Case Nos. 85525 & 85656

In the Supreme Court of Nevada

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Appellants, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Respondents.	Case No. 85525
UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Petitioners, *vs.* THE EIGHTH JUDICIAL DISTRICT COURT of the State of Nevada, in and for the County of Clark; and the Honorable NANCY L. ALLF, District Judge, Respondents, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Real Parties in Interest.	Case No. 85656

APPELLANTS' APPENDIX
VOLUME 3
PAGES 501–750

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CHRONOLOGICAL TABLE OF CONTENTS TO APPENDIX

Tab	Document	Date	Vol.	Pages
18.	Defendants' Opposition to Plaintiffs' Amended Motion to Remand	01/29/20	2	349–485
19.	Reply in Support of Amended Motion to Remand	02/05/20	2 3	486–500 501–518
20.	Order	02/20/20	3	519–524
21.	Order	02/24/20	3	525–542
22.	Notice of Entry of Order Re: Remand	02/27/20	3	543–552
23.	Defendants' Motion to Dismiss	03/12/20	3	553–698
24.	Notice of Intent to Take Default as to: (1) Defendant UnitedHealth Group, Inc. on All Claims; and (2) All Defendants on the First Amended Complaint's Eighth Claim for Relief	03/13/20	3 4	699–750 751
25.	Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	752–783
26.	Appendix of Exhibits in Support of Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	784–908
27.	Recorder's Transcript of Proceedings Re: Motions	04/03/20	4	909–918
28.	Defendants' Reply in Support of Motion to Dismiss	05/07/20	4	919–948
29.	Recorder's Transcript of Proceedings Re: Pending Motions	05/14/20	4	949-972
30.	First Amended Complaint	05/15/20	4 5	973–1000 1001–1021
31.	Recorder's Transcript of Hearing All Pending Motions	05/15/20	5	1022–1026
32.	Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint	05/26/20	5	1027–1172

Tab	Document	Date	Vol.	Pages
33.	Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	05/26/20	5	1173–1187
34.	Plaintiffs' Opposition to Defendants' Motion to Dismiss First Amended Complaint	05/29/20	5 6	1188–1250 1251–1293
35.	Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	05/29/20	6	1294–1309
36.	Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint	06/03/20	6	1310–1339
37.	Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motions to Dismiss Plaintiff's First Amended Complaint	06/03/20	6	1340–1349
38.	Transcript of Proceedings, All Pending Motions	06/05/20	6	1350–1384
39.	Transcript of Proceedings, All Pending Motions	06/09/20	6	1385–1471
40.	Notice of Entry of 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	06/24/20	6 7	1472–1500 1501–1516
41.	Notice of Entry of Stipulated Confidentiality and Protective Order	06/24/20	7	1517–1540
42.	Defendants' Answer to Plaintiffs' First Amended Complaint	07/08/20	7	1541–1590

Tab	Document	Date	Vol.	Pages
43.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	07/09/20	7	1591–1605
44.	Joint Case Conference Report	07/17/20	7	1606–1627
45.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	07/23/20	7	1628–1643
46.	Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement	07/29/20	7	1644–1663
47.	Amended Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement	07/29/20	7	1664–1683
48.	Errata	08/04/20	7	1684
49.	Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, or, in the Alternative, Motion in Limine on Order Shortening Time	08/28/20	7 8	1685–1700 1701–1845
50.	Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, Or, in The Alternative, Motion in Limine on Order Shortening Time	09/04/20	8	1846–1932
51.	Recorder's Transcript of Proceedings Re: Pending Motions	09/09/20	8	1933–1997
52.	Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	09/21/20	8 9	1998–2000 2001–2183
53.	Notice of Entry of Order Granting, in Part Plaintiffs' Motion to Compel Defendants' Production of Claims for At-Issue Claims,	09/28/20	9	2184–2195

Tab	Document	Date	Vol.	Pages
	Or, in The Alternative, Motion in Limine			
54.	Errata to Plaintiffs' Motion to Compel Defendants' List of Witnesses Production of Documents and Answers to Interrogatories	09/28/20	9	2196–2223
55.	Plaintiffs' Opposition to Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	09/29/20	9-10	2224–2292
56.	Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents, and Answers to Interrogatories on Order Shortening Time	10/06/20	10	2293–2336
57.	Reply in Support of Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures	10/07/20	10	2337–2362
58.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/08/20	10	2363–2446
59.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/22/20	10	2447–2481
60.	Defendants' Objections to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/23/20	10 11	2482–2500 2501–2572
61.	Defendants' Objections to Plaintiffs to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/26/20	11	2573–2670

Tab	Document	Date	Vol.	Pages
62.	Notice of Entry of Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on Order Shortening Time	10/27/20	11	2671–2683
63.	Notice of Entry of Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/27/20	11	2684–2695
64.	Defendants' Objections to Plaintiffs' Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs' to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	11/02/20	11	2696–2744
65.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	11/04/20	11 12	2745–2750 2751–2774
66.	Notice of Entry of Order Setting Defendants' Production & Response Schedule Re: Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	11/09/20	12	2775–2785
67.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/23/20	12	2786–2838
68.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/30/20	12	2839–2859
69.	Notice of Entry of Stipulated Electronically Stored Information Protocol Order	01/08/21	12	2860–2874

Tab	Document	Date	Vol.	Pages
70.	Appendix to Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/08/21	12 13 14	2875–3000 3001–3250 3251–3397
71.	Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/11/21	14	3398–3419
72.	Plaintiffs' Opposition to Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/12/21	14	3420–3438
73.	Recorder's Partial Transcript of Proceedings Re: Motions (Unsealed Portion Only)	01/13/21	14	3439–3448
74.	Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14	3449–3465
75.	Appendix to Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14 15	3466–3500 3501–3658
76.	Recorder's Transcript of Proceedings Re: Motions	01/21/21	15	3659–3692
77.	Notice of Entry of Order Granting Defendants' Motion for Appointment of Special Master	02/02/21	15	3693–3702
78.	Notice of Entry of Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	02/04/21	15	3703–3713
79.	Motion for Reconsideration of Order Denying Defendants' Motion to Compel	02/18/21	15 16	3714–3750 3751–3756

Tab	Document	Date	Vol.	Pages
	Plaintiffs Responses to Defendants' First and Second Requests for Production			
80.	Recorder's Transcript of Proceedings Re: Motions	02/22/21	16	3757–3769
81.	Recorder's Transcript of Proceedings Re: Motions	02/25/21	16	3770–3823
82.	Recorder's Transcript of Hearing Defendants' Motion to Extend All Case Management Deadlines and Continue Trial Setting on Order Shortening Time (Second Request)	03/03/21	16	3824–3832
83.	Plaintiffs' Opposition to Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/04/21	16	3833–3862
84.	Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	16	3863–3883
85.	Errata to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/12/21	16	3884–3886
86.	Notice of Entry of Report and Recommendation #1	03/16/21	16	3887–3894
87.	Reply in Support of Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/16/21	16	3895–3909
88.	Recorder's Transcript of Hearing All Pending Motions	03/18/21	16	3910–3915

Tab	Document	Date	Vol.	Pages
89.	Defendants' Opposition to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not be Held in Contempt and for Sanctions	03/22/21	16	3916–3966
90.	Recorder's Transcript of Hearing All Pending Motions	03/25/21	16	3967–3970
91.	Notice of Entry of Report and Recommendation #2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	03/29/21	16	3971–3980
92.	Recorder's Transcript of Hearing Motion to Associate Counsel on OST	04/01/21	16	3981–3986
93.	Recorder's Transcript of Proceedings Re: Motions	04/09/21	16 17	3987–4000 4001–4058
94.	Defendants' Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	04/12/21	17	4059–4079
95.	Notice of Entry of Report and Recommendation #3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time	04/15/21	17	4080–4091
96.	Recorder's Transcript of Hearing All Pending Motions	04/21/21	17	4092–4095
97.	Notice of Entry of Order Denying Motion for Reconsideration of Court's Order Denying Defendants' Motion to Compel Responses to	04/26/21	17	4096–4108

Tab	Document	Date	Vol.	Pages
	Defendants' First and Second Requests for Production			
98.	Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time	04/28/21	17	4109–4123
99.	Defendants' Errata to Their Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production	05/03/21	17	4124–4127
100.	Defendants' Objections to Plaintiffs' Proposed Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	05/05/21	17	4128–4154
101.	Recorder's Transcript of Hearing Motion for Leave to File Opposition to Defendants' Motion to Compel Responses to Second Set of Requests for Production on Order Shortening Time in Redacted and Partially Sealed Form	05/12/21	17	4155–4156
102.	Notice of Entry of Order of Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Question	05/26/21	17	4157–4165
103.	Recorder's Transcript of Proceedings Re: Motions	05/28/21	17	4166–4172
104.	Notice of Entry of Report and Recommendation #7 Regarding Defendants'	06/03/21	17	4173–4184

Tab	Document	Date	Vol.	Pages
	Motion to Compel Plaintiffs' Responses to Defendants' Amended Third Set of Requests for Production of Documents			
105.	Recorder's Transcript of Proceedings Re: Motions Hearing	06/03/21	17	4185–4209
106.	Recorder's Transcript of Proceedings Re: Motions Hearing	06/04/21	17	4210–4223
107.	Recorder's Transcript of Hearing Motion for Leave to File Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Second Set of Request for Production on Order Shortening Time in Redacted and Partially Sealed Form	06/09/21	17	4224–4226
108.	Defendants' Objections to Special Master Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Requests for Production of Documents	06/17/21	17	4227–4239
109.	Recorder's Transcript of Proceedings Re: Motions Hearing	06/23/21	17 18	4240–4250 4251–4280
110.	Plaintiffs' Response to Defendants' Objection to Special Master's Report and Recommendation #7 Regarding Defendants' Motion to Compel Responses to Amended Third Set of Request for Production of Documents	06/24/21	18	4281–4312
111.	Notice of Entry Report and Recommendations #9 Regarding Pending Motions	07/01/21	18	4313–4325
112.	United's Reply in Support of Motion to Compel Plaintiffs' Production of Documents	07/12/21	18	4326–4340

Tab	Document	Date	Vol.	Pages
	About Which Plaintiffs' Witnesses Testified on Order Shortening Time			
113.	Recorder's Transcript of Proceedings Re: Motions Hearing	07/29/21	18	4341–4382
114.	Notice of Entry of Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	08/03/21	18	4383–4402
115.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection	08/09/21	18	4403–4413
116.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time and Overruling Objection	08/09/21	18	4414–4424
117.	Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection	08/09/21	18	4425–4443
118.	Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Second Set of Requests for Production on Order Shortening Time and	08/09/21	18	4444–4464

Tab	Document	Date	Vol.	Pages
	Overruling Objection			
119.	Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Violating Protective Order	08/10/21	18	4465–4486
120.	Notice of Entry of Report and Recommendation #11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified	08/11/21	18	4487–4497
121.	Recorder's Transcript of Proceedings Re: Motions Hearing (Unsealed Portion Only)	08/17/21	18 19	4498–4500 4501–4527
122.	Plaintiffs' Opposition to United's Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Allegedly Violating Protective Order	08/24/21	19	4528–4609
123.	Recorder's Transcript of Proceedings Re: Motions Hearing	09/02/21	19	4610–4633
124.	Reply Brief on "Motion for Order to Show Cause Why Plaintiffs Should Not Be Hold in Contempt and Sanctioned for Violating Protective Order"	09/08/21	19	4634–4666
125.	Recorder's Partial Transcript of Proceedings Re: Motions Hearing	09/09/21	19	4667–4680
126.	Recorder's Partial Transcript of Proceedings Re: Motions Hearing (Via Blue Jeans)	09/15/21	19	4681–4708
127.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions and Overruling Objection	09/16/21	19	4709–4726

Tab	Document	Date	Vol.	Pages
128.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Request for Production of Documents and Overruling Objection	09/16/21	19	4727–4747
129.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed No to Answer and Overruling Objection	09/16/21	19 20	4748–4750 4751–4769
130.	Defendants' Motion for Partial Summary Judgment	09/21/21	20	4770–4804
131.	Defendants' Motion in Limine No. 1: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with other Market Players and Related Negotiations	09/21/21	20	4805–4829
132.	Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations	09/21/21	20	4830–4852
133.	Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Process and Reasonableness of billed Charges if Motion in Limine No. 3 is Denied	09/21/21	20	4853–4868
134.	Defendants' Motion in Limine No. 10 to Exclude Reference of Defendants' Corporate Structure (Alternative Moton to be Considered Only if court Denies Defendants' Counterpart Motion in Limine No. 9)	09/21/21	20	4869–4885

Tab	Document	Date	Vol.	Pages
135.	Defendants' Motion in Limine No. 13: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	09/21/21	20	4886–4918
136.	Defendants' Motion in Limine No. 14: Motion Offered in the Alternative to MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to Settlement Agreement Between CollectRX and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs	09/21/21	20	4919–4940
137.	Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/21/21	20	4941–4972
138.	Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	09/22/21	20 21	4973–5000 5001–5030
139.	Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided	09/22/21	21	5031–5054
140.	Defendants' Motion in Limine No. 9 to Authorize Defendants to Offer Evidence of Plaintiffs Organizational, Management, and Ownership Structure, Including Flow of Funds Between Related Entities, Operating Companies, Parent Companies, and Subsidiaries	09/22/21	21	5055–5080
141.	Defendants' Opposition to Plaintiffs' Motion	09/29/21	21	5081–5103

Tab	Document	Date	Vol.	Pages
	in Limine No. 1: to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges			
142.	Notice of Entry of Order Regarding Defendants' Objection to Special Master's Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents about which Plaintiffs' Witnesses Testified on Order Shortening Time	09/29/21	21	5104–5114
143.	Plaintiffs' Opposition to Defendants' Motion in Limine Nos. 3, 4, 5, 6 Regarding Billed Charges	09/29/21	21	5115–5154
144.	Plaintiffs' Opposition to Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/29/21	21	5155–5169
145.	Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/04/21	21	5170–5201
146.	Transcript of Proceedings Re: Motions (Via Blue Jeans)	10/06/21	21	5202–5234
147.	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/07/21	21	5235–5245
148.	Second Amended Complaint	10/07/21	21 22	5246–5250 5251–5264
149.	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and-or Argument Regarding the Fact that Plaintiffs Have	10/08/21	22	5265–5279

Tab	Document	Date	Vol.	Pages
	Dismissed Certain Claims and Parties on Order Shortening Time			
150.	Defendants' Answer to Plaintiffs' Second Amended Complaint	10/08/21	22	5280–5287
151.	Defendants' Objections to Plaintiffs' NRCP 16.1(a)(3) Pretrial Disclosures	10/08/21	22	5288–5294
152.	Plaintiffs' Objections to Defendants' Pretrial Disclosures	10/08/21	22	5295–5300
153.	Opposition to Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Regarding the Fact that Plaintiffs have Dismissed Certain Claims and Parties on Order Shortening Time	10/12/21	22	5301–5308
154.	Notice of Entry of Order Denying Defendants' Motion for Order to Show Cause Why Plaintiffs Should not be Held in Contempt for Violating Protective Order	10/14/21	22	5309–5322
155.	Defendants' Opposition to Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/18/21	22	5323–5333
156.	Media Request and Order Allowing Camera Access to Court Proceedings (Legal Newsline)	10/18/21	22	5334–5338
157.	Transcript of Proceedings Re: Motions	10/19/21	22 23	5339–5500 5501–5561
158.	Amended Transcript of Proceedings Re: Motions	10/19/21	23 24	5562–5750 5751–5784
159.	Amended Transcript of Proceedings Re: Motions	10/20/21	24	5785–5907
160.	Transcript of Proceedings Re: Motions	10/22/21	24	5908–6000

Tab	Document	Date	Vol.	Pages
			25	6001–6115
161.	Notice of Entry of Order Denying Defendants' Motion for Partial Summary Judgment	10/25/21	25	6116–6126
162.	Recorder's Transcript of Jury Trial – Day 1	10/25/21	25 26	6127–6250 6251–6279
163.	Recorder's Transcript of Jury Trial – Day 2	10/26/21	26	6280–6485
164.	Joint Pretrial Memorandum Pursuant to EDRC 2.67	10/27/21	26 27	6486–6500 6501–6567
165.	Recorder's Transcript of Jury Trial – Day 3	10/27/21	27 28	6568–6750 6751–6774
166.	Recorder's Transcript of Jury Trial – Day 4	10/28/21	28	6775–6991
167.	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 28	6992–6997
168.	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 29	6998–7000 7001–7003
169.	Defendants' Objection to Media Requests	10/28/21	29	7004–7018
170.	Supplement to Defendants' Objection to Media Requests	10/31/21	29	7019–7039
171.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 1 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with Other Market Players and Related Negotiations	11/01/21	29	7040–7051
172.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence	11/01/21	29	7052–7063

