 23 X 99053 ABCD 40 001 NPI 1760458053											
2 11 10 16 11 10 16 23 X 99053 ABCD 40 001 NPI 1760458053												2 11 10 16 11 10 16 23 X 99053 ABCD 40 001 NPI 1760458053											
3												3											
4												4											
5												5											
6												6											
25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438 <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
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.) BEHL DO, ANDREW SIGNATURE ON FILE 11/13/18												32. SERVICE FACILITY LOCATION INFORMATION MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS, NV 89128-0436 33. BILLING PROVIDER INFO & PH. # 800-562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 34. BILLING PROVIDER ID. # 1366429821 b. ZZ207P00000X											
SIGNED _____ DATE 11/13/18												SIGNED _____ DATE 11/13/18											

NMCCA Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

4 APPROVED SOME 1983 195 FORM N500 (02-12)

WCMS-1500CS-12

PA000257



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 12/27/18 SIGNED _____ 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 431 07 29 18												15. OTHER DATE QUAL 439 MM DD YY 07 29 18												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 07 29 18												19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____												21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. S72.012A B. W01.0XXA C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____												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) EPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PSOT / RPT / RPT / RPT I. ID. QUAL J. RENDERING PROVIDER ID. #																							
1 07 29 18 07 29 18 23 X 99285 AB 1360 001 NPI 1194131854												2 1360 001 NPI												3 1360 001 NPI											
4 1360 001 NPI												5 1360 001 NPI												6 1360 001 NPI											
25. FEDERAL TAX ID. NUMBER 88-0262438 SSN EIN [] [X] 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [] NO												28. TOTAL CHARGE \$ 1360 00 29. AMOUNT PAID \$ 0 00 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.) SIGNATURE ON FILE 12/27/18 SIGNED _____ DATE _____												32. SERVICE FACILITY LOCATION INFORMATION SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 1861439952												33. BILLING PROVIDER INFO & PH. # (800) 562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1518120971 22207P00000X											

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-7199 FORM 1500 (02-12)

WCMS-1500CS-12

PA000258



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 01/16/19 SIGNED _____ DATE _____										13. INVOKED 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 03 29 18 431										15. OTHER DATE QUAL MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 03 29 18 03 29 18										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																													
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. I61.9 B. I10 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 To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																																							
1 03 29 18 03 29 18 23 X 99291 AB 1765 001 NPI 1023138245										2 03 29 18 03 29 18 23 X 93010 B 67 001 NPI 1023138245										3 _____ NPI _____																													
4 _____ NPI _____										5 _____ NPI _____										6 _____ NPI _____																													
25. FEDERAL TAX I.D. NUMBER 88-0262438 SSN EIN _____										26. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										27. TOTAL CHARGE \$ 1832 00										28. AMOUNT PAID \$ 0 00										29. Rsvd for NUCC use									
30. 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.) SIGNATURE ON FILE SIGNED _____ DATE 01/16/19										31. SERVICE FACILITY LOCATION INFORMATION ST ROSE DOMINICAN HOSPI 3001 ST ROSE PKWY HENDERSON, NV 89052-3839 1770626426										32. BILLING PROVIDER INFO & PH. # (800) 562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1689013161 ZZ207P00000X																													

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED 01/16/19 BY CCM 11500 (02-12)

WCMS-1500CS-12

PA000259



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER
PATIENT AND INSURED INFORMATION

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

01/30/19

SIGNED

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
10 03 18 QUAL 431

15. OTHER DATE
QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. QUAL

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY
10 03 18 TO 10 03 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES
☐ YES ☒ NO

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

ICD Ind. 10

A. 148.91

B. _____

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. EPSCOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #

1	10	03	18	10	03	18	23	X	99291				A	1765	001			NPI	1548425259
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 gov. claims, see back)

☒ YES ☐ NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. Revd for NUCC Use

98-0262438

☐ X

\$ 1765 00

\$ 0 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.)

CHAN MD, STEPHANIE

SIGNATURE ON FILE

01/30/19

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

SOUTHERN HILLS HOSPITAL

9300 W SUNSET RD

LAS VEGAS, NV 89148-4844

1457306359

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MA

PO BOX 638972

CINCINNATI, OH 45263-8972

1679550149

1679550149

790-0116 (02-12) (OCR) IPT

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

GMS

APPROVED 01/30/19 FORM 1300 (02-12)



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND PROVIDER INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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.										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										SIGNATURE ON FILE									
SIGNED										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)										15. OTHER DATE									
MM DD YY										MM DD YY									
08 18 18										01/30/19									
QUAL 431																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
17a. NPI										FROM MM DD YY TO MM DD YY									
17b. NPI										FROM 08 18 18 TO 08 18 18									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES									
										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. K85.90 B. R03.0 C. L D. L																			
E. L F. L G. L H. L																			
I. L J. L K. L L. L																			
24. A. DATE(S) OF SERVICE										25. FEDERAL TAX I.D. NUMBER									
From To										SSN EIN									
MM DD YY MM DD YY										08-0262438									
B. PLACE OF SERVICE										26. PATIENT'S ACCOUNT NO.									
EMG																			
C. PROCEDURES, SERVICES, OR SUPPLIES										27. ACCEPT ASSIGNMENT?									
(Explain Unusual Circumstances)										(For govt. claims, see back)									
CPT/HCPCS MODIFIER										<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
D. DIAGNOSIS POINTER										28. TOTAL CHARGE									
										\$ 1360 00									
										29. AMOUNT PAID									
										\$ 0 00									
										30. Rvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER										32. SERVICE FACILITY LOCATION INFORMATION									
INCLUDING DEGREES OR CREDENTIALS										SUNRISE HOSPITAL AND ME									
(I certify that the statements on the reverse										3186 S MARYLAND PKWY									
apply to this bill and are made a part thereof.)										LAS VEGAS, NV 89109-2317									
HUNT MD, STEPHEN M										FREMONT EMERGENCY SERVICES MA									
SIGNATURE ON FILE										PO BOX 638972									
SIGNED										CINCINNATI, OH 45263-8972									
01/30/19										1518120971									
										ZZ207P00000X									

NUCC Instruction Manual available at: www.nucc.org

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APPROVED FORM 08-05-15 FORM 1300 (02-12)