Tab	Document	Date	Vol.	Pages
	Relating to Defendants' Agreements with Other Market Players and Related Negotiations			
173.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 3 to Allow Reference to Plaintiffs' Decision Making Processes Regarding Setting Billed Charges	11/01/21	29	7064–7075
174.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Processes and Reasonableness of Billed Charges if Motion in Limine No. 3 is Denied	11/01/21	29	7076–7087
175.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 12, Paired with Motion in Limine No. 11, to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement	11/01/21	29	7088–7099
176.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 5 Regarding Argument or Evidence that Amounts TeamHealth Plaintiffs Billed for Services are Reasonable [An Alternative Motion to Motion in Limine No. 6]	11/01/21	29	7100–7111
177.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	11/01/21	29	7112–7123
178.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the	11/01/21	29	7124–7135

Tab	Document	Date	Vol.	Pages
	Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided			
179.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 10 to Exclude Evidence of Defendants' Corporate Structure (Alternative Motion to be Considered Only if Court Denies Defendants' Counterpart Motion in Limine No. 9)	11/01/21	29	7136–7147
180.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 11, Paired with Motion in Limine No. 12, to Authorize Defendants to Discuss Plaintiffs' Conduct and Deliberations in Negotiating Reimbursement	11/01/21	29	7148–7159
181.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 13 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	11/01/21	29	7160–7171
182.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 14: Motion Offered in the Alternative MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to a Settlement Agreement Between CollectRx and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs	11/01/21	29	7172–7183
183.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 15 to Preclude Reference and Testimony	11/01/21	29	7184–7195

Tab	Document	Date	Vol.	Pages
	Regarding the TeamHealth Plaintiffs Policy not to Balance Bill			
184.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 18 to Preclude Testimony of Plaintiffs' Non-Retained Expert Joseph Crane, M.D.	11/01/21	29	7196–7207
185.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 20 to Exclude Defendants' Lobbying Efforts	11/01/21	29	7208–7219
186.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	11/01/21	29	7220–7231
187.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 27 to Preclude Evidence of Complaints Regarding Defendants' Out-Of-Network Rates or Payments	11/01/21	29	7232–7243
188.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 29 to Preclude Evidence Only Relating to Defendants' Evaluation and Development of a Company that Would Offer a Service Similar to Multiplan and Data iSight	11/01/21	29 30	7244–7250 7251–7255
189.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 32 to Exclude Evidence or Argument Relating to Materials, Events, or Conduct that Occurred on or After January 1, 2020	11/01/21	30	7256–7267
190.	Notice of Entry of Order Denying Defendants' Motion in Limine to Preclude Certain Expert Testimony and Fact Witness Testimony by Plaintiffs' Non-Retained	11/01/21	30	7268–7279

Tab	Document	Date	Vol.	Pages
	Expert Robert Frantz, M.D.			
191.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 38 to Exclude Evidence or Argument Relating to Defendants' use of MultiPlan and the Data iSight Service, Including Any Alleged Conspiracy or Fraud Relating to the use of Those Services	11/01/21	30	7280–7291
192.	Notice of Entry of Order Granting Plaintiffs' Motion in Limine to Exclude Evidence, Testimony And-Or Argument Regarding the Fact that Plaintiff have Dismissed Certain Claims	11/01/21	30	7292–7354
193.	Notice of Entry of Order Denying Defendants' Motion to Strike Supplement Report of David Leathers	11/01/21	30	7355–7366
194.	Plaintiffs' Notice of Amended Exhibit List	11/01/21	30	7367–7392
195.	Plaintiffs' Response to Defendants' Objection to Media Requests	11/01/21	30	7393–7403
196.	Recorder's Transcript of Jury Trial – Day 5	11/01/21	30 31	7404–7500 7501–7605
197.	Recorder's Transcript of Jury Trial – Day 6	11/02/21	31 32	7606–7750 7751–7777
198.	Defendants' Deposition Designations and Objections to Plaintiffs' Deposition Counter-Designations	11/03/21	32	7778–7829
199.	Defendants' Objections to Plaintiffs' Proposed Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	11/03/21	32	7830–7852
200.	Notice of Entry of Order Affirming and	11/03/21	32	7853–7874

Tab	Document	Date	Vol.	Pages
	Adopting Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified			
201.	Recorder's Transcript of Jury Trial – Day 7	11/03/21	32 33	7875–8000 8001–8091
202.	Notice of Entry of Order Granting Defendants' Motion in Limine No. 17	11/04/21	33	8092–8103
203.	Notice of Entry of Order Granting Defendants' Motion in Limine No. 25	11/04/21	33	8104–8115
204.	Notice of Entry of Order Granting Defendants' Motion in Limine No. 37	11/04/21	33	8116–8127
205.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 9	11/04/21	33	8128–8140
206.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 21	11/04/21	33	8141–8153
207.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 22	11/04/21	33	8154–8165
208.	Plaintiffs' Notice of Deposition Designations	11/04/21	33 34	8166–8250 8251–8342
209.	1st Amended Jury List	11/08/21	34	8343
210.	Recorder's Transcript of Jury Trial – Day 8	11/08/21	34 35	8344–8500 8501–8514
211.	Recorder's Amended Transcript of Jury Trial – Day 9	11/09/21	35	8515–8723
212.	Recorder's Transcript of Jury Trial – Day 9	11/09/21	35 36	8724–8750 8751–8932
213.	Recorder's Transcript of Jury Trial – Day 10	11/10/21	36	8933–9000

Tab	Document	Date	Vol.	Pages
			37	9001–9152
214.	Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at Trial Under Seal	11/12/21	37	9153–9161
215.	Notice of Entry of Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	11/12/21	37	9162–9173
216.	Plaintiffs' Trial Brief Regarding Defendants' Prompt Payment Act Jury Instruction Re: Failure to Exhaust Administrative Remedies	11/12/21	37	9174–9184
217.	Recorder's Transcript of Jury Trial – Day 11	11/12/21	37 38	9185–9250 9251–9416
218.	Plaintiffs' Trial Brief Regarding Specific Price Term	11/14/21	38	9417–9425
219.	2nd Amended Jury List	11/15/21	38	9426
220.	Defendants' Proposed Jury Instructions (Contested)	11/15/21	38	9427–9470
221.	Jointly Submitted Jury Instructions	11/15/21	38	9471–9495
222.	Plaintiffs' Proposed Jury Instructions (Contested)	11/15/21	38 39	9496–9500 9501–9513
223.	Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/15/21	39	9514–9521
224.	Recorder's Transcript of Jury Trial – Day 12	11/15/21	39 40	9522–9750 9751–9798
225.	Defendants' Response to TeamHealth Plaintiffs' Trial Brief Regarding Defendants' Prompt Pay Act Jury Instruction Re: Failure to Exhaust Administrative	11/16/21	40	9799–9806

Tab	Document	Date	Vol.	Pages
	Remedies			
226.	General Defense Verdict	11/16/21	40	9807–9809
227.	Plaintiffs' Proposed Verdict Form	11/16/21	40	9810–9819
228.	Recorder's Transcript of Jury Trial – Day 13	11/16/21	40 41	9820–10,000 10,001–10,115
229.	Reply in Support of Trial Brief Regarding Evidence and Argument Relating to Out-Of-State Harms to Non-Parties	11/16/21	41	10,116–10,152
230.	Response to Plaintiffs' Trial Brief Regarding Specific Price Term	11/16/21	41	10,153–10,169
231.	Special Verdict Form	11/16/21	41	10,169–10,197
232.	Trial Brief Regarding Jury Instructions on Formation of an Implied-In-Fact Contract	11/16/21	41	10,198–10,231
233.	Trial Brief Regarding Jury Instructions on Unjust Enrichment	11/16/21	41	10,232–10,248
234.	3rd Amended Jury List	11/17/21	41	10,249
235.	Defendants' Motion for Judgment as a Matter of Law	11/17/21	41 42	10,250 10,251–10,307
236.	Plaintiffs' Supplemental Jury Instruction (Contested)	11/17/21	42	10,308–10,313
237.	Recorder's Transcript of Jury Trial – Day 14	11/17/21	42 43	10,314–10,500 10,501–10,617
238.	Errata to Source on Defense Contested Jury Instructions	11/18/21	43	10,618–10,623
239.	Recorder's Transcript of Jury Trial – Day 15	11/18/21	43 44	10,624–10,750 10,751–10,946
240.	Defendants' Supplemental Proposed Jury Instructions (Contested)	11/19/21	44	10,947–10,952

Tab	Document	Date	Vol.	Pages
241.	Errata	11/19/21	44	10,953
242.	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	11/19/21	44	10,954–10,963
243.	Plaintiffs' Proposed Special Verdict Form	11/19/21	44	10,964–10,973
244.	Recorder's Transcript of Jury Trial – Day 16	11/19/21	44 45	10,974–11,000 11,001–11,241
245.	Response to Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/19/21	45 46	11,242–11,250 11,251–11,254
246.	Plaintiffs' Second Supplemental Jury Instructions (Contested)	11/20/21	46	11,255–11,261
247.	Defendants' Supplemental Proposed Jury Instruction	11/21/21	46	11,262–11,266
248.	Plaintiffs' Third Supplemental Jury Instructions (Contested)	11/21/21	46	11,267–11,272
249.	Recorder's Transcript of Jury Trial – Day 17	11/22/21	46 47	11,273–11,500 11.501–11,593
250.	Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,594–11,608
251.	Defendants' Opposition to Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,609–11,631
252.	4th Amended Jury List	11/23/21	47	11,632
253.	Recorder's Transcript of Jury Trial – Day 18	11/23/21	47 48	11,633–11,750 11,751–11,907

Tab	Document	Date	Vol.	Pages
254.	Recorder's Transcript of Jury Trial – Day 19	11/24/21	48	11,908–11,956
255.	Jury Instructions	11/29/21	48	11,957–11,999
256.	Recorder's Transcript of Jury Trial – Day 20	11/29/21	48 49	12,000 12,001–12,034
257.	Special Verdict Form	11/29/21	49	12,035–12,046
258.	Verdict(s) Submitted to Jury but Returned Unsigned	11/29/21	49	12,047–12,048
259.	Defendants' Proposed Second Phase Jury Instructions	12/05/21	49	12,049–12,063
260.	Plaintiffs' Proposed Second Phase Jury Instructions and Verdict Form	12/06/21	49	12,064–12,072
261.	Plaintiffs' Supplement to Proposed Second Phase Jury Instructions	12/06/21	49	12,072–12,077
262.	Recorder's Transcript of Jury Trial – Day 21	12/06/21	49	12,078–,12,135
263.	Defendants' Proposed Second Phase Jury Instructions-Supplement	12/07/21	49	12,136–12,142
264.	Jury Instructions Phase Two	12/07/21	49	12,143–12,149
265.	Special Verdict Form	12/07/21	49	12,150–12,152
266.	Recorder's Transcript of Jury Trial – Day 22	12/07/21	49 50	12,153–12,250 12,251–12,293
267.	Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,294–12,302
268.	Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,303–12,311
269.	Notice of Entry of Order Granting Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at	12/27/21	50	12,312–12,322

Tab	Document	Date	Vol.	Pages
	Trial Under Seal			
270.	Plaintiffs' Opposition to United's Motion to Seal	12/29/21	50	12,323–12,341
271.	Defendants' Motion to Apply the Statutory Cap on Punitive Damages	12/30/21	50	12,342–12,363
272.	Appendix of Exhibits to Defendants' Motion to Apply the Statutory Cap on Punitive Damage	12/30/21	50 51	12,364–12,500 12,501–12,706
273.	Defendants' Objection to Plaintiffs' Proposed Order Denying Defendants' Motion for Judgment as a Matter of Law	01/04/22	51	12,707–12,717
274.	Notice of Entry of Order Denying Defendants' Motion for Judgement as a Matter of Law	01/06/22	51	12,718–12,738
275.	Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51	12,739–12,747
276.	Motion to Seal Defendants' Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51 52	12,748–12,750 12,751–12,756
277.	Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing on Defendants' Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time	01/11/22	52	12,757–12,768
278.	Plaintiffs' Opposition to Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing	01/12/22	52	12,769–12,772
279.	Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for	01/20/22	52	12,773–12,790

Tab	Document	Date	Vol.	Pages
	Entry of Judgment			
280.	Appendix in Support of Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment	01/20/22	52	12,791–12,968
281.	Notice of Entry of Order Granting Plaintiffs' Proposed Schedule for Submission of Final Redactions	01/31/22	52	12,969–12,979
282.	Notice of Entry of Stipulation and Order Regarding Schedule for Submission of Redactions	02/08/22	52	12,980–12,996
283.	Defendants' Opposition to Plaintiffs' Cross-Motion for Entry of Judgment	02/10/22	52 53	12,997–13,000 13,001–13,004
284.	Defendant' Reply in Support of Their Motion to Apply the Statutory Cap on Punitive Damages	02/10/22	53	13,005–13,028
285.	Notice of Entry of Order Shortening Time for Hearing Re: Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits	02/14/22	53	13,029–13,046
286.	Defendants' Response to Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time	02/15/22	53	13,047–13,053
287.	Plaintiffs' Reply in Support of Cross Motion for Entry of Judgment	02/15/22	53	13,054–13,062
288.	Defendants' Index of Trial Exhibit Redactions in Dispute	02/16/22	53	13,063–13,073
289.	Notice of Entry of Stipulation and Order Regarding Certain Admitted Trial Exhibits	02/17/22	53	13,074–13,097
290.	Transcript of Proceedings Re: Motions Hearing	02/17/22	53	13,098–13,160

Tab	Document	Date	Vol.	Pages
291.	Objection to Plaintiffs' Proposed Judgment and Order Denying Motion to Apply Statutory Cap on Punitive Damages	03/04/22	53	13,161–13,167
292.	Notice of Entry of Judgment	03/09/22	53	13,168–13,178
293.	Notice of Entry of Order Denying Defendants' Motion to Apply Statutory Cap on Punitive Damages	03/09/22	53	13,179–13,197
294.	Health Care Providers' Verified Memorandum of Cost	03/14/22	53	13,198–13,208
295.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 1	03/14/22	53 54	13,209–13,250 13.251–13,464
296.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 2	03/14/22	54 55	13,465–13,500 13,501–13,719
297.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 3	03/14/22	55 56	13,720–13,750 13,751–13,976
298.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 4	03/14/22	56 57	13,977–14,000 14,001–14,186
299.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 5	03/14/22	57 58	14,187–14,250 14,251–14,421
300.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 6	03/14/22	58 59	14,422–14,500 14,501–14,673
301.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 7	03/14/22	59 60	14,674–14,750 14,751–14,920
302.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of	03/14/22	60 61	14,921–15,000 15,001–15,174

Tab	Document	Date	Vol.	Pages
	Cost Volume 8			
303.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 9	03/14/22	61 62	15,175–15,250 15,251–15,373
304.	Defendants' Motion to Retax Costs	03/21/22	62	15,374–15,388
305.	Health Care Providers' Motion for Attorneys' Fees	03/30/22	62	15,389–15,397
306.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 1	03/30/22	62 63	15,398–15,500 15,501–15,619
307.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 2	03/30/22	63 64	15,620–15,750 15,751–15,821
308.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 3	03/30/22	64 65	15,822–16,000 16,001–16,053
309.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 4	03/30/22	65	16,054–16,232
310.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 5	03/30/22	65 66	16,233–16,250 16,251–16,361
311.	Defendants Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions on Order Shortening Time	04/05/22	66	16,362–16,381
312.	Defendants' Motion for Remittitur and to Alter or Amend the Judgment	04/06/22	66	16,382–16,399
313.	Defendants' Renewed Motion for Judgment as a Matter of Law	04/06/22	66	16,400–16,448
314.	Motion for New Trial	04/06/22	66 67	16,449–16,500 16,501–16,677

Tab	Document	Date	Vol.	Pages
315.	Notice of Appeal	04/06/22	67	16,678–16,694
316.	Case Appeal Statement	04/06/22	67 68	16,695–16,750 16,751–16,825
317.	Plaintiffs' Opposition to Defendants' Rule 62(b) Motion for Stay	04/07/22	68	16,826–16,831
318.	Reply on "Defendants' Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions" (*on Order Shortening Time*)	04/07/22	68	16,832–16,836
319.	Transcript of Proceedings Re: Motions Hearing	04/07/22	68	16,837–16,855
320.	Opposition to Defendants' Motion to Retax Costs	04/13/22	68	16,856–16,864
321.	Appendix in Support of Opposition to Defendants' Motion to Retax Costs	04/13/22	68 69	16,865–17,000 17,001–17,035
322.	Defendants' Opposition to Plaintiffs' Motion for Attorneys' Fees	04/20/22	69	17,036–17,101
323.	Transcript of Proceedings Re: Motions Hearing	04/21/22	69	17,102–17,113
324.	Notice of Posting *Supersedeas* Bond	04/29/22	69	17,114–17,121
325.	Defendants' Reply in Support of Motion to Retax Costs	05/04/22	69	17,122–17,150
326.	Health Care Providers' Reply in Support of Motion for Attorneys' Fees	05/04/22	69	17,151–17,164
327.	Plaintiffs' Opposition to Defendants' Motion for Remittitur and to Alter or Amend the Judgment	05/04/22	69	17,165–17,178
328.	Plaintiffs' Opposition to Defendants' Motion for New Trial	05/04/22	69 70	17,179–17,250 17,251–17,335
329.	Plaintiffs' Opposition to Defendants' Renewed Motion for Judgment as a Matter	05/05/22	70	17,336–17,373