PA000261



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Y

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
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.												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												SIGNATURE ON FILE											
SIGNED												SIGNED											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)												15. OTHER DATE											
MM DD YY												QUAL											
08 26 18												08 26 18											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
17a. NPI												FROM TO											
17b. NPI												08 26 18 08 26 18											
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 (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. 672.012A B. W07.XXXA C. L D. L												23. PRIOR AUTHORIZATION NUMBER											
E. L F. L G. L H. L																							
I. L J. L K. L L. L																							
24. A. DATE(S) OF SERVICE												B. PLACE OF SERVICE											
From To												EMG											
MM DD YY MM DD YY												CPT/HCPCS MODIFIER											
1 08 26 18 08 26 18 23 X												99285											
2 08 26 18 08 26 18 23 X												99053											
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER												26. PATIENT'S ACCOUNT NO.											
38-0262438												27. ACCEPT ASSIGNMENT? (For gov. claims, see back)											
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.)												28. TOTAL CHARGE											
SPENCE MD, ROBERT LEW												\$ 1404 00											
SIGNATURE ON FILE												29. AMOUNT PAID											
SIGNED 01/30/19												\$ 0 00											
33. BILLING PROVIDER INFO & PH #												30. Revd for NUCC Use											
FREMONT EMERGENCY SERVICES MA																							
PO BOX 638972																							
CINCINNATI, OH 45263-A972																							
f518120971												Z7207P00000X											

NUCC Instruction Manual available at: www.nucc.org

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APPROVED FOR SUBMISSION FORM 1500 (02-12)

PA000262



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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.										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										SIGNATURE ON FILE									
SIGNED										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)										15. OTHER DATE									
11/24/18 QUAL 431										QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
17a. NPI										FROM 11/24/18 TO 11/24/18									
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 (24E)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. I69.320 B. I69.351 C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 11/24/18 11/24/18 23 X 99285 AB 1360 001										NPI 1962883280									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
88-0262438										27. ACCEPT ASSIGNMENT? YES NO									
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 PROVIDER LOCATION INFORMATION									
GRUNSETH MD, ARON										SUNRISE HOSPITAL AND ME									
SIGNATURE ON FILE										3186 S MARYLAND PKWY									
SIGNED 01/30/19										LAS VEGAS, NV 89109-2317									
33. BILLING PROVIDER INFO & PH #										34. BILLING PROVIDER INFO & PH #									
800-7562-2945										FREMONT EMERGENCY SERVICES MA									
PO BOX 638972										CINCINNATI, OH 45263-8972									
518120971										72207P00000X									

NUCC Instructions Manual available at: www.nucc.org

PLEASE PRINT OR TYPE GMS

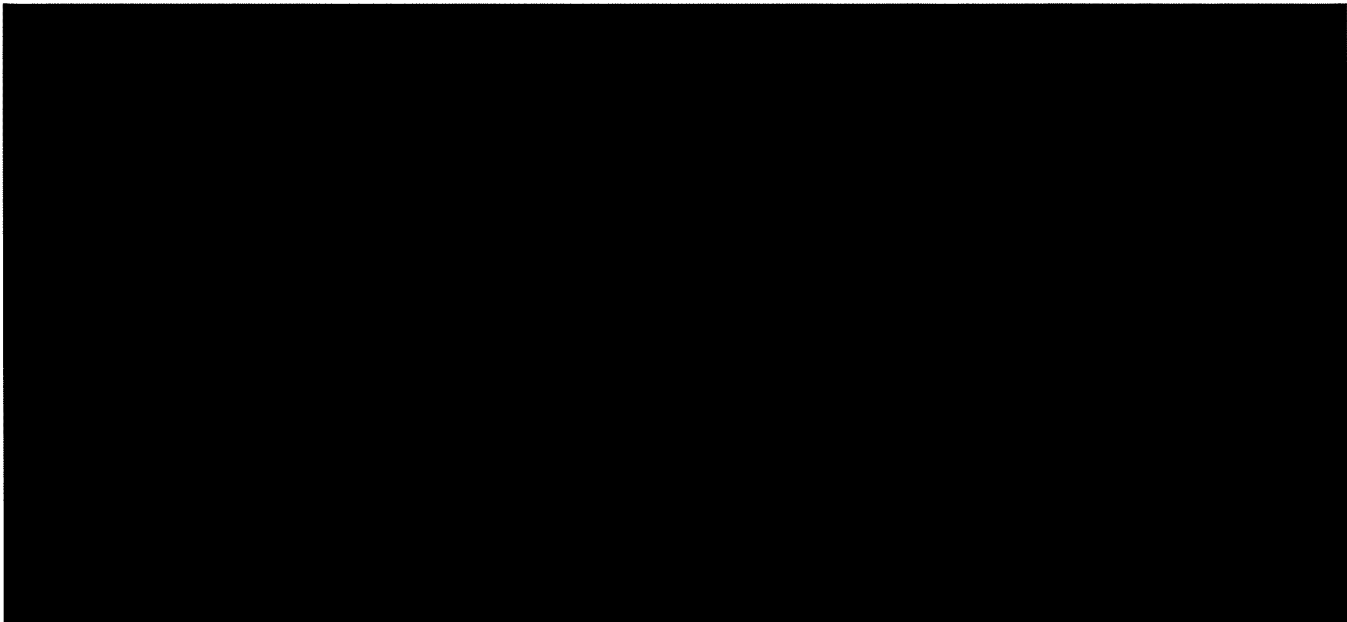
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PA000263



KAISER
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM



SIGNATURE ON FILE

DATE 02/15/19

SIGNATURE ON FILE

08 19 18 431

K74.60

E87.1

R18.8

R74.0

08 19 18

08 19 18

X

08 19 18 08 19 18 23 X

99285

ABCD

1360 001

1437413549

88-0262438

EX

EX

1360 00

0 00

NOTLEY MD, DAVID ALLE
SIGNATURE ON FILE

02/15/19

ST ROSE DOMINICAN HOSPI
8280 W WARM SPRINGS RD
LAS VEGAS, NV 89113-3612
1528101284

800-562-2945
FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
1689013161 77207P00000X

SAD 52800

PLEASE PRINT OR TYPE

MME

50 COMM NPI FORM

PA000264



SIERRA HEALTH
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

02/21/19

SIGNED

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
10 26 18

QUAL 431

15. OTHER DATE

MM DD YY

QUAL

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM MM DD YY TO MM DD YY

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

FROM MM DD YY TO MM DD YY

20. OUTSIDE LAB? \$ CHARGES

☐ YES ☒ NO

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

ICD Ind. 0

A. I61.9

B. I03.0

C. I

D. I

E. I

F. I

G. I

H. I

22. RESUBMISSION CODE

ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE

From To

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. EPST/Physi Pay

I. ID. QUAL

J. RENDERING PROVIDER ID. #

1	10:26:18	10:26:18	23	X	99291	25				AB	1765	001		NPI	1932529609
2	10:26:18	10:26:18	23	X	31500					A	1073	001		NPI	1932529609
3	10:26:18	10:26:18	23	X	99053					AB	44	001		NPI	1932529609
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER

SSN EIN

88-0262438

☐ ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)

☒ YES ☐ NO

28. TOTAL CHARGE

\$ 2882.00

29. AMOUNT PAID

\$ 0.00

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.)

LIFFERTH DO, ROBERT

SIGNATURE ON FILE

SIGNED

02/21/19

SUNRISE HOSPITAL AND ME

3186 S MARYLAND PKWY

LAS VEGAS, NV 89109-2317

*1861439952

33. BILLING PROVIDER INFO & PH. # (800)-562-2945

FREMONT EMERGENCY SERVICES MA

PO BOX 638972

CINCINNATI, OH 45263-8972

*1518120971

b. ZZ207P00000X

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APPROVED FOR CARRIER FORM 1500 (02-12)

WCMS-1500CS-12

PA000265

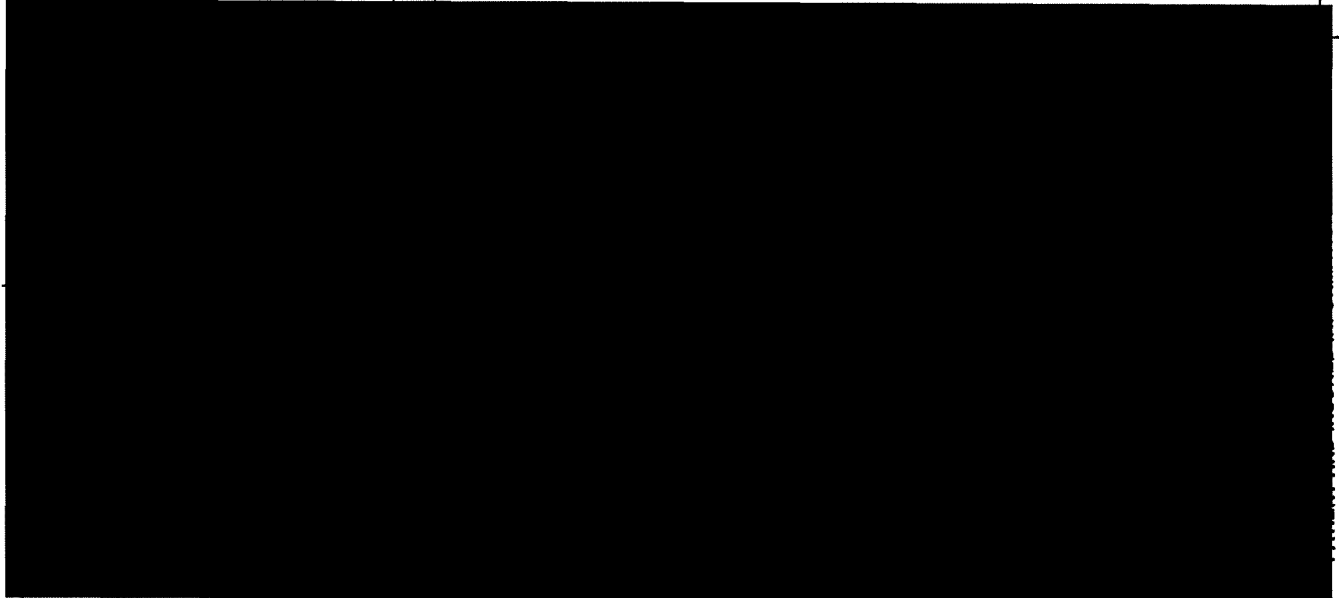


KAISER-CA
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

CARRIER



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 _____ DATE 02/25/19												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 10 13 18 QUAL 431												15. OTHER DATE QUAL 439 MM DD YY 10 13 18												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 10 13 18 TO MM DD YY 10 13 18												19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																															
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES												21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. S22.41XA B. S32.018A C. S22.028A ICD Ind. 0 D. S52.022B 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 EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ID. ID. ID. I. QUAL J. RENDERING PROVIDER ID. #																																																											
1 10 13 18 10 13 18 23 X 99291 ABCD 1765 001 NPI 1730169111												2 1765 001 NPI												3 1765 001 NPI																																															
4 1765 001 NPI												5 1765 001 NPI												6 1765 001 NPI																																															
25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438 <input type="checkbox"/> <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO. _____												27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ 1765 00												29. AMOUNT PAID \$ 0 00												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) MARTINEZ MD, DENNIS A SIGNATURE ON FILE SIGNED _____ DATE 02/25/19												32. SERVICE FACILITY LOCATION INFORMATION SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 1861439952												33. BILLING PROVIDER INFO & PH. # (800) 562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1518120971 ZZ207P00000X																																															