Tab	Document	Date	Vol.	Pages
	of Law			
330.	Reply in Support of Defendants' Motion for Remittitur and to Alter or Amend the Judgment	06/22/22	70	17,374–17,385
331.	Reply in Support of Defendants' Renewed Motion for Judgment as a Matter of Law	06/22/22	70	17,386–17,411
332.	Reply in Support of Motion for New Trial	06/22/22	70	17,412–17,469
333.	Notice of Supplemental Attorneys Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees	06/24/22	70 71	17,470–17,500 17,501–17,578
334.	Defendants' Response to Improper Supplement Entitled "Notice of Supplemental Attorney Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees"	06/28/22	71	17,579–17,593
335.	Notice of Entry of Order Granting Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	06/29/22	71	17,594–17,609
336.	Transcript of Proceedings Re: Motions Hearing	06/29/22	71	17,610–17,681
337.	Order Amending Oral Ruling Granting Defendants' Motion to Retax	07/01/22	71	17,682–17,688
338.	Notice of Entry of Order Denying Defendants' Motion for Remittitur and to Alter or Amend the Judgment	07/19/22	71	17,689–17,699
339.	Defendants' Objection to Plaintiffs' Proposed Order Approving Plaintiffs' Motion for Attorneys' Fees	07/26/22	71	17,700–17,706
340.	Notice of Entry of Order Approving Plaintiffs' Motion for Attorney's Fees	08/02/22	71	17,707–17,725

Tab	Document	Date	Vol.	Pages
341.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Retax Costs	08/02/22	71	17,726–17,739
342.	Amended Case Appeal Statement	08/15/22	71 72	17,740–17,750 17,751–17,803
343.	Amended Notice of Appeal	08/15/22	72	17,804–17,934
344.	Reply in Support of Supplemental Attorney's Fees Request	08/22/22	72	17,935–17,940
345.	Objection to Plaintiffs' Proposed Orders Denying Renewed Motion for Judgment as a Matter of Law and Motion for New Trial	09/13/22	72	17,941–17,950
346.	Recorder's Transcript of Hearing Re: Hearing	09/22/22	72	17,951–17,972
347.	Limited Objection to "Order Unsealing Trial Transcripts and Restoring Public Access to Docket"	10/06/22	72	17,973–17,978
348.	Defendants' Motion to Redact Portions of Trial Transcript	10/06/22	72	17,979–17,989
349.	Plaintiffs' Opposition to Defendants' Motion to Redact Portions of Trial Transcript	10/07/22	72	17,990–17,993
350.	Transcript of Proceedings re Status Check	10/10/22	72 73	17,994–18,000 18,001–18,004
351.	Notice of Entry of Order Approving Supplemental Attorney's Fee Award	10/12/22	73	18,005–18,015
352.	Notice of Entry of Order Denying Defendants' Motion for New Trial	10/12/22	73	18,016–18,086
353.	Notice of Entry of Order Denying Defendants' Renewed Motion for Judgment as a Matter of Law	10/12/22	73	18,087–18,114
354.	Notice of Entry of Order Unsealing Trial Transcripts and Restoring Public Access to	10/12/22	73	18,115–18,125

Tab	Document	Date	Vol.	Pages
	Docket			
355.	Notice of Appeal	10/12/22	73 74	18,126–18,250 18,251–18,467
356.	Case Appeal Statement	10/12/22	74 75	18,468–18,500 18,501–18,598
357.	Notice of Entry of Order Denying "Motion to Redact Portions of Trial Transcript"	10/13/22	75	18,599–18,608
358.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits	10/18/22	75 76	18,609–18,750 18,751–18,755
359.	Recorder's Transcript of Hearing Status Check	10/20/22	76	18,756–18,758
360.	Notice of Entry of Stipulation and Order Regarding Expiration of Temporary Stay for Sealed Redacted Transcripts	10/25/22	76	18,759–18,769
361.	Notice of Filing of Writ Petition	11/17/22	76	18,770–18855
362.	Trial Exhibit D5502		76 77	18,856–19,000 19,001–19,143
491.	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	145 146	35,813–36,062 36,063–36,085
492.	Transcript Re: Proposed Jury Instructions	11/21/21	146	36,086–36,250

Filed Under Seal

Tab	Document	Date	Vol.	Pages
363.	Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	09/28/20	78	19,144–19,156

364.	Plaintiffs' Reply in Support of Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	04/01/21	78	19,157–19,176
365.	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	04/01/21	78	19,177–19,388
366.	Plaintiffs' Response to Defendants Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	04/19/21	78 79	19,389–19,393 19,394–19,532
367.	Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time	05/05/21	79	19,533–19,581
368.	Appendix to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time	05/21/21	79 80 81	19,582–19,643 19,644–19,893 19,894–20,065
369.	Plaintiffs' Opposition to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 and #3 on Order Shortening Time	06/01/21	81 82	20,066–20,143 20,144–20,151
370.	Defendants' Objection to the Special Master's Report and Recommendation No. 5 Regarding Defendants' Motion for Protective Order Regarding Confidentiality	06/01/21	82	20,152–20,211

	Designations (Filed April 15, 2021)			
371.	Plaintiffs' Response to Defendants' Objection to Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions	06/16/21	82	20,212–20,265
372.	United's Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time	06/24/21	82	20,266–20,290
373.	Appendix to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time	06/24/21	82 83 84	20,291–20,393 20,394–20,643 20,644–20,698
374.	Plaintiffs' Opposition to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time	07/06/21	84	20,699–20,742
375.	Defendants' Motion for Leave to File Defendants' Objection to the Special Master's Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Under Seal	07/15/21	84	20,743–20,750
376.	Plaintiffs' Response to Defendants' Objection to Special Master Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Questions	07/22/21	84	20,751–20,863
377.	Objection to R&R #11 Regarding United's Motion to Compel Documents About Which Plaintiffs' Witnesses Testified	08/25/21	84 85	20,864–20,893 20,894–20,898

378.	Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	09/21/21	85	20,899–20,916
379.	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	09/21/21	85	20,917–21,076
380.	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges	09/21/21	85	21,077–21,089
381.	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges	09/21/21	85 86	21,090–21,143 21,144–21,259
382.	Motion in Limine No. 3 to Allow References to Plaintiffs' Decision Making Process Regarding Settling Billing Charges	09/21/21	86	21,260–21,313
383.	Defendants' Motion in Limine No. 5 Regarding Arguments or Evidence that Amounts TeamHealth Plaintiffs billed for Serves are Reasonable [an Alternative to Motion in Limine No. 6]	09/21/21	86	21,314–21,343
384.	Defendants' Motion in Limine No. 6 Regarding Argument or Evidence That Amounts Teamhealth Plaintiffs Billed for Services are Reasonable	09/21/21	86	21,344–21,368
385.	Appendix to Defendants' Motion in Limine No. 13 (Volume 1 of 6)	09/21/21	86 87	21,369–21,393 21,394–21,484

386.	Appendix to Defendants' Motion in Limine No. 13 (Volume 2 of 6)	09/21/21	87	21,485–21,614
387.	Appendix to Defendants' Motion in Limine No. 13 (Volume 3 of 6)	09/21/21	87 88	21,615–21,643 21,644–21,744
388.	Appendix to Defendants' Motion in Limine No. 13 (Volume 4 of 6)	09/21/21	88	21,745–21,874
389.	Appendix to Defendants' Motion in Limine No. 13 (Volume 5 of 6)	09/21/21	88 89	21,875–21,893 21,894–22,004
390.	Appendix to Defendants' Motion in Limine No. 13 (Volume 6 of 6)	09/21/21	89	22,005–22,035
391.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 1 of 8	09/21/21	89 90	22,036–22,143 22,144–22,176
392.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 2 of 8	09/21/21	90	22,177–22,309
393.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 3 of 8	09/22/21	90 91	22,310–22,393 22,394–22,442
394.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 4 of 8	09/22/21	91	22,443–22,575
395.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 5 of 8	09/22/21	91	22,576–22,609
396.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 6 of 8	09/22/21	91 92 93	22,610–22,643 22,644–22,893 22,894–23,037
397.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7a of 8	09/22/21	93 94	23,038–23,143 23,144–23,174
398.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7b of 8	09/22/21	94	23,175–23,260
399.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8a of 8	09/22/21	94 95	23,261–23,393 23,394–23,535
400.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8b of 8	09/22/21	95 96	23,536–23,643 23,634–23,801
401.	Defendants' Motion in Limine No. 11 Paired	09/22/21	96	23,802–23,823

	with Motion in Limine No. 12 to Authorize Defendants to Discuss Plaintiffs' Conduct and deliberations in Negotiating Reimbursement			
402.	Errata to Defendants' Motion in Limine No. 11	09/22/21	96	23,824–23,859
403.	Defendants' Motion in Limine No. 12 Paired with Motion in Limine No. 11 to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement	09/22/21	96	23,860–23,879
404.	Errata to Defendants' Motion in Limine No. 12	09/22/21	96 97	23,880–23,893 23,894–23,897
405.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 1)	09/22/21	97	23,898–24,080
406.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 2)	09/22/21	97 98	24,081–24,143 24,144–24,310
407.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 3)	09/22/21	98 99 100	24,311–24,393 24,394–24,643 24,644–24,673
408.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 4)	09/22/21	100 101 102	24,674–24,893 24,894–25,143 25,144–25,204
409.	Appendix to Defendants' Motion in Limine No. 14 – Volume 1 of 6	09/22/21	102	25,205–25,226
410.	Appendix to Defendants' Motion in Limine No. 14 – Volume 2 of 6	09/22/21	102	25,227–25,364
411.	Appendix to Defendants' Motion in Limine No. 14 – Volume 3 of 6	09/22/21	102 103	25,365–25,393 25,394–25,494
412.	Appendix to Defendants' Motion in Limine No. 14 – Volume 4 of 6	09/22/21	103	25,495–25,624
413.	Appendix to Defendants' Motion in Limine	09/22/21	103	25,625–25,643

	No. 14 – Volume 5 of 6		104	25,644–25,754
414.	Appendix to Defendants' Motion in Limine No. 14 – Volume 6 of 6	09/22/21	104	25,755–25,785
415.	Plaintiffs' Combined Opposition to Defendants Motions in Limine 1, 7, 9, 11 & 13	09/29/21	104	25,786–25,850
416.	Plaintiffs' Combined Opposition to Defendants' Motions in Limine No. 2, 8, 10, 12 & 14	09/29/21	104	25,851–25,868
417.	Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders	09/29/21	104 105	25,869–25,893 25,894–25,901
418.	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 1	09/29/21	105 106	25,902–26,143 26,144–26,216
419.	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 2	09/29/21	106 107	26,217–26,393 26,394–26,497
420.	Plaintiffs' Opposition to Defendants' Motion for Partial Summary Judgment	10/05/21	107	26,498–26,605
421.	Defendants' Reply in Support of Motion for Partial Summary Judgment	10/11/21	107 108	26,606–26,643 26,644–26,663
422.	Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/17/21	108	26,664–26,673
423.	Appendix of Exhibits in Support of Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for	10/17/21	108 109	26,674–26,893 26,894–26,930

	Partial Summary Judgment			
424.	Response to Sur-Reply Arguments in Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/21/21	109	26,931–26,952
425.	Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties	10/31/21	109	26,953–26,964
426.	Plaintiffs' Response to Defendants' Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties	11/08/21	109	26,965–26,997
427.	Excerpts of Recorder's Transcript of Jury Trial – Day 9	11/09/21	109	26,998–27003
428.	Preliminary Motion to Seal Attorneys' Eyes Documents Used at Trial	11/11/21	109	27,004–27,055
429.	Appendix of Selected Exhibits to Trial Briefs	11/16/21	109	27,056–27,092
430.	Excerpts of Recorder's Transcript of Jury Trial – Day 13	11/16/21	109	27,093–27,099
431.	Defendants' Omnibus Offer of Proof	11/22/21	109 110	27,100–27,143 27,144–27,287
432.	Motion to Seal Certain Confidential Trial Exhibits	12/05/21	110	27,288–27,382
433.	Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits	12/08/21	110 111	27,383–27,393 27,394–27,400
434.	Motion to Seal Certain Confidential Trial Exhibits	12/13/21	111	27,401–27,495
435.	Defendant's Omnibus Offer of Proof for Second Phase of Trial	12/14/21	111	27,496–27,505

436.	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 1	12/14/21	111 112	27,506–27,643 27,644–27,767
437.	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 2	12/14/21	112 113	27,768–27,893 27,894–27,981
438.	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 3	12/14/21	113 114	27,982–28,143 28,144–28,188
439.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 1 of 18	12/24/21	114	28,189–28,290
440.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 2 of 18	12/24/21	114 115	28,291–28,393 28,394–28,484
441.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18	12/24/21	115 116	28,485–28,643 28,644–28,742
442.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18	12/24/21	116 117	28,743–28,893 28,894–28,938
443.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18	12/24/21	117	28,939–29,084
444.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18	12/24/21	117 118	29,085–29,143 29,144–29,219
445.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 7 of 18	12/24/21	118	29,220–29,384
446.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 8 of 18	12/24/21	118 119	29,385–29,393 29,394–29,527

447.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18	12/24/21	119 120	29,528–29,643 29,644–29,727
448.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 10 of 18	12/24/21	120 121	29,728–29,893 29,894–29,907
449.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 11 of 18	12/24/21	121	29,908–30,051
450.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18	12/24/21	121 122	30,052–30,143 30,144–30,297
451.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18	12/24/21	122 123	30,298–30,393 30,394–30,516
452.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18	12/24/21	123 124	30,517–30,643 30,644–30,677
453.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18	12/24/21	124	30,678–30,835
454.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18	12/24/21	124 125	30,836–30,893 30,894–30,952
455.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18	12/24/21	125	30,953–31,122
456.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18	12/24/21	125 126	30,123–31,143 31,144–31,258
457.	Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits	01/05/22	126	31,259–31,308
458.	Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial	01/05/22	126	31,309–31,393

	Exhibits		127	31,394–31,500
459.	Transcript of Proceedings Re: Motions	01/12/22	127	31,501–31,596
460.	Transcript of Proceedings Re: Motions	01/20/22	127 128	31,597–31,643 31,644–31,650
461.	Transcript of Proceedings Re: Motions	01/27/22	128	31,651–31,661
462.	Defendants' Index of Trial Exhibit Redactions in Dispute	02/10/22	128	31,662–31,672
463.	Transcript of Proceedings Re: Motions Hearing	02/10/22	128	31,673–31,793
464.	Transcript of Proceedings Re: Motions Hearing	02/16/22	128	31,794–31,887
465.	Joint Status Report and Table Identifying the Redactions to Trial Exhibits That Remain in Dispute	03/04/22	128 129	31,888–31,893 31,894–31,922
466.	Transcript of Proceedings re Hearing Regarding Unsealing Record	10/05/22	129	31,923–31,943
467.	Transcript of Proceedings re Status Check	10/06/22	129	31,944–31,953
468.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 1)	10/07/22	129 130	31,954–32,143 32,144–32,207
469.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 2)	10/07/22	130 131	32,208–32,393 32,394–32,476
470.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 3)	10/07/22	131 132	32,477–32,643 32,644–32,751
471.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume	10/07/22	132 133	32,752–32,893 32,894–33,016

	4)			
472.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 5)	10/07/22	133 134	33,017–33,143 33,144–33,301
473.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 6)	10/07/22	134 135	33,302–33,393 33,394–33,529
474.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 7)	10/07/22	135 136	33,530–33,643 33,644–33,840
475.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 8)	10/07/22	136 137	33,841–33,893 33,894–34,109
476.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 9)	10/07/22	137 138	34,110–34,143 34,144–34,377
477.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 10)	10/07/22	138 139 140	34,378–34,393 34,394–34,643 34,644–34,668
478.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 11)	10/07/22	140 141	34,669–34,893 34,894–34,907
479.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 12)	10/07/22	141 142	34,908–35,143 35,144–35,162
480.	Appendix B to Order Granting in Part and	10/07/22	142	35,163–35,242

	Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 13)			
481.	Exhibits P473_NEW, 4002, 4003, 4005, 4006, 4166, 4168, 4455, 4457, 4774, and 5322 to "Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits" (Tabs 98, 106, 107, 108, 109, 111, 112, 113, 114, 118, and 119)	10/07/22	142	35,243–35,247
482.	Transcript of Status Check	10/10/22	142	35,248–35,258
483.	Recorder's Transcript of Hearing re Hearing	10/13/22	142	35,259–35,263
484.	Trial Exhibit D5499		142 143	35,264–35,393 35,394–35,445
485.	Trial Exhibit D5506		143	35,446
486.	Appendix of Exhibits in Support of Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	09/28/20	143	35,447–35,634
487.	Defendants' Motion to Supplement Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time	05/24/21	143 144	35,635–35,643 35,644–35,648
488.	Motion in Limine No. 3 to Allow References to Plaintiffs; Decision Making Processes Regarding Setting Billed Charges	09/21/21	144	35,649–35,702
489.	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: to Exclude Evidence Subject to the Court's Discovery Orders (Exhibit 43)	09/29/21	144	35,703–35,713
490.	Notice of Filing of Expert Report of Bruce Deal, Revised on November 14, 2021	04/18/23	144	35,714–35,812

ALPHABETICAL TABLE OF CONTENTS TO APPENDIX

Tab	Document	Date	Vol.	Pages
468	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 1) (Filed Under Seal)	10/07/22	129 130	31,954–32,143 32,144–32,207
469	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 2) (Filed Under Seal)	10/07/22	130 131	32,208–32,393 32,394–32,476
470	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 3) (Filed Under Seal)	10/07/22	131 132	32,477–32,643 32,644–32,751
471	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 4) (Filed Under Seal)	10/07/22	132 133	32,752–32,893 32,894–33,016
472	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 5) (Filed Under Seal)	10/07/22	133 134	33,017–33,143 33,144–33,301
473	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 6) (Filed Under Seal)	10/07/22	134 135	33,302–33,393 33,394–33,529
474	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 7) (Filed Under Seal)	10/07/22	135 136	33,530–33,643 33,644–33,840
475	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 8) (Filed Under Seal)	10/07/22	136 137	33,841–33,893 33,894–34,109
476	Appendix B to Order Granting in Part and	10/07/22	137	34,110–34,143

Tab	Document	Date	Vol.	Pages
	Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 9) (Filed Under Seal)		138	34,144–34,377
477	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 10) (Filed Under Seal)	10/07/22	138 139 140	34,378–34,393 34,394–34,643 34,644–34,668
478	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 11) (Filed Under Seal)	10/07/22	140 141	34,669–34,893 34,894–34,907
479	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 12) (Filed Under Seal)	10/07/22	141 142	34,908–35,143 35,144–35,162
480	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 13) (Filed Under Seal)	10/07/22	142	35,163–35,242
321	Appendix in Support of Opposition to Defendants' Motion to Retax Costs	04/13/22	68 69	16,865–17,000 17,001–17,035
280	Appendix in Support of Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment	01/20/22	52	12,791–12,968
306	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 1	03/30/22	62 63	15,398–15,500 15,501–15,619
307	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 2	03/30/22	63 64	15,620–15,750 15,751–15,821
308	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees	03/30/22	64 65	15,822–16,000 16,001–16,053

Tab	Document	Date	Vol.	Pages
	Volume 3			
309	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 4	03/30/22	65	16,054–16,232
310	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 5	03/30/22	65 66	16,233–16,250 16,251–16,361
295	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 1	03/14/22	53 54	13,209–13,250 13.251–13,464
296	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 2	03/14/22	54 55	13,465–13,500 13,501–13,719
297	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 3	03/14/22	55 56	13,720–13,750 13,751–13,976
298	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 4	03/14/22	56 57	13,977–14,000 14,001–14,186
299	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 5	03/14/22	57 58	14,187–14,250 14,251–14,421
300	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 6	03/14/22	58 59	14,422–14,500 14,501–14,673
301	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 7	03/14/22	59 60	14,674–14,750 14,751–14,920
302	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 8	03/14/22	60 61	14,921–15,000 15,001–15,174
303	Appendix of Exhibits in Support of Health	03/14/22	61	15,175–15,250

Tab	Document	Date	Vol.	Pages
	Care Providers' Verified Memorandum of Cost Volume 9		62	15,251–15,373
486	Appendix of Exhibits in Support of Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time (Filed Under Seal)	09/28/20	143	35,447–35,634
423	Appendix of Exhibits in Support of Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/17/21	108 109	26,674–26,893 26,894–26,930
379	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal)	09/21/21	85	20,917–21,076
381	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges (Filed Under Seal)	09/21/21	85 86	21,090–21,143 21,144–21,259
26	Appendix of Exhibits in Support of Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	784–908
491	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	145 146	35,813–36,062 36,063–36,085
365	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to	04/01/21	78	19,177–19,388

Tab	Document	Date	Vol.	Pages
	Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions (Filed Under Seal)			
272	Appendix of Exhibits to Defendants' Motion to Apply the Statutory Cap on Punitive Damage	12/30/21	50 51	12,364–12,500 12,501–12,706
436	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 1 (Filed Under Seal)	12/14/21	111 112	27,506–27,643 27,644–27,767
437	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 2 (Filed Under Seal)	12/14/21	112 113	27,768–27,893 27,894–27,981
438	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 3 (Filed Under Seal)	12/14/21	113 114	27,982–28,143 28,144–28,188
429	Appendix of Selected Exhibits to Trial Briefs (Filed Under Seal)	11/16/21	109	27,056–27,092
405	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 1) (Filed Under Seal)	09/22/21	97	23,898–24,080
406	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 2) (Filed Under Seal)	09/22/21	97 98	24,081–24,143 24,144–24,310
407	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 3) (Filed Under Seal)	09/22/21	98 99 100	24,311–24,393 24,394–24,643 24,644–24,673
408	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 4) (Filed Under Seal)	09/22/21	100 101 102	24,674–24,893 24,894–25,143 25,144–25,204
391	Appendix to Defendants' Motion for Partial Summary Judgment Volume 1 of 8 (Filed Under Seal)	09/21/21	89 90	22,036–22,143 22,144–22,176

Tab	Document	Date	Vol.	Pages
392	Appendix to Defendants' Motion for Partial Summary Judgment Volume 2 of 8 (Filed Under Seal)	09/21/21	90	22,177–22,309
393	Appendix to Defendants' Motion for Partial Summary Judgment Volume 3 of 8 (Filed Under Seal)	09/22/21	90 91	22,310–22,393 22,394–22,442
394	Appendix to Defendants' Motion for Partial Summary Judgment Volume 4 of 8 (Filed Under Seal)	09/22/21	91	22,443–22,575
395	Appendix to Defendants' Motion for Partial Summary Judgment Volume 5 of 8 (Filed Under Seal)	09/22/21	91	22,576–22,609
396	Appendix to Defendants' Motion for Partial Summary Judgment Volume 6 of 8 (Filed Under Seal)	09/22/21	91 92 93	22,610–22,643 22,644–22,893 22,894–23,037
397	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7a of 8 (Filed Under Seal)	09/22/21	93 94	23,038–23,143 23,144–23,174
398	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7b of 8 (Filed Under Seal)	09/22/21	94	23,175–23,260
399	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8a of 8 (Filed Under Seal)	09/22/21	94 95	23,261–23,393 23,394–23,535
400	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8b of 8 (Filed Under Seal)	09/22/21	95 96	23,536–23,643 23,634–23,801
385	Appendix to Defendants' Motion in Limine No. 13 (Volume 1 of 6) (Filed Under Seal)	09/21/21	86 87	21,369–21,393 21,394–21,484
386	Appendix to Defendants' Motion in Limine No. 13 (Volume 2 of 6) (Filed Under Seal)	09/21/21	87	21,485–21,614
387	Appendix to Defendants' Motion in Limine	09/21/21	87	21,615–21,643

Tab	Document	Date	Vol.	Pages
	No. 13 (Volume 3 of 6) (Filed Under Seal)		88	21,644–21,744
388	Appendix to Defendants' Motion in Limine No. 13 (Volume 4 of 6) (Filed Under Seal)	09/21/21	88	21,745–21,874
389	Appendix to Defendants' Motion in Limine No. 13 (Volume 5 of 6) (Filed Under Seal)	09/21/21	88 89	21,875–21,893 21,894–22,004
390	Appendix to Defendants' Motion in Limine No. 13 (Volume 6 of 6) (Filed Under Seal)	09/21/21	89	22,005–22,035
409	Appendix to Defendants' Motion in Limine No. 14 – Volume 1 of 6 (Filed Under Seal)	09/22/21	102	25,205–25,226
410	Appendix to Defendants' Motion in Limine No. 14 – Volume 2 of 6 (Filed Under Seal)	09/22/21	102	25,227–25,364
411	Appendix to Defendants' Motion in Limine No. 14 – Volume 3 of 6 (Filed Under Seal)	09/22/21	102 103	25,365–25,393 25,394–25,494
412	Appendix to Defendants' Motion in Limine No. 14 – Volume 4 of 6 (Filed Under Seal)	09/22/21	103	25,495–25,624
413	Appendix to Defendants' Motion in Limine No. 14 – Volume 5 of 6 (Filed Under Seal)	09/22/21	103 104	25,625–25,643 25,644–25,754
414	Appendix to Defendants' Motion in Limine No. 14 – Volume 6 of 6 (Filed Under Seal)	09/22/21	104	25,755–25,785
373	Appendix to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal)	06/24/21	82 83 84	20,291–20,393 20,394–20,643 20,644–20,698
70	Appendix to Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/08/21	12 13 14	2875–3000 3001–3250 3251–3397
368	Appendix to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time (Filed	05/21/21	79 80 81	19,582–19,643 19,644–19,893 19,894–20,065

Tab	Document	Date	Vol.	Pages
	Under Seal)			
418	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 1 (Filed Under Seal)	09/29/21	105 106	25,902–26,143 26,144–26,216
419	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 2 (Filed Under Seal)	09/29/21	106 107	26,217–26,393 26,394–26,497
489	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: to Exclude Evidence Subject to the Court's Discovery Orders (Exhibit 43) (Filed Under Seal)	09/29/21	144	35,703–35,713
75	Appendix to Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14 15	3466–3500 3501–3658
316	Case Appeal Statement	04/06/22	67 68	16,695–16,750 16,751–16,825
356	Case Appeal Statement	10/12/22	74 75	18,468–18,500 18,501–18,598
16	Civil Order to Statistically Close Case	12/10/19	2	309
1	Complaint (Business Court)	04/15/19	1	1–17
284	Defendant' Reply in Support of Their Motion to Apply the Statutory Cap on Punitive Damages	02/10/22	53	13,005–13,028
435	Defendant's Omnibus Offer of Proof for Second Phase of Trial (Filed Under Seal)	12/14/21	111	27,496–27,505

Tab	Document	Date	Vol.	Pages
	Trial Under Seal			
130	Defendants' Motion for Partial Summary Judgment	09/21/21	20	4770–4804
312	Defendants' Motion for Remittitur and to Alter or Amend the Judgment	04/06/22	66	16,382–16,399
131	Defendants' Motion in Limine No. 1: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with other Market Players and Related Negotiations	09/21/21	20	4805–4829
134	Defendants' Motion in Limine No. 10 to Exclude Reference of Defendants' Corporate Structure (Alternative Moton to be Considered Only if court Denies Defendants' Counterpart Motion in Limine No. 9)	09/21/21	20	4869–4885
401	Defendants' Motion in Limine No. 11 Paired with Motion in Limine No. 12 to Authorize Defendants to Discuss Plaintiffs' Conduct and deliberations in Negotiating Reimbursement (Filed Under Seal)	09/22/21	96	23,802–23,823
403	Defendants' Motion in Limine No. 12 Paired with Motion in Limine No. 11 to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement (Filed Under Seal)	09/22/21	96	23,860–23,879
135	Defendants' Motion in Limine No. 13: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	09/21/21	20	4886–4918
136	Defendants' Motion in Limine No. 14: Motion Offered in the Alternative to MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to Settlement Agreement	09/21/21	20	4919–4940

Tab	Document	Date	Vol.	Pages
	Between CollectRX and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs			
132	Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations	09/21/21	20	4830–4852
137	Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/21/21	20	4941–4972
383	Defendants' Motion in Limine No. 5 Regarding Arguments or Evidence that Amounts TeamHealth Plaintiffs billed for Serves are Reasonable [an Alternative to Motion in Limine No. 6] (Filed Under Seal)	09/21/21	86	21,314–21,343
384	Defendants' Motion in Limine No. 6 Regarding Argument or Evidence That Amounts Teamhealth Plaintiffs Billed for Services are Reasonable (Filed Under Seal)	09/21/21	86	21,344–21,368
138	Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	09/22/21	20 21	4973–5000 5001–5030
139	Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided	09/22/21	21	5031–5054
140	Defendants' Motion in Limine No. 9 to Authorize Defendants to Offer Evidence of	09/22/21	21	5055–5080

Tab	Document	Date	Vol.	Pages
339	Defendants' Objection to Plaintiffs' Proposed Order Approving Plaintiffs' Motion for Attorneys' Fees	07/26/22	71	17,700–17,706
273	Defendants' Objection to Plaintiffs' Proposed Order Denying Defendants' Motion for Judgment as a Matter of Law	01/04/22	51	12,707–12,717
94	Defendants' Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	04/12/21	17	4059–4079
98	Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time	04/28/21	17	4109–4123
370	Defendants' Objection to the Special Master's Report and Recommendation No. 5 Regarding Defendants' Motion for Protective Order Regarding Confidentiality Designations (Filed April 15, 2021) (Filed Under Seal)	06/01/21	82	20,152–20,211
61	Defendants' Objections to Plaintiffs to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/26/20	11	2573–2670
151	Defendants' Objections to Plaintiffs' NRCP 16.1(a)(3) Pretrial Disclosures	10/08/21	22	5288–5294
64	Defendants' Objections to Plaintiffs' Order Denying Defendants' Motion to Compel	11/02/20	11	2696–2744

Tab	Document	Date	Vol.	Pages
	Motion for Entry of Judgment		53	13,001–13,004
322	Defendants' Opposition to Plaintiffs' Motion for Attorneys' Fees	04/20/22	69	17,036–17,101
155	Defendants' Opposition to Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/18/21	22	5323–5333
141	Defendants' Opposition to Plaintiffs' Motion in Limine No. 1: to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges	09/29/21	21	5081–5103
417	Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal)	09/29/21	104 105	25,869–25,893 25,894–25,901
50	Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, Or, in The Alternative, Motion in Limine on Order Shortening Time	09/04/20	8	1846–1932
56	Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents, and Answers to Interrogatories on Order Shortening Time	10/06/20	10	2293–2336
251	Defendants' Opposition to Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,609–11,631
89	Defendants' Opposition to Plaintiffs' Renewed Motion for Order to Show Cause	03/22/21	16	3916–3966

Tab	Document	Date	Vol.	Pages
	Why Defendants Should Not be Held in Contempt and for Sanctions			
220	Defendants' Proposed Jury Instructions (Contested)	11/15/21	38	9427–9470
259	Defendants' Proposed Second Phase Jury Instructions	12/05/21	49	12,049–12,063
263	Defendants' Proposed Second Phase Jury Instructions-Supplement	12/07/21	49	12,136–12,142
313	Defendants' Renewed Motion for Judgment as a Matter of Law	04/06/22	66	16,400–16,448
421	Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/11/21	107 108	26,606–26,643 26,644–26,663
74	Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14	3449–3465
28	Defendants' Reply in Support of Motion to Dismiss	05/07/20	4	919–948
36	Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint	06/03/20	6	1310–1339
325	Defendants' Reply in Support of Motion to Retax Costs	05/04/22	69	17,122–17,150
457	Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	01/05/22	126	31,259–31,308
37	Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motions to Dismiss Plaintiff's First Amended Complaint	06/03/20	6	1340–1349
334	Defendants' Response to Improper Supplement Entitled "Notice of	06/28/22	71	17,579–17,593