PHYSICIAN OR SUPPLIER INFORMATION

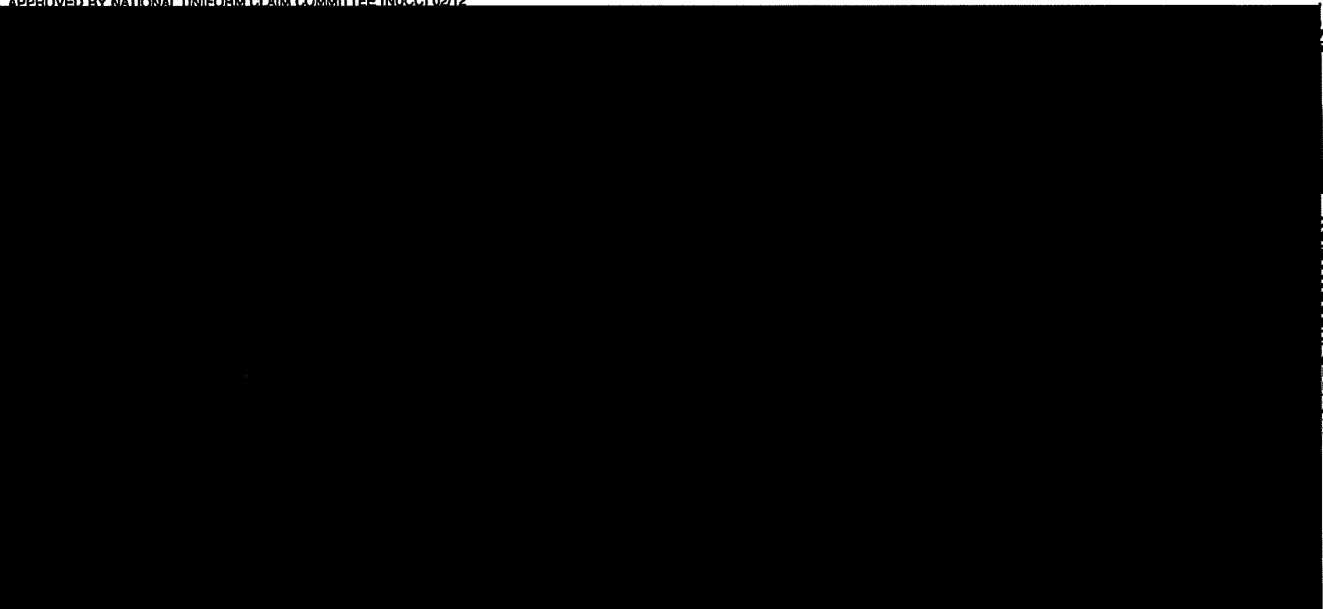


KAISER
POB 15392
LAS VEGAS NV 89114

CARRIER

HEALTH INSURANCE CLAIM FORM

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



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 03/29/19 SIGNED _____ DATE _____										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 (JMP) 10/17/18 QUAL 431										15. OTHER DATE QUAL _____ MM ____ DD ____ YY ____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM ____ DD ____ YY ____ TO MM ____ DD ____ YY ____									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 10/17/18 TO 10/17/18										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										23. PRIOR AUTHORIZATION NUMBER _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. I48.91 B. F10.129 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ J. _____ K. _____										24. A. DATE(S) OF SERVICE From MM ____ DD ____ YY ____ To MM ____ DD ____ YY ____ B. PLACE OF SERVICE EMG _____ C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS _____ MODIFIER _____ E. DIAGNOSIS POINTER _____ F. \$ CHARGES _____ G. DAYS OR UNITS _____ H. ID. QUAL. _____ J. RENDERING PROVIDER ID. # _____																			
1 10/17/18 10/17/18 23 X 99291 AB 1765 001										NPI 1205063286																			
2																				NPI									
3																				NPI									
4																				NPI									
5																				NPI									
6																				NPI									
25. FEDERAL TAX I.D. NUMBER 88-0262438 SSN EIN _____ 26. PATIENT'S ACCOUNT NO. _____ 27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1765.00 29. AMOUNT PAID \$ 0.00 30. Rsvd for NUCC use										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true and accurate to the best of my knowledge and belief.) PHILIPPS DO, HEBER SA SIGNATURE ON FILE 03/29/19 SIGNED _____ DATE _____									
32. SERVICE FACILITY LOCATION INFORMATION SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 1861439952										33. BILLING PROVIDER INFO & PH. # 7800-562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1518120971 b. ZZ207E00000X										34. OUTSOURCED SERVICE									

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB 0938-1197 FORM 4900 (02-12)

WCMS-1500CS-12

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PA000267

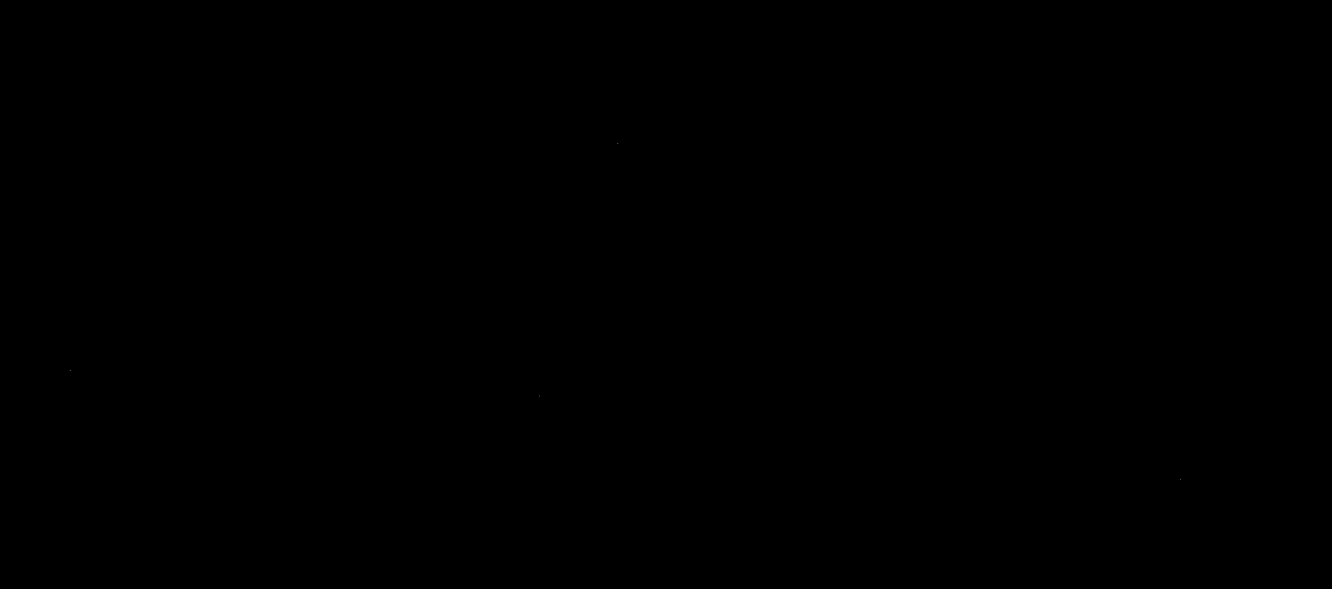


SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

CARRIER

HEALTH INSURANCE CLAIM FORM

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



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 04/02/19 SIGNED _____ 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) 09/11/18 QUAL: 431												15. OTHER DATE QUAL: MM DD YY												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 09/11/18 TO 09/11/18												19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																															
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												21. RESUBMISSION CODE												22. PRIOR AUTHORIZATION NUMBER																																															
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. K92.2 B. K31.84 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09/11/18 09/11/18 B. PLACE OF SERVICE 23 X C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 99285 E. DIAGNOSIS POINTER AB F. \$ CHARGES 1360.00 G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. NPI J. RENDERING PROVIDER ID. # 1326294844																																																											
25. FEDERAL TAX I.D. NUMBER 88-0262438												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ 1360.00												29. AMOUNT PAID \$ 0.00												30. Rsvd for NUCC use											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true and correct.) SIGNATURE ON FILE 04/02/19 SIGNED _____ DATE _____												32. SERVICE FACILITY LOCATION INFORMATION SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 1861439952												33. BILLING PROVIDER INFO & PH. # FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1518120971 7800-562-2945 ZZ207P00000X																																															



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
LAS VEGAS NV 89114-5392

HEALTH INSURANCE CLAIM FORM

NUCC INSTRUCTION MANUAL AVAILABLE AT: WWW.NUCC.ORG

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

04/02/19

SIGNED

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)
12/06/18 QUAL 431

15. OTHER DATE
QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. NPI
17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM 12/06/18 TO 12/06/18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES
☐ YES ☒ NO

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

A. E11.65 B. K31.84 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 To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER

F. \$ CHARGES G. DAYS OR UNITS H. ID. QUAL I. RENDERING PROVIDER ID. #

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25. FEDERAL TAX I.D. NUMBER
88-0262438

SSN EIN
☒ X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?
☒ YES ☐ NO

28. TOTAL CHARGE
\$ 1360.00

29. AMOUNT PAID
\$ 0.00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse are true and correct.)

ANDERSON MD, ERIC COH
SIGNATURE ON FILE

04/02/19

SIGNED

5220

DATE

32. SERVICE FACILITY LOCATION INFORMATION
MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS, NV 89128-0436

1104870187

33. BILLING PROVIDER INFO & PH. # 7800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972

CINCINNATI, OH 45263-8972

1366429821 b. ZZ207P00000X

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WCMS-1500CS-12

PA000269



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
Attn: Kaiser Claims
LAS VEGAS, NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true and correct to the best of my knowledge and belief.) SIGNED _____ DATE 04/04/19 SIGNATURE ON FILE										32. SERVICE FACILITY LOCATION INFORMATION SOUTHERN HILLS HOSPITAL 9300 W SUNSET RD LAS VEGAS, NV 89148-4844 1457306359										33. BILLING PROVIDER INFO & PH # (800) 562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI, OH 45263-8972 1679550149 b 77207P00000X																																							

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CARRIER — 

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

PATIENT AND INSURED INFORMATION

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<p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to me and all my staff and agents thereof.)</p> <p>TANG DO, MICHAEL SIGNATURE ON FILE 04/04/19 DATE</p>																																																																																																																																													
<p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS, NV 89109-2317 4861439952</p>																																																																																																																																													
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PHYSICIAN OR SUPPLIER INFORMATION



SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
Attn: Kaiser Claims
LAS VEGAS, NV 89114-5392

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PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

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SIGNATURE ON FILE

04/04/19

SIGNED

DATE

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SIGNED

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MM DD YY
10 17 18 QUAL 431

15. OTHER DATE
QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY
10 17 18 10 17 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB?

☐ YES☒ NO

\$ CHARGES

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

ICD Ind. 10

A. R07.2

B. R73.9

C. I10

D.

E.

F.

G.

H.

I.

J.

K.

L.

22. RESUBMISSION

ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY
10 17 18 10 17 18
B. PLACE OF SERVICE
C. EMG
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)
CPT/HCPCS 99285
E. DIAGNOSIS POINTER
ABC

F. \$ CHARGES

1360 00

G. DAYS OR UNITS

H. SP201 Family Plan

I. ID. QUAL

J. RENDERING PROVIDER ID. #

1972505675

1

2

3

4

5

6

25. FEDERAL TAX I.D. NUMBER

SSN EIN

88-0262438

☐ ☒

26. ACCEPT ASSIGNMENT?

☒ YES ☐ NO

28. TOTAL CHARGE

\$ 1360 00

29. AMOUNT PAID

\$ 0 00

30. Revd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

INCLUDING DEGREES OR CREDENTIALS

(I certify that the statements on the reverse

DUNAGAN M, CLARENCE

SIGNATURE ON FILE

04/04/19

SIGNED

MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS, NV 89128-0436

1104870187

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MA

PO BOX 638972

CINCINNATI, OH 45263-8972

1366429821

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750-0118 (02-12) (OCR) (PT)

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LAS VEGAS, NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

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17a. NPI

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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES
☐ YES ☒ NO

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

ICD-10

A. I50.9 B. I48.91 C. R09.02 D. R06.00
E. F. G. H. I. J. K. L.

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29. AMOUNT PAID

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CLARK MD, RUSSELL PAT

MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS, NV 89128-0436FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972

SIGNATURE ON FILE

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EXHIBIT 7

EXHIBIT 7

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

HILL COUNTRY EMERGENCY
MEDICAL ASSOCIATES, P.A.,
LONGHORN EMERGENCY
MEDICINE ASSOCIATES, P.A.,
CENTRAL TEXAS EMERGENCY
ASSOCIATES, P.A., and
EMERGENCY ASSOCIATES OF
CENTRAL TEXAS,

Plaintiffs,

V.

UNITEDHEALTHCARE INSURANCE
COMPANY and UNITEDHEALTHCARE
OF TEXAS, INC.,

Defendants.

1:19-CV-548-RP

ORDER

Before the Court are Hill Country Emergency Medical Associates, P.A., Longhorn Emergency Medicine Associations, P.A., Central Texas Emergency Associates, P.A. and Emergency Associates of Central Texas, P.A.’s (“Plaintiffs”) motion to remand, (Dkt. 12), Defendants UnitedHealthcare Insurance Company and UnitedHealthcare of Texas, Inc.’s (“Defendants”) response, (Dkt. 16), and the Plaintiffs’ reply, (Dkt. 17). After considering the parties’ arguments, the record, and the relevant law, the Court finds that the motion should be denied.