Tab	Document	Date	Vol.	Pages
	Supplemental Attorney Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees"			
286	Defendants' Response to Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time	02/15/22	53	13,047–13,053
225	Defendants' Response to TeamHealth Plaintiffs' Trial Brief Regarding Defendants' Prompt Pay Act Jury Instruction Re: Failure to Exhaust Administrative Remedies	11/16/21	40	9799–9806
12	Defendants' Statement of Removal	05/30/19	1	123–126
33	Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	05/26/20	5	1173–1187
247	Defendants' Supplemental Proposed Jury Instruction	11/21/21	46	11,262–11,266
240	Defendants' Supplemental Proposed Jury Instructions (Contested)	11/19/21	44	10,947–10,952
48	Errata	08/04/20	7	1684
241	Errata	11/19/21	44	10,953
402	Errata to Defendants' Motion in Limine No. 11 (Filed Under Seal)	09/22/21	96	23,824–23,859
404	Errata to Defendants' Motion in Limine No. 12 (Filed Under Seal)	09/22/21	96 97	23,880–23,893 23,894–23,897
54	Errata to Plaintiffs' Motion to Compel Defendants' List of Witnesses Production of Documents and Answers to Interrogatories	09/28/20	9	2196–2223
85	Errata to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for	03/12/21	16	3884–3886

Tab	Document	Date	Vol.	Pages
	Sanctions			
238	Errata to Source on Defense Contested Jury Instructions	11/18/21	43	10,618–10,623
430	Excerpts of Recorder's Transcript of Jury Trial – Day 13 (Filed Under Seal)	11/16/21	109	27,093–27,099
427	Excerpts of Recorder's Transcript of Jury Trial – Day 9 (Filed Under Seal)	11/09/21	109	26,998–27003
481	Exhibits P473_NEW, 4002, 4003, 4005, 4006, 4166, 4168, 4455, 4457, 4774, and 5322 to "Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits" (Tabs 98, 106, 107, 108, 109, 111, 112, 113, 114, 118, and 119) (Filed Under Seal)	10/07/22	142	35,243–35,247
30	First Amended Complaint	05/15/20	4 5	973–1000 1001–1021
13	Freemont Emergency Services (MANDAVIA), Ltd's Response to Statement of Removal	05/31/19	1	127–138
226	General Defense Verdict	11/16/21	40	9807–9809
305	Health Care Providers' Motion for Attorneys' Fees	03/30/22	62	15,389–15,397
326	Health Care Providers' Reply in Support of Motion for Attorneys' Fees	05/04/22	69	17,151–17,164
294	Health Care Providers' Verified Memorandum of Cost	03/14/22	53	13,198–13,208
44	Joint Case Conference Report	07/17/20	7	1606–1627
164	Joint Pretrial Memorandum Pursuant to EDRC 2.67	10/27/21	26 27	6486–6500 6501–6567
465	Joint Status Report and Table Identifying	03/04/22	128	31,888–31,893

Tab	Document	Date	Vol.	Pages
	the Redactions to Trial Exhibits That Remain in Dispute (Filed Under Seal)		129	31,894–31,922
221	Jointly Submitted Jury Instructions	11/15/21	38	9471–9495
255	Jury Instructions	11/29/21	48	11,957–11,999
264	Jury Instructions Phase Two	12/07/21	49	12,143–12,149
347	Limited Objection to "Order Unsealing Trial Transcripts and Restoring Public Access to Docket"	10/06/22	72	17,973–17,978
156	Media Request and Order Allowing Camera Access to Court Proceedings (Legal Newsline)	10/18/21	22	5334–5338
167	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 28	6992–6997
168	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 29	6998–7000 7001–7003
314	Motion for New Trial	04/06/22	66 67	16,449–16,500 16,501–16,677
119	Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Violating Protective Order	08/10/21	18	4465–4486
79	Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	02/18/21	15 16	3714–3750 3751–3756
488	Motion in Limine No. 3 to Allow References to Plaintiffs; Decision Making Processes Regarding Setting Billed Charges (Filed Under Seal)	09/21/21	144	35,649–35,702

Tab	Document	Date	Vol.	Pages
382	Motion in Limine No. 3 to Allow References to Plaintiffs' Decision Making Process Regarding Settling Billing Charges (Filed Under Seal)	09/21/21	86	21,260–21,313
133	Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Process and Reasonableness of billed Charges if Motion in Limine No. 3 is Denied	09/21/21	20	4853–4868
11	Motion to Remand	05/24/19	1	101–122
432	Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	12/05/21	110	27,288–27,382
434	Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	12/13/21	111	27,401–27,495
267	Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,294–12,302
275	Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51	12,739–12,747
276	Motion to Seal Defendants' Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51 52	12,748–12,750 12,751–12,756
268	Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,303–12,311
315	Notice of Appeal	04/06/22	67	16,678–16,694
355	Notice of Appeal	10/12/22	73 74	18,126–18,250 18,251–18,467
292	Notice of Entry of Judgment	03/09/22	53	13,168–13,178
115	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2	08/09/21	18	4403–4413

Tab	Document	Date	Vol.	Pages
	Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection			
116	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time and Overruling Objection	08/09/21	18	4414–4424
127	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions and Overruling Objection	09/16/21	19	4709–4726
128	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Request for Production of Documents and Overruling Objection	09/16/21	19	4727–4747
129	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed No to Answer and Overruling Objection	09/16/21	19 20	4748–4750 4751–4769
200	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified	11/03/21	32	7853–7874

Tab	Document	Date	Vol.	Pages
340	Notice of Entry of Order Approving Plaintiffs' Motion for Attorney's Fees	08/02/22	71	17,707–17,725
351	Notice of Entry of Order Approving Supplemental Attorney's Fee Award	10/12/22	73	18,005–18,015
357	Notice of Entry of Order Denying "Motion to Redact Portions of Trial Transcript"	10/13/22	75	18,599–18,608
40	Notice of Entry of 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	06/24/20	6 7	1472–1500 1501–1516
274	Notice of Entry of Order Denying Defendants' Motion for Judgement as a Matter of Law	01/06/22	51	12,718–12,738
352	Notice of Entry of Order Denying Defendants' Motion for New Trial	10/12/22	73	18,016–18,086
154	Notice of Entry of Order Denying Defendants' Motion for Order to Show Cause Why Plaintiffs Should not be Held in Contempt for Violating Protective Order	10/14/21	22	5309–5322
161	Notice of Entry of Order Denying Defendants' Motion for Partial Summary Judgment	10/25/21	25	6116–6126
338	Notice of Entry of Order Denying Defendants' Motion for Remittitur and to Alter or Amend the Judgment	07/19/22	71	17,689–17,699
171	Notice of Entry of Order Denying Defendants' Motion in Limine No. 1 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with Other Market Players and Related Negotiations	11/01/21	29	7040–7051

Tab	Document	Date	Vol.	Pages
172	Notice of Entry of Order Denying Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations	11/01/21	29	7052–7063
173	Notice of Entry of Order Denying Defendants' Motion in Limine No. 3 to Allow Reference to Plaintiffs' Decision Making Processes Regarding Setting Billed Charges	11/01/21	29	7064–7075
174	Notice of Entry of Order Denying Defendants' Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Processes and Reasonableness of Billed Charges if Motion in Limine No. 3 is Denied	11/01/21	29	7076–7087
175	Notice of Entry of Order Denying Defendants' Motion in Limine No. 12, Paired with Motion in Limine No. 11, to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement	11/01/21	29	7088–7099
176	Notice of Entry of Order Denying Defendants' Motion in Limine No. 5 Regarding Argument or Evidence that Amounts TeamHealth Plaintiffs Billed for Services are Reasonable [An Alternative Motion to Motion in Limine No. 6]	11/01/21	29	7100–7111
177	Notice of Entry of Order Denying Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	11/01/21	29	7112–7123
178	Notice of Entry of Order Denying	11/01/21	29	7124–7135

Tab	Document	Date	Vol.	Pages
	Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided			
179	Notice of Entry of Order Denying Defendants' Motion in Limine No. 10 to Exclude Evidence of Defendants' Corporate Structure (Alternative Motion to be Considered Only if Court Denies Defendants' Counterpart Motion in Limine No. 9)	11/01/21	29	7136–7147
180	Notice of Entry of Order Denying Defendants' Motion in Limine No. 11, Paired with Motion in Limine No. 12, to Authorize Defendants to Discuss Plaintiffs' Conduct and Deliberations in Negotiating Reimbursement	11/01/21	29	7148–7159
181	Notice of Entry of Order Denying Defendants' Motion in Limine No. 13 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	11/01/21	29	7160–7171
182	Notice of Entry of Order Denying Defendants' Motion in Limine No. 14: Motion Offered in the Alternative MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to a Settlement Agreement Between CollectRx and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs	11/01/21	29	7172–7183
183	Notice of Entry of Order Denying	11/01/21	29	7184–7195

Tab	Document	Date	Vol.	Pages
	Defendants' Motion in Limine No. 15 to Preclude Reference and Testimony Regarding the TeamHealth Plaintiffs Policy not to Balance Bill			
184	Notice of Entry of Order Denying Defendants' Motion in Limine No. 18 to Preclude Testimony of Plaintiffs' Non-Retained Expert Joseph Crane, M.D.	11/01/21	29	7196–7207
185	Notice of Entry of Order Denying Defendants' Motion in Limine No. 20 to Exclude Defendants' Lobbying Efforts	11/01/21	29	7208–7219
186	Notice of Entry of Order Denying Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	11/01/21	29	7220–7231
187	Notice of Entry of Order Denying Defendants' Motion in Limine No. 27 to Preclude Evidence of Complaints Regarding Defendants' Out-Of-Network Rates or Payments	11/01/21	29	7232–7243
188	Notice of Entry of Order Denying Defendants' Motion in Limine No. 29 to Preclude Evidence Only Relating to Defendants' Evaluation and Development of a Company that Would Offer a Service Similar to Multiplan and Data iSight	11/01/21	29 30	7244–7250 7251–7255
189	Notice of Entry of Order Denying Defendants' Motion in Limine No. 32 to Exclude Evidence or Argument Relating to Materials, Events, or Conduct that Occurred on or After January 1, 2020	11/01/21	30	7256–7267
191	Notice of Entry of Order Denying Defendants' Motion in Limine No. 38 to Exclude Evidence or Argument Relating to	11/01/21	30	7280–7291

Tab	Document	Date	Vol.	Pages
	Defendants' use of MultiPlan and the Data iSight Service, Including Any Alleged Conspiracy or Fraud Relating to the use of Those Services			
190	Notice of Entry of Order Denying Defendants' Motion in Limine to Preclude Certain Expert Testimony and Fact Witness Testimony by Plaintiffs' Non-Retained Expert Robert Frantz, M.D.	11/01/21	30	7268–7279
293	Notice of Entry of Order Denying Defendants' Motion to Apply Statutory Cap on Punitive Damages	03/09/22	53	13,179–13,197
62	Notice of Entry of Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on Order Shortening Time	10/27/20	11	2671–2683
78	Notice of Entry of Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	02/04/21	15	3703–3713
193	Notice of Entry of Order Denying Defendants' Motion to Strike Supplement Report of David Leathers	11/01/21	30	7355–7366
353	Notice of Entry of Order Denying Defendants' Renewed Motion for Judgment as a Matter of Law	10/12/22	73	18,087–18,114
97	Notice of Entry of Order Denying Motion for Reconsideration of Court's Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production	04/26/21	17	4096–4108

Tab	Document	Date	Vol.	Pages
	Court's Discovery Orders			
147	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/07/21	21	5235–5245
242	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	11/19/21	44	10,954–10,963
192	Notice of Entry of Order Granting Plaintiffs' Motion in Limine to Exclude Evidence, Testimony And-Or Argument Regarding the Fact that Plaintiff have Dismissed Certain Claims	11/01/21	30	7292–7354
63	Notice of Entry of Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/27/20	11	2684–2695
335	Notice of Entry of Order Granting Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	06/29/22	71	17,594–17,609
281	Notice of Entry of Order Granting Plaintiffs' Proposed Schedule for Submission of Final Redactions	01/31/22	52	12,969–12,979
114	Notice of Entry of Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	08/03/21	18	4383–4402
53	Notice of Entry of Order Granting, in Part Plaintiffs' Motion to Compel Defendants'	09/28/20	9	2184–2195

Tab	Document	Date	Vol.	Pages
	Production of Claims for At-Issue Claims, Or, in The Alternative, Motion in Limine			
102	Notice of Entry of Order of Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Question	05/26/21	17	4157–4165
22	Notice of Entry of Order Re: Remand	02/27/20	3	543–552
142	Notice of Entry of Order Regarding Defendants' Objection to Special Master's Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents about which Plaintiffs' Witnesses Testified on Order Shortening Time	09/29/21	21	5104–5114
66	Notice of Entry of Order Setting Defendants' Production & Response Schedule Re: Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	11/09/20	12	2775–2785
285	Notice of Entry of Order Shortening Time for Hearing Re: Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits	02/14/22	53	13,029–13,046
354	Notice of Entry of Order Unsealing Trial Transcripts and Restoring Public Access to Docket	10/12/22	73	18,115–18,125
86	Notice of Entry of Report and Recommendation #1	03/16/21	16	3887–3894
120	Notice of Entry of Report and Recommendation #11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs'	08/11/21	18	4487–4497

Tab	Document	Date	Vol.	Pages
	Witnesses Testified			
91	Notice of Entry of Report and Recommendation #2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	03/29/21	16	3971–3980
95	Notice of Entry of Report and Recommendation #3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time	04/15/21	17	4080–4091
104	Notice of Entry of Report and Recommendation #7 Regarding Defendants' Motion to Compel Plaintiffs' Responses to Defendants' Amended Third Set of Requests for Production of Documents	06/03/21	17	4173–4184
41	Notice of Entry of Stipulated Confidentiality and Protective Order	06/24/20	7	1517–1540
69	Notice of Entry of Stipulated Electronically Stored Information Protocol Order	01/08/21	12	2860–2874
289	Notice of Entry of Stipulation and Order Regarding Certain Admitted Trial Exhibits	02/17/22	53	13,074–13,097
360	Notice of Entry of Stipulation and Order Regarding Expiration of Temporary Stay for Sealed Redacted Transcripts	10/25/22	76	18,759–18,769
282	Notice of Entry of Stipulation and Order Regarding Schedule for Submission of Redactions	02/08/22	52	12,980–12,996
111	Notice of Entry Report and Recommendations #9 Regarding Pending Motions	07/01/21	18	4313–4325

Tab	Document	Date	Vol.	Pages
490	Notice of Filing of Expert Report of Bruce Deal, Revised on November 14, 2021 (Filed Under Seal)	04/18/23	144	35,714–35,812
361	Notice of Filing of Writ Petition	11/17/22	76	18,770–18855
24	Notice of Intent to Take Default as to: (1) Defendant UnitedHealth Group, Inc. on All Claims; and (2) All Defendants on the First Amended Complaint's Eighth Claim for Relief	03/13/20	3 4	699–750 751
324	Notice of Posting *Supersedeas* Bond	04/29/22	69	17,114–17,121
10	Notice of Removal to Federal Court	05/14/19	1	42–100
333	Notice of Supplemental Attorneys Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees	06/24/22	70 71	17,470–17,500 17,501–17,578
291	Objection to Plaintiffs' Proposed Judgment and Order Denying Motion to Apply Statutory Cap on Punitive Damages	03/04/22	53	13,161–13,167
345	Objection to Plaintiffs' Proposed Orders Denying Renewed Motion for Judgment as a Matter of Law and Motion for New Trial	09/13/22	72	17,941–17,950
377	Objection to R&R #11 Regarding United's (Filed Under Seal)Motion to Compel Documents About Which Plaintiffs' Witnesses Testified (Filed Under Seal)	08/25/21	84 85	20,864–20,893 20,894–20,898
320	Opposition to Defendants' Motion to Retax Costs	04/13/22	68	16,856–16,864
153	Opposition to Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Regarding the Fact that Plaintiffs have Dismissed Certain Claims and Parties on Order Shortening Time	10/12/21	22	5301–5308

Tab	Document	Date	Vol.	Pages
20	Order	02/20/20	3	519–524
21	Order	02/24/20	3	525–542
337	Order Amending Oral Ruling Granting Defendants' Motion to Retax	07/01/22	71	17,682–17,688
2	Peremptory Challenge of Judge	04/17/19	1	18–19
415	Plaintiffs' Combined Opposition to Defendants Motions in Limine 1, 7, 9, 11 & 13 (Filed Under Seal)	09/29/21	104	25,786–25,850
416	Plaintiffs' Combined Opposition to Defendants' Motions in Limine No. 2, 8, 10, 12 & 14 (Filed Under Seal)	09/29/21	104	25,851–25,868
145	Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/04/21	21	5170–5201
422	Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/17/21	108	26,664–26,673
378	Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal)	09/21/21	85	20,899–20,916
380	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges (Filed Under Seal)	09/21/21	85	21,077–21,089
149	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and-or Argument	10/08/21	22	5265–5279