I. BACKGROUND

This case involves a dispute over the rate of reimbursement for out-of-network emergency care provided to patients with insurance plans (“Plans”) administered by the Defendants. Plaintiffs provide physician staffing for emergency rooms across central Texas. Defendants, United Healthcare Insurance Company and United Healthcare of Texas, Inc., administer preferred provider plans (“PPO”) and health maintenance organization (“HMO”) plans, respectively. (Orig. Pet., Dkt

1-3, at 3). In their original petition, Plaintiffs allege that the Defendants have not properly paid more than 7,000 claims for the emergency services provided to Defendants’ health plan enrollees. (*Id.* at 7). While Plaintiffs concede that Defendants paid these claims, they allege that Defendants paid them at “unacceptably low rates” that were “significantly less than the usual and customary rate for the services provided.” (*Id.*). Because Plaintiffs have no contracts with Defendants, they provided all emergency services to Defendants’ health plan members as “out-of-network” or “non-participating” providers. (*Id.* at 6). In other words, the parties did not enter into a provider agreement that specifies an agreed rate of reimbursement for these emergency services. (*Id.*).

Plaintiffs sued Defendants in state court for improper payment on the emergency service claims, asserting violations of the Texas Insurance Code and the Texas Prompt Pay Act, as well as claims for quantum meruit and declaratory relief. (Compl., Dkt. 1-3, at 9–13). Defendants removed this case to federal court on the basis of complete preemption by the Employee Retirement Income Security Act (“ERISA”). (Notice of Removal, Dkt. 1, at 3). In their Notice of Removal, Defendants contend—and Plaintiffs do not dispute—that the health plans at issue include ERISA-regulated plans. Plaintiffs dispute that ERISA preempts their state-law causes of action and now move to remand. (Mot. Remand, Dkt. 12, at 2). Thus, to determine whether removal is proper, this Court must decide whether Plaintiffs’ state law claims are in fact completely preempted by ERISA’s civil enforcement scheme.

II. LEGAL STANDARD

A defendant may remove any civil action from state court to a district court of the United States that has original jurisdiction. 28 U.S.C. § 1441(a). The party seeking removal “bears the burden of establishing that federal jurisdiction exists and that removal was proper.” *Manguno v. Prudential Prop. & Cas. Ins. Co.*, 276 F.3d 720, 723 (5th Cir. 2002). The removal statute must “be strictly construed, and any doubt about the propriety of removal must be resolved in favor of

remand.” *Gasch v. Hartford Accident & Indem. Co.*, 491 F.3d 278, 281–82 (5th Cir. 2007); *Hood ex rel. Mississippi v. JP Morgan Chase & Co.*, 737 F.3d 78, 84 (5th Cir. 2013) (“Any ambiguities are construed against removal and in favor of remand to state court.”). A district court is required to remand the case to state court if, at any time before final judgment, it determines that it lacks subject matter jurisdiction. 28 U.S.C. § 1447(c).

Determining whether a case arises under federal law ordinarily turns on the well-pleaded complaint rule. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). Under the well-pleaded complaint rule, a defendant may not remove a case to federal court unless the plaintiff’s complaint establishes that the case arises under federal law. *Id.* Complete preemption, however, is an exception to the well-pleaded complaint rule. *Id.* When a federal statute “wholly displaces the state-law cause of action through complete preemption,” the state claim can be removed. *Id.*

ERISA is one such federal statute with the “extraordinary pre-emptive power” to “convert[s] an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.” *Id.* (quoting *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65–66 (1987)). Congress enacted ERISA “to provide a uniform regulatory regime over employee benefit plans” and equipped ERISA with “expansive pre-emption provisions” to ensure that the regulation of employee benefit plans would be “exclusively a federal concern.” *Id.* at 208. Any state-law cause of action that “duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.” *Id.* State-law causes of action that implicate ERISA’s civil enforcement provisions are therefore “necessarily federal” and removable to federal court. *Id.*

ERISA’s civil enforcement scheme is stated in § 502(a) of the Act. Section 502(a)(1)(B) provides that a civil action may be brought by a participant or beneficiary “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his

rights to future benefits under the terms of the plan.” ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). State-law claims that are within the scope of § 502(a)(1)(B) are completely preempted by ERISA and removable to federal court. *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 529 (5th Cir. 2009). In *Davila*, the Supreme Court articulated the test for determining whether ERISA completely preempts a non-federal cause of action. 542 U.S. 200 at 210. Under *Davila*, a party’s state-law claim falls within the scope of § 502(a)(1)(B) and is therefore completely preempted if: (1) an individual could have brought his claim under § 502(a)(1)(B), and (2) there is no independent legal duty that is implicated by defendant’s actions. *Id.* As the party seeking removal on the basis of ERISA preemption, the Defendants bear the burden of satisfying this two-part inquiry. *See Lone Star OB/GYN Assocs.*, 579 F.3d at 528 (“The party seeking removal bears the burden of showing that federal jurisdiction is proper” and “the district court may not remand if the defendant demonstrates the presence of a substantial federal claim, *e.g.*, one completely preempted by ERISA.”).

III. DISCUSSION

Upon examination of the Plaintiffs’ original petition, the state statutes upon which their state law claims are based, the various health plan documents, and the parties’ briefing, the Court determines that the Defendants have shown Plaintiffs’ claims fall within § 502(a)(1)(B) of the ERISA statute and are therefore preempted.

A. Whether plaintiffs could have brought this action under ERISA

The first part of the *Davila* inquiry requires the Court to determine whether Plaintiffs could have brought their claims under § 502(a)(1)(B). *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). In other words, the Court must determine whether Plaintiffs have standing to sue under the ERISA statute. *Spring E.R., LLC v. Aetna Life Ins. Co.*, No. CIV.A. H-09-2001, 2010 WL 598748, at *2 (S.D. Tex. Feb. 17, 2010).

ERISA confers standing on plan “participants” and “beneficiaries.” 29 U.S.C. § 1132 (“A civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan”). While a health care provider does not have independent standing to recover benefits under an ERISA plan, a health care provider has derivative standing to sue under ERISA upon a valid assignment of plan benefits. *Dallas Cty. Hosp. Dist. v. Associates’ Health & Welfare Plan*, 293 F.3d 282, 285 (5th Cir. 2002).

Here, Plaintiffs have derivative standing to sue under ERISA as assignees of plan benefits.¹ (Resp., Dkt. 16, at 3). In their original petition, Plaintiffs state that they “received an assignment of the insured’s benefits from each patient” and that they filed claims for such benefits with the Insurance Companies “as the insured’s assignee[s].” (Orig. Pet., Dkt. 1-3, at 11). Thus, standing considerations do not bar Plaintiffs from pursuing a remedy under ERISA.

While Plaintiffs do not dispute that they have derivative standing to sue under ERISA, they nevertheless contend that they could not have brought their claims pursuant to § 502(a)(1)(B) because they are not seeking the payment of wrongly-denied ERISA plan benefits. (Mot. Remand, Dkt. 12, at 2). Instead, Plaintiffs argue that the Defendants reimbursed them for the emergency services provided to Plan members below the usual and customary rate required under Texas law. (Orig. Pet., Dkt. 1-3, at 9). That is, Plaintiffs contend, “the claims at issue involve no questions of whether the claim is payable; rather, they involve only the issue of whether the Insurance Companies

¹ Plaintiffs do not dispute that they seek payment for emergency care rendered to patients insured by Defendants. (Orig. Pet., Dkt. 12, at 4 (“From January 2016 to September 2018, Plaintiff Doctors provided emergency medical services to thousands of the Insurance Companies’ members.”)). And Plaintiffs do not contest that at least some of the insurance plans at issue include ERISA-governed plans. (Not. Removal, Dkt. 1, at 2–3); Mot. Remand, Dkt. 12, at 2). Instead, Plaintiffs assert that their right to payment arises from Texas law, not the terms of an ERISA-governed health plan. (*Id.* (“The central issue in this case is whether the Insurance Companies are violating Texas law by reimbursing Plaintiff Doctors at unlawfully inadequate rates.”)).

paid the claim at the required usual and customary rate.” (*Id.*). Therefore, Plaintiffs aver, their claims “concern the rate of payment, not the right to payment.” (Mot. Remand, Dkt. 12, at 7). This distinction matters, say Plaintiffs, because courts have routinely held *that right to payment* cases “sometimes are preempted by ERISA” because they involve a benefits determination under the Plans, while *rate of payment* cases are not preempted by ERISA because they merely “implicate the sufficiency of the rate of payment.” (Pls.’ Reply, Dkt. 17, at 2 (citing *Lone Star OB/GYN Assocs. V. Aetna Health, Inc.*, 579 F.3d 525, 532 (5th Cir. 2009) (“Where, however, a medical service is determined to be covered and the only remaining issue is the proper contractual rate of payment, coverage and benefit determinations are not implicated and the claims are not preempted.”))).

The rate of payment/right to payment distinction is inapplicable here. In cases where the Fifth Circuit has made such a distinction, the healthcare providers seeking reimbursement had negotiated separate provider agreements specifying a contractual rate of reimbursement. *See, e.g., Lone Star OB/GYN Assocs.*, 579 F.3d at 530. For example, in *Lone Star OB/GYN Assocs.*, the principal case relied upon by Plaintiffs, Lone Star OB/GYN Associates (“Lone Star”) had a provider agreement with Aetna Health Inc. (“Aetna”), an administrator of employee welfare benefit plans regulated by ERISA. *Id.* at 528. The provider agreement between Lone Star and Aetna established the rate of payment Aetna was required to pay Lone Star for treating its plan members. *Id.* at 530. In calculating the amount of reimbursement owed to Lone Star for treating its plan members, Aetna would first determine the reimbursement rate under the Aetna Market Fee Schedule for each medical procedure performed by the doctor and then pay Lone Star “the fixed percentage (set out in the Provider Agreement) of that amount.” *Id.* Lone Star argued that “mere consultation of an ERISA plan [was] not enough to bring the claims within the scope of § 502(a).” *Id.* The Court agreed and clarified that a claim implicating “the *rate* of payment as set out in the

Provider Agreement, rather than the *right* to payment under the terms of the benefit plan, does not run afoul of *Davila* and is not preempted by ERISA.” *Id.* (emphasis in original).

The Court went on to hold that Lone Star’s “claims for underpayment under the Provider Agreement, which do not implicate coverage determinations under the terms of the relevant plan, are not preempted under ERISA.” *Id.* at 533. Because the Fifth Circuit could not determine from the record which claims Aetna partially paid because it denied the service for lack of coverage under the plan and which claims it partially paid because it erroneously calculated the contractual rate of reimbursement under the Provider Agreement, the Fifth Circuit remanded to the district court “to determine whether any of the payment claims submitted by Lone Star implicate a coverage determination under the plan and thus a federal issue under ERISA.” *Id.*

Here, there is no independent provider agreement between Plaintiffs and Defendants with a fee schedule separate from the ERISA plan. As Defendants rightly note, “Plaintiffs are out-of-network providers who have no contract with Defendants and no agreed-upon rate of payment.” (Resp., Dkt. 16, at 7). Instead, Plaintiffs secured assignments of ERISA benefits from insured patients and filed claims for such benefits with the Defendants “as the insured’s assignee.” (Orig. Pet., Dkt. 1-3, at 11). Plaintiffs’ right to reimbursement flows derivatively from each insured’s rights under the terms of their insurance plans—and Plaintiffs do not dispute that the Plans at issue are ERISA-governed plans. Any alleged underpayment of claims necessarily arose from a benefits determination under the Plans at issue rather than “an error in calculating the contractual rate” specified in an independent provider agreement. *Lone Star*, 579 F.3d at 533. Absent an independent provider agreement with a separate fee schedule, both the right to payment and the rate of reimbursement would depend on the terms of the ERISA plan.

Because Defendants have shown that Plaintiffs have derivative standing to sue as assignees of plan benefits, Defendants have sufficiently demonstrated that Plaintiffs could have brought their

claims pursuant to § 502(a)(1)(B). Moreover, the right to payment/rate of payment distinction asserted by Plaintiffs does not apply here because Plaintiffs were out-of-network providers who never negotiated a separate provider agreement with Defendants with an agreed-upon rate of payment. *See Lone Star OB/GYN Assoc.*, 579 F.3d at 530–32. Having found that the Plaintiffs could have brought their claims under the first *Davila* prong, the Court will now proceed to the next step of the analysis—whether Texas law creates a legal duty “independent” of the ERISA plans at issue. 542 U.S. 200 at 210.

B. Whether Texas law creates a right to reimbursement independent of the ERISA-regulated plans.

Under *Davila*’s second prong, a cause of action is completely preempted by ERISA “where there is no other independent legal duty that is implicated by a defendant’s actions.” *Id.* Therefore, the Court must determine whether Plaintiffs are “in fact suing under obligations created by the plan itself, or under obligations independent of the plan and the plan member.” *Spring E.R., LLC*, 2010 WL 598748, at *5. If one of Plaintiffs’ claims does not rest on an independent legal duty under Texas law, the Court may not remand. *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 337 (5th Cir. 1999) (“If the plaintiff moves to remand, all the defendant has to do is demonstrate a substantial federal claim, *e.g.*, one completely preempted by ERISA, and the court may not remand.”).