Tab	Document	Date	Vol.	Pages
	Regarding the Fact that Plaintiffs Have Dismissed Certain Claims and Parties on Order Shortening Time			
363	Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time (Filed Under Seal)	09/28/20	78	19,144–19,156
49	Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, or, in the Alternative, Motion in Limine on Order Shortening Time	08/28/20	7 8	1685–1700 1701–1845
250	Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,594–11,608
194	Plaintiffs' Notice of Amended Exhibit List	11/01/21	30	7367–7392
208	Plaintiffs' Notice of Deposition Designations	11/04/21	33 34	8166–8250 8251–8342
152	Plaintiffs' Objections to Defendants' Pretrial Disclosures	10/08/21	22	5295–5300
328	Plaintiffs' Opposition to Defendants' Motion for New Trial	05/04/22	69 70	17,179–17,250 17,251–17,335
420	Plaintiffs' Opposition to Defendants' Motion for Partial Summary Judgment (Filed Under Seal)	10/05/21	107	26,498–26,605
327	Plaintiffs' Opposition to Defendants' Motion for Remittitur and to Alter or Amend the Judgment	05/04/22	69	17,165–17,178
144	Plaintiffs' Opposition to Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/29/21	21	5155–5169
143	Plaintiffs' Opposition to Defendants' Motion	09/29/21	21	5115–5154

Tab	Document	Date	Vol.	Pages
	in Limine Nos. 3, 4, 5, 6 Regarding Billed Charges			
279	Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment	01/20/22	52	12,773–12,790
374	Plaintiffs' Opposition to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal)	07/06/21	84	20,699–20,742
25	Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	752–783
34	Plaintiffs' Opposition to Defendants' Motion to Dismiss First Amended Complaint	05/29/20	5 6	1188–1250 1251–1293
349	Plaintiffs' Opposition to Defendants' Motion to Redact Portions of Trial Transcript	10/07/22	72	17,990–17,993
278	Plaintiffs' Opposition to Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing	01/12/22	52	12,769–12,772
369	Plaintiffs' Opposition to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 and #3 on Order Shortening Time (Filed Under Seal)	06/01/21	81 82	20,066–20,143 20,144–20,151
329	Plaintiffs' Opposition to Defendants' Renewed Motion for Judgment as a Matter of Law	05/05/22	70	17,336–17,373
317	Plaintiffs' Opposition to Defendants' Rule 62(b) Motion for Stay	04/07/22	68	16,826–16,831
35	Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended	05/29/20	6	1294–1309

Tab	Document	Date	Vol.	Pages
	Complaint Addressing Plaintiffs' Eighth Claim for Relief			
83	Plaintiffs' Opposition to Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/04/21	16	3833–3862
55	Plaintiffs' Opposition to Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	09/29/20	9-10	2224–2292
72	Plaintiffs' Opposition to Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/12/21	14	3420–3438
122	Plaintiffs' Opposition to United's Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Allegedly Violating Protective Order	08/24/21	19	4528–4609
270	Plaintiffs' Opposition to United's Motion to Seal	12/29/21	50	12,323–12,341
222	Plaintiffs' Proposed Jury Instructions (Contested)	11/15/21	38 39	9496–9500 9501–9513
260	Plaintiffs' Proposed Second Phase Jury Instructions and Verdict Form	12/06/21	49	12,064–12,072
243	Plaintiffs' Proposed Special Verdict Form	11/19/21	44	10,964–10,973
227	Plaintiffs' Proposed Verdict Form	11/16/21	40	9810–9819
84	Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	16	3863–3883

Tab	Document	Date	Vol.	Pages
287	Plaintiffs' Reply in Support of Cross Motion for Entry of Judgment	02/15/22	53	13,054–13,062
364	Plaintiffs' Reply in Support of Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions (Filed Under Seal)	04/01/21	78	19,157–19,176
366	Plaintiffs' Response to Defendants Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order (Filed Under Seal)	04/19/21	78 79	19,389–19,393 19,394–19,532
195	Plaintiffs' Response to Defendants' Objection to Media Requests	11/01/21	30	7393–7403
371	Plaintiffs' Response to Defendants' Objection to Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions (Filed Under Seal)	06/16/21	82	20,212–20,265
376	Plaintiffs' Response to Defendants' Objection to Special Master Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Questions (Filed Under Seal)	07/22/21	84	20,751–20,863
110	Plaintiffs' Response to Defendants' Objection to Special Master's Report and Recommendation #7 Regarding Defendants' Motion to Compel Responses to Amended	06/24/21	18	4281–4312

Tab	Document	Date	Vol.	Pages
	Third Set of Request for Production of Documents			
367	Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time (Filed Under Seal)	05/05/21	79	19,533–19,581
426	Plaintiffs' Response to Defendants' Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties (Filed Under Seal)	11/08/21	109	26,965–26,997
246	Plaintiffs' Second Supplemental Jury Instructions (Contested)	11/20/21	46	11,255–11,261
261	Plaintiffs' Supplement to Proposed Second Phase Jury Instructions	12/06/21	49	12,072–12,077
236	Plaintiffs' Supplemental Jury Instruction (Contested)	11/17/21	42	10,308–10,313
248	Plaintiffs' Third Supplemental Jury Instructions (Contested)	11/21/21	46	11,267–11,272
216	Plaintiffs' Trial Brief Regarding Defendants' Prompt Payment Act Jury Instruction Re: Failure to Exhaust Administrative Remedies	11/12/21	37	9174–9184
223	Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/15/21	39	9514–9521
218	Plaintiffs' Trial Brief Regarding Specific Price Term	11/14/21	38	9417–9425
428	Preliminary Motion to Seal Attorneys' Eyes Documents Used at Trial (Filed Under Seal)	11/11/21	109	27,004–27,055
211	Recorder's Amended Transcript of Jury Trial – Day 9	11/09/21	35	8515–8723

Tab	Document	Date	Vol.	Pages
73	Recorder's Partial Transcript of Proceedings Re: Motions (Unsealed Portion Only)	01/13/21	14	3439–3448
125	Recorder's Partial Transcript of Proceedings Re: Motions Hearing	09/09/21	19	4667–4680
126	Recorder's Partial Transcript of Proceedings Re: Motions Hearing (Via Blue Jeans)	09/15/21	19	4681–4708
31	Recorder's Transcript of Hearing All Pending Motions	05/15/20	5	1022–1026
88	Recorder's Transcript of Hearing All Pending Motions	03/18/21	16	3910–3915
90	Recorder's Transcript of Hearing All Pending Motions	03/25/21	16	3967–3970
96	Recorder's Transcript of Hearing All Pending Motions	04/21/21	17	4092–4095
82	Recorder's Transcript of Hearing Defendants' Motion to Extend All Case Management Deadlines and Continue Trial Setting on Order Shortening Time (Second Request)	03/03/21	16	3824–3832
101	Recorder's Transcript of Hearing Motion for Leave to File Opposition to Defendants' Motion to Compel Responses to Second Set of Requests for Production on Order Shortening Time in Redacted and Partially Sealed Form	05/12/21	17	4155–4156
107	Recorder's Transcript of Hearing Motion for Leave to File Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Second Set of Request for Production on Order Shortening Time in Redacted and Partially Sealed Form	06/09/21	17	4224–4226
92	Recorder's Transcript of Hearing Motion to Associate Counsel on OST	04/01/21	16	3981–3986

Tab	Document	Date	Vol.	Pages
483	Recorder's Transcript of Hearing re Hearing (Filed Under Seal)	10/13/22	142	35,259–35,263
346	Recorder's Transcript of Hearing Re: Hearing	09/22/22	72	17,951–17,972
359	Recorder's Transcript of Hearing Status Check	10/20/22	76	18,756–18,758
162	Recorder's Transcript of Jury Trial – Day 1	10/25/21	25 26	6127–6250 6251–6279
213	Recorder's Transcript of Jury Trial – Day 10	11/10/21	36 37	8933–9000 9001–9152
217	Recorder's Transcript of Jury Trial – Day 11	11/12/21	37 38	9185–9250 9251–9416
224	Recorder's Transcript of Jury Trial – Day 12	11/15/21	39 40	9522–9750 9751–9798
228	Recorder's Transcript of Jury Trial – Day 13	11/16/21	40 41	9820–10,000 10,001–10,115
237	Recorder's Transcript of Jury Trial – Day 14	11/17/21	42 43	10,314–10,500 10,501–10,617
239	Recorder's Transcript of Jury Trial – Day 15	11/18/21	43 44	10,624–10,750 10,751–10,946
244	Recorder's Transcript of Jury Trial – Day 16	11/19/21	44 45	10,974–11,000 11,001–11,241
249	Recorder's Transcript of Jury Trial – Day 17	11/22/21	46 47	11,273–11,500 11.501–11,593
253	Recorder's Transcript of Jury Trial – Day 18	11/23/21	47 48	11,633–11,750 11,751–11,907
254	Recorder's Transcript of Jury Trial – Day 19	11/24/21	48	11,908–11,956
163	Recorder's Transcript of Jury Trial – Day 2	10/26/21	26	6280–6485
256	Recorder's Transcript of Jury Trial – Day 20	11/29/21	48 49	12,000 12,001–12,034

Tab	Document	Date	Vol.	Pages
262	Recorder's Transcript of Jury Trial – Day 21	12/06/21	49	12,078–,12,135
266	Recorder's Transcript of Jury Trial – Day 22	12/07/21	49 50	12,153–12,250 12,251–12,293
165	Recorder's Transcript of Jury Trial – Day 3	10/27/21	27 28	6568–6750 6751–6774
166	Recorder's Transcript of Jury Trial – Day 4	10/28/21	28	6775–6991
196	Recorder's Transcript of Jury Trial – Day 5	11/01/21	30 31	7404–7500 7501–7605
197	Recorder's Transcript of Jury Trial – Day 6	11/02/21	31 32	7606–7750 7751–7777
201	Recorder's Transcript of Jury Trial – Day 7	11/03/21	32 33	7875–8000 8001–8091
210	Recorder's Transcript of Jury Trial – Day 8	11/08/21	34 35	8344–8500 8501–8514
212	Recorder's Transcript of Jury Trial – Day 9	11/09/21	35 36	8724–8750 8751–8932
27	Recorder's Transcript of Proceedings Re: Motions	04/03/20	4	909–918
76	Recorder's Transcript of Proceedings Re: Motions	01/21/21	15	3659–3692
80	Recorder's Transcript of Proceedings Re: Motions	02/22/21	16	3757–3769
81	Recorder's Transcript of Proceedings Re: Motions	02/25/21	16	3770–3823
93	Recorder's Transcript of Proceedings Re: Motions	04/09/21	16 17	3987–4000 4001–4058
103	Recorder's Transcript of Proceedings Re: Motions	05/28/21	17	4166–4172
43	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	07/09/20	7	1591–1605

Tab	Document	Date	Vol.	Pages
45	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	07/23/20	7	1628–1643
58	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/08/20	10	2363–2446
59	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/22/20	10	2447–2481
65	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	11/04/20	11 12	2745–2750 2751–2774
67	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/23/20	12	2786–2838
68	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/30/20	12	2839–2859
105	Recorder's Transcript of Proceedings Re: Motions Hearing	06/03/21	17	4185–4209
106	Recorder's Transcript of Proceedings Re: Motions Hearing	06/04/21	17	4210–4223
109	Recorder's Transcript of Proceedings Re: Motions Hearing	06/23/21	17 18	4240–4250 4251–4280
113	Recorder's Transcript of Proceedings Re: Motions Hearing	07/29/21	18	4341–4382
123	Recorder's Transcript of Proceedings Re: Motions Hearing	09/02/21	19	4610–4633
121	Recorder's Transcript of Proceedings Re: Motions Hearing (Unsealed Portion Only)	08/17/21	18 19	4498–4500 4501–4527
29	Recorder's Transcript of Proceedings Re: Pending Motions	05/14/20	4	949-972
51	Recorder's Transcript of Proceedings Re: Pending Motions	09/09/20	8	1933–1997
15	Rely in Support of Motion to Remand	06/28/19	2	276–308
124	Reply Brief on "Motion for Order to Show	09/08/21	19	4634–4666

Tab	Document	Date	Vol.	Pages
	Cause Why Plaintiffs Should Not Be Hold in Contempt and Sanctioned for Violating Protective Order"			
19	Reply in Support of Amended Motion to Remand	02/05/20	2 3	486–500 501–518
330	Reply in Support of Defendants' Motion for Remittitur and to Alter or Amend the Judgment	06/22/22	70	17,374–17,385
57	Reply in Support of Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures	10/07/20	10	2337–2362
331	Reply in Support of Defendants' Renewed Motion for Judgment as a Matter of Law	06/22/22	70	17,386–17,411
332	Reply in Support of Motion for New Trial	06/22/22	70	17,412–17,469
87	Reply in Support of Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/16/21	16	3895–3909
344	Reply in Support of Supplemental Attorney's Fees Request	08/22/22	72	17,935–17,940
229	Reply in Support of Trial Brief Regarding Evidence and Argument Relating to Out-Of-State Harms to Non-Parties	11/16/21	41	10,116–10,152
318	Reply on "Defendants' Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions" (*on Order Shortening Time*)	04/07/22	68	16,832–16,836
245	Response to Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/19/21	45 46	11,242–11,250 11,251–11,254

Tab	Document	Date	Vol.	Pages
230	Response to Plaintiffs' Trial Brief Regarding Specific Price Term	11/16/21	41	10,153–10,169
424	Response to Sur-Reply Arguments in Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/21/21	109	26,931–26,952
148	Second Amended Complaint	10/07/21	21 22	5246–5250 5251–5264
458	Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	01/05/22	126 127	31,309–31,393 31,394–31,500
231	Special Verdict Form	11/16/21	41	10,169–10,197
257	Special Verdict Form	11/29/21	49	12,035–12,046
265	Special Verdict Form	12/07/21	49	12,150–12,152
6	Summons – Health Plan of Nevada, Inc.	04/30/19	1	29–31
9	Summons – Oxford Health Plans, Inc.	05/06/19	1	38–41
8	Summons – Sierra Health and Life Insurance Company, Inc.	04/30/19	1	35–37
7	Summons – Sierra Health-Care Options, Inc.	04/30/19	1	32–34
3	Summons - UMR, Inc. dba United Medical Resources	04/25/19	1	20–22
4	Summons – United Health Care Services Inc. dba UnitedHealthcare	04/25/19	1	23–25
5	Summons – United Healthcare Insurance Company	04/25/19	1	26–28
433	Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits (Filed	12/08/21	110 111	27,383–27,393 27,394–27,400

Tab	Document	Date	Vol.	Pages
	Under Seal)			
170	Supplement to Defendants' Objection to Media Requests	10/31/21	29	7019–7039
439	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 1 of 18 (Filed Under Seal)	12/24/21	114	28,189–28,290
440	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 2 of 18 (Filed Under Seal)	12/24/21	114 115	28,291–28,393 28,394–28,484
441	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 (Filed Under Seal)	12/24/21	115 116	28,485–28,643 28,644–28,742
442	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18 (Filed Under Seal)	12/24/21	116 117	28,743–28,893 28,894–28,938
443	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18 (Filed Under Seal)	12/24/21	117	28,939–29,084
444	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18 (Filed Under Seal)	12/24/21	117 118	29,085–29,143 29,144–29,219
445	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 7 of 18 (Filed Under Seal)	12/24/21	118	29,220–29,384
446	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 8 of 18 (Filed Under Seal)	12/24/21	118 119	29,385–29,393 29,394–29,527
447	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18 (Filed Under Seal)	12/24/21	119 120	29,528–29,643 29,644–29,727
448	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial	12/24/21	120 121	29,728–29,893 29,894–29,907

Tab	Document	Date	Vol.	Pages
	Exhibits – Volume 10 of 18 (Filed Under Seal)			
449	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 11 of 18 (Filed Under Seal)	12/24/21	121	29,908–30,051
450	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18 (Filed Under Seal)	12/24/21	121 122	30,052–30,143 30,144–30,297
451	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18 (Filed Under Seal)	12/24/21	122 123	30,298–30,393 30,394–30,516
452	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18 (Filed Under Seal)	12/24/21	123 124	30,517–30,643 30,644–30,677
453	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18 (Filed Under Seal)	12/24/21	124	30,678–30,835
454	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18 (Filed Under Seal)	12/24/21	124 125	30,836–30,893 30,894–30,952
455	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18 (Filed Under Seal)	12/24/21	125	30,953–31,122
456	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18 (Filed Under	12/24/21	125 126	30,123–31,143 31,144–31,258