Plaintiffs assert state-law and common-law causes of action that they contend create an independent legal duty under Texas law requiring insurers to “reimburse out-of-network providers of emergency medical services at the usual and customary rate (i.e. the general prevailing cost of a service within a geographic area.)” (Mot. Remand, Dkt. 12, at 8). Specifically, Plaintiffs assert claims for violations of the Texas Insurance Code and the Texas Prompt Pay Act, as well as claims for quantum meruit and declaratory relief. (Compl., Dkt. 1-3, at 9-13). Reprising their right to payment/rate of payment argument, Plaintiffs contend their causes of action “involve no questions of whether the claim is payable; rather, they involve only the issue of whether the [Defendants] paid

the claim[s] at the required and customary rate” under Texas law. (*Id.*). While causes of action implicating the right to payment would trigger ERISA preemption, Plaintiffs maintain their state-law and common-law causes of action solely implicate the rate of payment guaranteed under Texas law, a duty independent of ERISA. (Mot. Remand, Dkt. 12, at 6).

Plaintiffs’ causes of action do not implicate legal duties independent of ERISA; rather Plaintiffs’ claims for reimbursement hinge on the terms of the ERISA-governed plans. Plaintiffs concede that Defendants determined all the claims at issue to be payable. (Pls.’ Reply, Dkt. 17, at 1–2). As Defendants rightly note, “Plaintiffs have no provider agreements with Defendants and no other contractual basis on which they were entitled to seek reimbursement from Defendants.” (Resp., Dkt. 16, at 10). Any potential liability for underpayment would therefore derive entirely from the rights and obligations encompassed within the terms of the benefit plans at issue. While the Texas statutes cited by Plaintiffs state rules for reimbursement of emergency care by non-network providers, these statutes still link reimbursement to either a plan’s terms or a separate provider agreement, which Plaintiffs—as out-of-network providers—have not negotiated. *See, e.g.*, Tex. Ins. Code § 1301.155 (“If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the usual and customary rate or at an agreed rate *and at the preferred level of benefits* until the insured can reasonably be expected to transfer to a preferred provider”) (emphasis added). As assignees of plan benefits, Plaintiffs’ reimbursement claims are not based on Texas law; they are inextricably linked to the reimbursement obligation set forth in the plans’ terms.

ERISA completely preempts Plaintiffs’ quantum meruit claim for similar reasons. Plaintiffs contend they are entitled to recover in quantum meruit because the Defendants “received the benefit of having its healthcare obligations to its plan members discharged and their enrollees received the benefit of the emergency care provided to them by Plaintiff Doctors.” (Orig. Pet., Dkt.

1-3, at 13). But under Texas law, recovery under a quantum meruit theory is “based upon a promise implied by law to pay for beneficial services rendered and knowingly accepted.” *Leasehold Expense Recovery, Inc. v. Mothers Work, Inc.*, 331 F.3d 452, 462 (5th Cir. 2003) (quoting *Black Lake Pipe Line v. Union Const. Co., Inc.*, 538 S.W.2d 80, 86 (Tex. 1976)). The implied promise to reimburse Plaintiffs for emergency care arises from the terms of each patient’s insurance plan. Determining “the reasonable value of services rendered” would hinge on an analysis and interpretation of Plaintiffs’ entitlement to benefits under the Plans’ terms. *Id.*

Plaintiffs insist that because they are “seeking reimbursement for approved claims at the usual and customary rate guaranteed to them by Texas law” rather than denied benefits, their quantum meruit claim does not depend on the implied agreement to pay benefits captured by the plans’ terms. (Pls.’ Reply, Dkt. 17, at 2). But Defendants only received the benefit of emergency care for their plan members that was covered under their enrollees’ ERISA-governed healthcare plans. *Spring E.R., LLC*, 2010 WL 598748, at *6. Defendants therefore accepted the benefit of Plaintiffs’ emergency care according to the terms of their enrollees’ plans. The rate of reimbursement for the benefit of such service would therefore turn on the reimbursement obligations under the ERISA plans held by the insured patients. Plaintiffs—having provided emergency care in accordance with the Plans’ terms—would be entitled to the rate of reimbursement specified in the Plans, no more and no less. Plaintiffs’ quantum meruit claim is therefore preempted.

Defendants have demonstrated that Plaintiffs (1) could have brought their claims pursuant to ERISA’s civil enforcement scheme and that (2) at least one of Plaintiffs’ state-law claims does not rest on a legal duty independent of ERISA. *Davila*, 542 U.S. 200 at 210. Therefore, the Court need not reach the question of whether Plaintiffs’ Prompt Pay Act claim or other Insurance Code claims

are also preempted by ERISA.² Because Defendants have shown that ERISA completely preempts at least one of Plaintiffs' claims, this Court cannot remand this action.

IV. CONCLUSION

For these reasons, **IT IS ORDERED** that Plaintiffs' Motion to Remand, (Dkt. 12), is **DENIED**.

SIGNED on December 10, 2019.



ROBERT PITMAN
UNITED STATES DISTRICT JUDGE

² Defendants need only demonstrate that one of Plaintiffs' stated claims is completely preempted by ERISA, as federal question jurisdiction requires only one "substantial federal claim, e.g., one completely preempted by ERISA." *Giles*, 172 F.3d at 337. So long as the Court has proper removal jurisdiction over one federal claim, "it may exercise supplemental jurisdiction over any remaining state law claims." *Id.* Thus, the Court need not analyze each of Plaintiffs' state-law claims to determine whether they present an independent legal duty. *Id.* The Court does note that the cases cited by Plaintiffs for the proposition that their Texas Prompt Pay Act claim rests on an independent duty precluding removal jurisdiction are inapposite because they involve either separate provider agreements or common-law misrepresentation claims, neither of which are present here. *See Lone Star*, 579 F.3d at 532 (holding that claims for underpayment under a separately-negotiated provider agreement brought pursuant to the Texas Prompt Pay Act that did not implicate coverage determinations were not preempted by ERISA); *Kindred Hosps. Ltd. P'ship v. Aetna Life Ins. Co.*, No. 3:16-CV-3379-D, 2017 WL 2505001, at *7 (N.D. Tex. June 9, 2017) (holding that plaintiffs' common-law misrepresentation claim based on an insurance company's pre-admission representations about coverage and claim for breach of an independent provider agreement were not completely preempted).