Tab	Document	Date	Vol.	Pages
	Seal)			
466	Transcript of Proceedings re Hearing Regarding Unsealing Record (Filed Under Seal)	10/05/22	129	31,923–31,943
350	Transcript of Proceedings re Status Check	10/10/22	72 73	17,994–18,000 18,001–18,004
467	Transcript of Proceedings re Status Check (Filed Under Seal)	10/06/22	129	31,944–31,953
157	Transcript of Proceedings Re: Motions	10/19/21	22 23	5339–5500 5501–5561
160	Transcript of Proceedings Re: Motions	10/22/21	24 25	5908–6000 6001–6115
459	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/12/22	127	31,501–31,596
460	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/20/22	127 128	31,597–31,643 31,644–31,650
461	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/27/22	128	31,651–31,661
146	Transcript of Proceedings Re: Motions (Via Blue Jeans)	10/06/21	21	5202–5234
290	Transcript of Proceedings Re: Motions Hearing	02/17/22	53	13,098–13,160
319	Transcript of Proceedings Re: Motions Hearing	04/07/22	68	16,837–16,855
323	Transcript of Proceedings Re: Motions Hearing	04/21/22	69	17,102–17,113
336	Transcript of Proceedings Re: Motions Hearing	06/29/22	71	17,610–17,681
463	Transcript of Proceedings Re: Motions Hearing (Filed Under Seal)	02/10/22	128	31,673–31,793

Tab	Document	Date	Vol.	Pages
464	Transcript of Proceedings Re: Motions Hearing (Filed Under Seal)	02/16/22	128	31,794–31,887
38	Transcript of Proceedings, All Pending Motions	06/05/20	6	1350–1384
39	Transcript of Proceedings, All Pending Motions	06/09/20	6	1385–1471
46	Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement	07/29/20	7	1644–1663
482	Transcript of Status Check (Filed Under Seal)	10/10/22	142	35,248–35,258
492	Transcript Re: Proposed Jury Instructions	11/21/21	146	36,086–36,250
425	Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties (Filed Under Seal)	10/31/21	109	26,953–26,964
232	Trial Brief Regarding Jury Instructions on Formation of an Implied-In-Fact Contract	11/16/21	41	10,198–10,231
233	Trial Brief Regarding Jury Instructions on Unjust Enrichment	11/16/21	41	10,232–10,248
484	Trial Exhibit D5499 (Filed Under Seal)		142 143	35,264–35,393 35,394–35,445
362	Trial Exhibit D5502		76 77	18,856–19,000 19,001–19,143
485	Trial Exhibit D5506 (Filed Under Seal)		143	35,446
372	United's Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal)	06/24/21	82	20,266–20,290
112	United's Reply in Support of Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified	07/12/21	18	4326–4340

Tab	Document	Date	Vol.	Pages
	on Order Shortening Time			
258	Verdict(s) Submitted to Jury but Returned Unsigned	11/29/21	49	12,047–12,048

CERTIFICATE OF SERVICE

I certify that on April 18, 2023, I submitted the foregoing appendix for filing *via* the Court's eFlex electronic filing system.

Electronic notification will be sent to the following:

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I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage prepaid, at Las Vegas, Nevada, addressed as follows:

The Honorable Nancy L. Allf
DISTRICT COURT JUDGE – DEPT. 27
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/s/ Jessie M. Helm
An Employee of Lewis Roca Rothgerber Christie LLP

INDEX OF EXHIBITS

Description	Exhibit No.
Amended Complaint filed in *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*	1

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EXHIBIT 1

Amended Complaint filed in Marin Gen. Hosp. v. Modesto & Empire Traction Co.

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EXHIBIT 1

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARIN GENERAL HOSPITAL, a non-profit California corporation, Plaintiff, vs. MODESTO & EMPIRE TRACTION COMPANY, a California corporation, MEDICAL BENEFITS AMINISTRATION OF MD., INC. a Maryland corporation,. RONALD J. WILSON, an individual, and DOES 1-50 inclusive, Defendants	Case No.: 3:07-cv-01027-SI FIRST AMENDED COMPLAINT FOR DAMAGES FOR: 1. BREACH OF ORAL CONTRACT; 2. NEGLIGENT MISREPRESENTATION; 3. QUANTUM MERUIT; AND 4. ESTOPPEL

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Plaintiff, MARIN GENERAL HOSPITAL ("Hospital") is informed and believes and thereon alleges as follows:[1]

PARTIES

1. **Hospital expressly disavows this action implicates any of the rights Hospital may have gained through an assignment of benefits from patient S.M. To the extent recovery on any of the claims asserted herein rely upon such an assignment, Hospital declines such recover in this action. Hospital elects to bring this suit specifically and exclusively on the basis of causes of action arising under the laws of the State of California.**

2. Hospital, a non-profit California corporation is a and at all times was, licensed by the State of California to conduct business as a health care provider in the County of Marin.

3. Defendant Modesto & Empire Traction Company ("Modesto"), is a for profit California corporation with its principal place of business in Modesto County, California. Modesto provides self- funded medical insurance to its employees, and/or officers, and their dependants.

4. Defendant Medical Benefits Administrators of MD, Inc. ("MBAMD") is a Maryland corporation, and has its principal place of business in Abington, Maryland. MBAMD administers member benefit plans on behalf of employers and organizations that provide self-funded medical insurance on behalf of their employees, officers, and/or members.

[1] Amendments to the original complaint are signified by **boldface** and ~~strikeouts~~.

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5. Defendant Ronald J. Wilson ("Wilson") is an individual and at all relevant times herein mentioned was the Chief Executive Officer and Chairman of MBAMD.

6. There exists, and at all times herein mentioned there existed, a unity of interest and ownership between Wilson and MBAMD, such that any individuality and separateness between them have ceased and MBAMD is the alter ego of Wilson in that MBAMD is and, and at all times herein mentioned was, so inadequately capitalized that, compared with the business to be done by MBAMD and the risks of loss, its capitalization was trifling.

7. Adherence to the fiction of the separate existence of MBAMD as an entity distinct from Wilson would permit an abuse of the corporate privilege and would promote injustice in that Hospital is informed and beliefs and thereon alleges Wilson made loans to MBAMD and guaranteed certain of its obligations thereby enabling MBAMD to engage in business activities, without adequate financing and without capital stock, which invited the public generally and Hospital in particular to deal with MBAMD to Hospital's loss.

8. Modesto provided health care benefits to patient S.M - - whose name has been withheld for privacy purposes - - under a self-funded medical insurance plan.

9. Defendants at all relevant times transacted business either personally or through its agents and/or assigns within the State of California. The violations alleged in this complaint herein have been and are being carried out in California.

10. Hospital is unaware of the true names and capacities, whether corporate, associate, individual, partnership or otherwise of Defendants DOES 1-50, inclusive, and therefore sues those defendants named DOE by such fictitious names. Hospital will seek leave of the Court to amend this Complaint to allege their true names and capacities when ascertained.

11. At all relevant times defendants, including the defendants named DOE, were and are the agents, employees, employers, joint venturers, representatives, alter egos, subsidiaries, and/or partners of one or more of the other defendants, and was, in performing the acts complained of herein, acting within the scope of such agency, employment, joint venture, or partnership authority, and/or is in some other way responsible for the acts of one or more of the other Defendants.

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12. MBAMD was charge with administering health plan benefits to Modesto member S.M.

13. For all dates herein alleged defendants provided insurance coverage and thereby an obligation exists for reimbursement for medically necessary services, supplies and /or equipment provided S.M.

FACTUAL BACKGROUND

14. On or about April 19, 2004, S.M. was admitted to Hospital for a scheduled lumbar fusion procedure.

15. Hospital provided medical services, supplied, and/or equipment to S.M. from April 19, 2004 to April 24, 2004.

16. On or before April 19, 2004, patient S.M. was enrolled in Modesto's self-funded health plan.

17. Prior to S.M.'s admission, Hospital was advised of patient S.M.'s health insurance coverage through Modesto's self-funded health plan.

18. On or about April 8, 2004 Hospital contacted MBAMD, by telephone, which verified patient S.M.'s eligibility and coverage.

19. On or about April 8, 2004, defendants also authorized the care provided to patient S.M and issued the authorization number "CRW4098003LF" to Hospital.

20. Hospital, in reliance on defendants' verbal statements of coverage and authorization for the treatment of patient S.M., provided medical services, supplies, and /or equipment to patient S.M. with the understanding that defendants would pay Hospital's hospital bills at 90% of Hospital's total billed charges for said services, supplies and/or equipment.

21. Hospital timely and properly submitted a valid bill to defendants in the amount of $178,926.54.

22. On or about July 7, 2004 defendants issued a payment in the amount of $46,655.54, resulting in a balance still due and owing from defendants in the amount of $114,378.35 for the services provided to patient S.M. after application of a 10% discount.

23. Despite ~~requests~~ **written demands** to defendants that full

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reimbursement to Hospital for the medical services, supplies and equipment provided to patient S.M, defendants refuse to pay Hospital the full amount due.

24. On or about December 8, 2004defendants issued to Hospital a final denial for the remaining balance for the services provided to patient S.M.

25. ~~Hospital has exhausted all of its administrative appeals~~. Hospital sent written demands to defendants to rectify the underpayment.

26. As a direct and proximate result of defendants' conduct, the medical bill for Hospital's provision of medical services, supplies, and equipment to patient S.M. from April 19, 2004 to April 24, 2004 remains underpaid by $114,378.35. Hospital thus has suffered damages in the amount of $114,378.35.

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FIRST CAUSE OF ACTION

(Breach of Implied Contract)

(Against all defendants)

27. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

28. On or about April 8, 2004, Hospital informed defendants, that patient S.M. was scheduled for a lumbar fusion procedure at Hospital.

29. Defendants confirmed that patient S.M. health plan coverage and authorized the medical services, supplies, and equipment Hospital eventually provided to patient S.M.

30. As a result of the custom and practice in the healthcare field, and prior dealings between the parties Hospital and defendants understood that, because defendants authorized and made a representation of coverage upon which Hospital reasonably relied, by providing medically necessary services, Hospital would be paid by defendants for such medical services, supplies and equipment provided to patient S.M. at a 10% discount from its total billings.

31. Defendants, therefore, understood that Hospital's provision of medical services, supplies, and equipment to patient S.M. from April 19, 2004 to April 24, 2004 would require defendants to pay Hospital's bills at 90% of Hospital's total billed charges for said services, supplies and/or equipment for a total amount of $161,033.87.

32. Hospital timely submitted a bill to defendants. The total charges for the medical services, supplies, and equipment provided to patient S.M. amounted to $178,926.54.

33. On or about July 7, 2004, defendants issued a partial payment in the amount of $46,655.54.

34. Because defendants only paid the partial amount of $46,655.54 this claim has been underpaid, and the balance still due from Defendants amounts to $114,378.35.

35. Defendants acknowledged and accepted financial responsibility for the medical services, supplies, and equipment provided to patient S.M. by Hospital, and agreed to pay for those services, supplies and equipment.

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36. Hospital has performed all conditions, covenants, and promises required on its part to be performed in accordance with the terms and conditions of this contract implied in fact at the rate agreed upon prior to patient S.M.'s hospitalization.

37. On or about December 8, 2004,defendants breached this implied agreement by issuing its final refusal to fully reimburse Hospital for the medical services, supplies and/or equipment provided to patient S.M. at the agreed upon rate.

38. As a direct and proximate result of defendants' breach of implied contract, Hospital has suffered damages in the amount of $114,378.35.

SECOND CAUSE OF ACTION

(Breach of Oral Contract)

(Against all defendants)

39. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

40. On or about April 8, 2004, Hospital and defendants entered into an oral agreement whereby Hospital agreed to provided medically necessary services, supplies, and equipment to Defendant's enrollee (patient S.M.) in return for which Hospital agreed to pay Hospital's bills at 90% of Hospital's total billed charges for said services, supplies and/or equipment.

41. Hospital supplied medical services, supplies and equipment to Modesto's enrollee, patient S.M., from April 19, 2004 to April 24, 2004, and has

performed all conditions, covenants, and promises required on its part to be performed in accordance with the terms and conditions of this oral contract.

42. On or about December 8, 2004, defendants breached this oral agreement by issuing its final refusal to properly reimburse Hospital for the medical services, supplies and/or equipment provided to patient S.M.

43. As a direct and proximate result of defendants' breach of implied contract, Hospital has suffered damages in the amount of $114,378.35, after payments previously made by defendants are taken into account.

THIRD CAUSE OF ACTION

(Negligent Misrepresentation)

(Against all defendants)

44. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

45. On or about April 8, 2004,defendants represented to Hospital that patient S.M., an enrollee under Modesto's self-funded health plan and that defendants would compensate Hospital for its provision of medical services, supplies and equipment to patient S.M. at 90% of Hospital's total billed charges for said services, supplies and/or equipment for a total amount of $161,033.87.

46. Defendants or their agents made those representations with the intention of inducing Hospital to act in reliance on these representations by providing services, supplies, and equipment to patient S.M. and in preventing Hospital from making other arrangements for payment.

47. When defendants or their agents made those representations to Hospital without reasonable grounds for believing them to be true.

48. On or about December 8, 2004, after the medical services, supplies and equipment were provided to patient S.M., defendants informed Hospital that they refused to issue any further payment to correct the underpayment of the claim.

49. At the time the representations were made by defendants, Hospital was ignorant of the falsity of defendants' representations and believed them to be true.

50. In reasonable reliance upon those representations, Hospital was induced to provide patient S.M. with medically necessary services, supplies, and equipment and refrain from making other arrangements to obtain payment.

51. As a direct and proximate result of its reliance Hospital has suffered damages in the sum of $114,378.35.

FOURTH CAUSE OF ACTION

(Quantum Meruit)

(Against all defendants)

52. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

53. As a direct and proximate result of defendants' assurances and representations that patient S.M. had health plan coverage from which payment

would be made, Hospital rendered care to patient S.M. with a value of $178,926.54.

54. Hospital has requested full payment from defendants or their agents for the charges incurred for the medical services, supplies and equipment provided by Hospital Center to patient S.M.

55. Defendants or their agents have failed to pay fully for the medically necessary services, supplies and equipment provided to patient S.M., but to date defendants have only paid $46,655.54.

56. As a result of defendants or their agent's failure to perform according to the assurances and representations made to Hospital, Hospital has suffered damages in the amount of $132,271.00.

FIFTH CAUSE OF ACTION

(Estoppel)

(Against all defendants)

57. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

58. Defendants or their agents represented to Hospital that patient S.M. had health plan coverage and that payment would be made for all hospital bills incurred at 90% of Hospital's total billed charges for said services, supplies and/or equipment for a total amount of $161,033.87 after applying the discount.

59. When promising, assuring and representing to Hospital that

patient S.M.. had a policy of health plan coverage that would reimburse Hospital for the medical services, supplied and /or equipment rendered to Modesto's plan enrollee, defendants knew, or should have known, that Hospital would be reasonably induced to rely on defendants' or their agent's promises, assurances and representations.

60. As a direct and proximate result of Defendants' or their agents making representations to Hospital that patient S.M. had health plan coverage and that payment would be made for the charges incurred, Hospital actually, reasonably, and justifiably relied upon such representations and was thereby induced to provide medical services, supplies and /or equipment to provide medical services, supplies and/ or equipment to patient S.M. defendants have not fully performed their promises, assurances or representations to pay Hospital.

61. Hospital reasonably and justifiably relied upon such representations and assurances in providing the services, supplies and/or equipment, and in refraining from pursuing other avenues of reimbursement.

62. As a direct and proximate cause of their conduct, defendants should be estopped from denying Hospital has suffered substantial detrimental damages in the sum of at least $114,378.35.

PRAYER FOR RELIEF

WHEREFORE, MARIN GENERAL HOSPIRAL prays for judgment as follows:

1. For the 1st, 2nd, 3rd and 5th causes of action the principal of sum of $114,378.35;

2. For the 4th cause of action the principal sum of $132,271.00

3. For all causes of action interest on such principal sum at the rate of fifteen percent (15%) per annum, pursuant to Cal. Health & Safety Code § 1371;

4. For all causes of action pre-judgment interest on such principal sum, at the legal rate, pursuant to Cal. Civ. Code § 3287 (a); and

5. For all causes of action such other and further relief as the court deems just and proper.

Dated: 18 May 2007

STEPHENSON, ACQUISTO & COLMAN

Viola Rita Brown
Attorneys for
MARIN GENERAL HOSPITAL

PROOF OF SERVICE

I am employed in the county of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 303 North Glenoaks Boulevard, Suite 700, Burbank, California 91502-3226. On 18 May 2007, I served the foregoing document(s) entitled:

FIRST AMENDED COMPLAINT FOR DAMAGES

by placing a true copy thereof enclosed in a sealed envelope addressed per the attached Service List.

[X] BY MAIL: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the United States Postal Service on that same day with postage thereon fully prepaid at Burbank, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit. [C.C.P. 1013a(3); F.R.C.P. 5(b)]

[ ] BY FEDERAL EXPRESS: I caused such envelope(s), with overnight Federal Express Delivery Charges to be paid by this firm, to be deposited with the Federal Express Corporation at a regularly maintained facility on the aforementioned date. [C.C.P. 1013(c) 1013(d)]

[ ] BY EXPRESS MAIL: I caused such envelope(s), with postage thereon fully prepaid and addressed to the party(s) shown above, to be deposited in a facility operated by the U.S. Postal Service and regularly maintained for the receipt of Express Mail on the aforementioned date. [C.C.P. 1013(c)]

[ ] BY TELECOPIER: Service was effected on all parties at approximately ____:____ am/pm by transmitting said document(s) from this firm's facsimile machine (818/559-4477) to the facsimile machine number(s) shown above. Transmission to said numbers was successful as evidenced by a Transmission Report produced by the machine indicating the documents had been transmitted completely and without error. C.R.C. 2008(e), Cal. Civ. Proc. Code § 1013(e).

[X] State: I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

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[ ] Federal: I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

CONSUELO MARQUEZ

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SERVICE LIST

Bradley A. Post, Esq.

BORTON PETRINI, LLP

2014 Tulare Street, Suite 631

Fresno, CA 93721

CERTIFIED RECEIPT NUMBER
7006 0100 0004 5633 0241

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

* * *

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., et al., Plaintiff(s), v. UNITEDHEALTH GROUP, INC., et al., Defendant(s).	Case No. 2:19-CV-832 JCM (VCF) ORDER

Presently before the court is plaintiffs' Fremont Emergency Services; Team Physicians of Nevada-Mandavia; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("plaintiffs") amended motion to remand. (ECF No. 49). Defendant United Healthcare Insurance Company ("United") filed a response (ECF No. 64), to which plaintiffs replied (ECF No. 71).

I. Background

Plaintiffs are professional emergency medical service groups that staff the emergency departments at hospitals and other facilities throughout Nevada. (ECF No. 40 at 5). Plaintiffs have been providing emergency services and care to patients in the emergency department, regardless of an individual's insurance coverage or ability to pay. *Id.*

United and plaintiffs have never had a written agreement governing the rates of reimbursement for emergency services rendered. *Id.* at 6. Nonetheless, plaintiffs have submitted claims to United seeking reimbursement for emergency care and United has routinely paid them.

Id. at 10. From 2008–2017, United normally paid plaintiffs at a range of 75–90%. *Id.* However, beginning in 2019, United continued to pay the claims submitted but reduced the rates of reimbursement to levels ranging from 12–60%, below the usual and customary rates. *Id.*

Plaintiffs' amended complaint asserts eight state law causes of action, all stemming from United's alleged underpayment of claims. *Id.* at 32–44. Plaintiffs originally brought suit against United in the Eighth Judicial District Court, and United timely removed the action. (ECF No. 1). Plaintiffs now move to remand the case. (ECF No. 49).

II. Legal Standard

Pursuant to 28 U.S.C. § 1441(a), "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a). "A federal court is presumed to lack jurisdiction in a particular case unless the contrary affirmatively appears." *Stock West, Inc. v. Confederated Tribes of Colville Reservation*, 873 F.2d 1221, 1225 (9th Cir. 1989).

Upon notice of removability, a defendant has thirty days to remove a case to federal court once he knows or should have known that the case was removable. *Durham v. Lockheed Martin Corp.*, 445 F.3d 1247, 1250 (9th Cir. 2006) (citing 28 U.S.C. § 1446(b)(2)). Defendants are not charged with notice of removability "until they've received a paper that gives them enough information to remove." *Id.* at 1251.

Specifically, "the 'thirty day time period [for removal] . . . starts to run from defendant's receipt of the initial pleading only when that pleading affirmatively reveals on its face' the facts necessary for federal court jurisdiction." *Id.* at 1250 (quoting *Harris v. Bankers Life & Casualty Co.*, 425 F.3d 689, 690–91 (9th Cir. 2005) (alterations in original)). "Otherwise, the thirty-day

clock doesn't begin ticking until a defendant receives 'a copy of an amended pleading, motion, order or other paper' from which it can determine that the case is removable. *Id*. (quoting 28 U.S.C. § 1446(b)(3)).

A plaintiff may challenge removal by timely filing a motion to remand. 28 U.S.C. § 1447(c). On a motion to remand, the removing defendant faces a strong presumption against removal, and bears the burden of establishing that removal is proper. *Sanchez v. Monumental Life Ins. Co.*, 102 F.3d 398, 403–04 (9th Cir. 1996); *Gaus v. Miles, Inc.*, 980 F.2d 564, 566–67 (9th Cir. 1992).

III. Discussion

As an initial matter, United bears the burden of proving that plaintiffs' complaint contains a cause of action within this court's jurisdiction. "In scrutinizing a complaint in search of a federal question, a court applies the well-pleaded complaint rule." *Ansley*, 340 F.3d at 861 (citing *Caterpillar Inc. v. Williams,* 482 U.S. 386, 392 (1987)). "For removal to be appropriate under the well-pleaded complaint rule, a federal question must appear on the face of a properly pleaded complaint." *Id.* (citing *Rivet v. Regions Bank of La.,* 522 U.S. 470, 475 (1998)).

The "well-pleaded complaint rule" governs federal question jurisdiction. This rule provides that district courts can exercise jurisdiction under 28 U.S.C. § 1331 only when a federal question appears on the face of a well-pleaded complaint. *See, e.g.*, *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). Thus, a plaintiff "may avoid federal jurisdiction by exclusive reliance on state law." *Id*. Moreover, "an anticipated or actual federal defense generally does not qualify a case for removal[.]" *Jefferson County v. Acker*, 527 U.S. 423, 431 (1999).

Although plaintiffs bring claims solely under state law, United argues that removal is proper under 28 U.S.C § 1441 based on the exception of complete preemption by § 502(a) of

ERISA. For the reasons set forth below, the court finds that defendant's asserted basis for removal is improper and grants plaintiffs' motion to remand.

"ERISA is one of only a few federal statutes under which two types of preemption may arise: conflict preemption and complete preemption." *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F. 3d 1337, 1343 (11th Cir. 2009). While conflict preemption is a defense to preempted state law claims, the doctrine does not normally allow for removal to federal court. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). On the other hand, complete preemption is a judicially recognized exception to the well-pleaded complaint rule that allows removal of claims within the scope of ERISA § 502(a) to federal court. *Davila* 542 U.S. at 209; *Marin General Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 945 (9th Cir. 2009).

In *Davila*, the Supreme Court established a two-pronged test to determine whether a state law claim is completely preempted by ERISA. *Davila*, 542 U.S. at 210. Complete preemption exists only when (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(b)," and (2) "there is no other independent legal duty that is implicated by a defendant's actions." *Id.* at 210. The test is conjunctive; a claim is completely preempted only if both prongs are satisfied. *Marin*, 581 F.3d at 947.

Under prong 1 of the *Davila* test, the Ninth Circuit has distinguished between claims involving the "right to payment" and claims involving the proper "amount of payment." *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc*., 187 F.3d 1045, 1051 (9th Cir. 1999). Claims involving the "right to payment" generally fall within the scope of § 502(a)(1)(b), while claims involving the "amount of payment" generally fall outside the scope of § 502(a)(1)(b). *Id.*

Although *Blue Cross* preceded *Davila*, the Ninth Circuit has expressly found that its analysis and holding are consistent with the *Davila* framework and remain good law. *Marin*, 581 F.3d at 948.

Here, plaintiffs allege claims disputing the amount of payment from United. (ECF No. 40). They do not contend they are owed an additional amount from the patients' ERISA plans. *See id.* Instead, they allege these claims arise from their alleged implied-in-fact contract with United. *Id.*

United attempts to distinguish the implied-in-fact contract from other types of contracts referenced in the case law. (ECF No. 64). However, Nevada courts have found that implied-in-fact agreements and express agreements have the same legal effects. *See Magnum Opes Constr. v. Sanpete Steel Corp.,* 2013 WL 7158997 (Nev. 2013); *Certified Fire Prot. Inc. v. Precision Constr*., 283 P. 3d 250, 256 (Nev. 2012).

Consequently, the court finds that plaintiffs' claims fall outside the scope of § 502(a) of ERISA, failing prong 1 of the *Davila* test. No further analysis under *Davila* is necessary. Plaintiffs' motion to remand is granted.

Additionally, while plaintiffs correctly indicate that 28 U.S.C § 1447(c) allows the court to impose attorney's fees and costs on a party who improperly removes a case to federal court, "Congress has unambiguously left the award of fees to the discretion of the district court." *Gotro v. R & B Realty Group*, 69 F.3d 1485, 1487 (9th Cir. 1995) (*citing Moore v. Permanente Medical Group*, 981 F.2d 443, 446 (9th Cir. 1992). There was a reasonable dispute concerning whether the complete preemption exception under ERISA § 502 applied to the claims. Therefore, the court declines to award attorney's fees to the plaintiffs.

. . .

. . .

IV. Conclusion

Accordingly,

IT IS HEREBY ORDERED, ADJUDGED, and DECREED that plaintiffs' amended motion to remand (ECF No. 49) be, and the same hereby is, GRANTED.

IT IS FURTHER ORDERED that the matter of *Fremont Emergency Services (Mandavia), Ltd. v. United Healthcare Insurance Company et al.,* case number 2:19-cv-00832-JCM-VCF, be, and the same hereby is, REMANDED to the Eighth Judicial District Court.

The clerk shall close the case accordingly.

DATED February 20, 2020.

James C. Mahan

UNITED STATES DISTRICT JUDGE

21

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

* * *

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., et al.,

Plaintiff(s),

v.

UNITEDHEALTH GROUP, INC., et al.,

Defendant(s).

Case No. 2:19-CV-832 JCM (VCF)

ORDER

Presently before the court is plaintiffs' Fremont Emergency Services; Team Physicians of Nevada-Mandavia; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("plaintiffs") amended motion to remand. (ECF No. 49). Defendant United Healthcare Insurance Company ("United") filed a response (ECF No. 64), to which plaintiffs replied (ECF No. 71).

I. Background

Plaintiffs are professional emergency medical service groups that staff the emergency departments at hospitals and other facilities throughout Nevada. (ECF No. 40 at 5). Plaintiffs have been providing emergency services and care to patients in the emergency department, regardless of an individual's insurance coverage or ability to pay. *Id.*

United and plaintiffs have never had a written agreement governing the rates of reimbursement for emergency services rendered. *Id.* at 6. Nonetheless, plaintiffs have submitted claims to United seeking reimbursement for emergency care and United has routinely paid them.

James C. Mahan
U.S. District Judge

Id. at 10. From 2008–2017, United normally paid plaintiffs at a range of 75–90%. *Id.* However, beginning in 2019, United continued to pay the claims submitted but reduced the rates of reimbursement to levels ranging from 12–60%, below the usual and customary rates. *Id.*

Plaintiffs' amended complaint asserts eight state law causes of action, all stemming from United's alleged underpayment of claims. *Id.* at 32–44. Plaintiffs originally brought suit against United in the Eighth Judicial District Court, and United timely removed the action. (ECF No. 1). Plaintiffs now move to remand the case. (ECF No. 49).

II. Legal Standard

Pursuant to 28 U.S.C. § 1441(a), "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a). "A federal court is presumed to lack jurisdiction in a particular case unless the contrary affirmatively appears." *Stock West, Inc. v. Confederated Tribes of Colville Reservation*, 873 F.2d 1221, 1225 (9th Cir. 1989).

Upon notice of removability, a defendant has thirty days to remove a case to federal court once he knows or should have known that the case was removable. *Durham v. Lockheed Martin Corp.*, 445 F.3d 1247, 1250 (9th Cir. 2006) (citing 28 U.S.C. § 1446(b)(2)). Defendants are not charged with notice of removability "until they've received a paper that gives them enough information to remove." *Id.* at 1251.

Specifically, "the 'thirty day time period [for removal] . . . starts to run from defendant's receipt of the initial pleading only when that pleading affirmatively reveals on its face' the facts necessary for federal court jurisdiction." *Id.* at 1250 (quoting *Harris v. Bankers Life & Casualty Co.*, 425 F.3d 689, 690–91 (9th Cir. 2005) (alterations in original)). "Otherwise, the thirty-day

clock doesn't begin ticking until a defendant receives 'a copy of an amended pleading, motion, order or other paper' from which it can determine that the case is removable. *Id.* (quoting 28 U.S.C. § 1446(b)(3)).

A plaintiff may challenge removal by timely filing a motion to remand. 28 U.S.C. § 1447(c). On a motion to remand, the removing defendant faces a strong presumption against removal, and bears the burden of establishing that removal is proper. *Sanchez v. Monumental Life Ins. Co.*, 102 F.3d 398, 403–04 (9th Cir. 1996); *Gaus v. Miles, Inc.*, 980 F.2d 564, 566–67 (9th Cir. 1992).

III. Discussion

As an initial matter, United bears the burden of proving that plaintiffs' complaint contains a cause of action within this court's jurisdiction. "In scrutinizing a complaint in search of a federal question, a court applies the well-pleaded complaint rule." *Ansley*, 340 F.3d at 861 (citing *Caterpillar Inc. v. Williams,* 482 U.S. 386, 392 (1987)). "For removal to be appropriate under the well-pleaded complaint rule, a federal question must appear on the face of a properly pleaded complaint." *Id.* (citing *Rivet v. Regions Bank of La.,* 522 U.S. 470, 475 (1998)).

The "well-pleaded complaint rule" governs federal question jurisdiction. This rule provides that district courts can exercise jurisdiction under 28 U.S.C. § 1331 only when a federal question appears on the face of a well-pleaded complaint. *See, e.g.*, *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). Thus, a plaintiff "may avoid federal jurisdiction by exclusive reliance on state law." *Id.* Moreover, "an anticipated or actual federal defense generally does not qualify a case for removal[.]" *Jefferson County v. Acker*, 527 U.S. 423, 431 (1999).

Although plaintiffs bring claims solely under state law, United argues that removal is proper under 28 U.S.C § 1441 based on the exception of complete preemption by § 502(a) of

ERISA. For the reasons set forth below, the court finds that defendant's asserted basis for removal is improper and grants plaintiffs' motion to remand.

"ERISA is one of only a few federal statutes under which two types of preemption may arise: conflict preemption and complete preemption." *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F. 3d 1337, 1343 (11th Cir. 2009). While conflict preemption is a defense to preempted state law claims, the doctrine does not normally allow for removal to federal court. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). On the other hand, complete preemption is a judicially recognized exception to the well-pleaded complaint rule that allows removal of claims within the scope of ERISA § 502(a) to federal court. *Davila* 542 U.S. at 209; *Marin General Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 945 (9th Cir. 2009).

In *Davila*, the Supreme Court established a two-pronged test to determine whether a state law claim is completely preempted by ERISA. *Davila*, 542 U.S. at 210. Complete preemption exists only when (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(b)," and (2) "there is no other independent legal duty that is implicated by a defendant's actions." *Id.* at 210. The test is conjunctive; a claim is completely preempted only if both prongs are satisfied. *Marin*, 581 F.3d at 947.

Under prong 1 of the *Davila* test, the Ninth Circuit has distinguished between claims involving the "right to payment" and claims involving the proper "amount of payment." *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999). Claims involving the "right to payment" generally fall within the scope of § 502(a)(1)(b), while claims involving the "amount of payment" generally fall outside the scope of § 502(a)(1)(b). *Id.*

Although *Blue Cross* preceded *Davila*, the Ninth Circuit has expressly found that its analysis and holding are consistent with the *Davila* framework and remain good law. *Marin*, 581 F.3d at 948.

Here, plaintiffs allege claims disputing the amount of payment from United. (ECF No. 40). They do not contend they are owed an additional amount from the patients' ERISA plans. *See id.* Instead, they allege these claims arise from their alleged implied-in-fact contract with United. *Id.*

United attempts to distinguish the implied-in-fact contract from other types of contracts referenced in the case law. (ECF No. 64). However, Nevada courts have found that implied-in-fact agreements and express agreements have the same legal effects. *See Magnum Opes Constr. v. Sanpete Steel Corp.*, 2013 WL 7158997 (Nev. 2013); *Certified Fire Prot. Inc. v. Precision Constr.*, 283 P. 3d 250, 256 (Nev. 2012).

Consequently, the court finds that plaintiffs' claims fall outside the scope of § 502(a) of ERISA, failing prong 1 of the *Davila* test. No further analysis under *Davila* is necessary. Plaintiffs' motion to remand is granted.

Additionally, while plaintiffs correctly indicate that 28 U.S.C § 1447(c) allows the court to impose attorney's fees and costs on a party who improperly removes a case to federal court, "Congress has unambiguously left the award of fees to the discretion of the district court." *Gotro v. R & B Realty Group*, 69 F.3d 1485, 1487 (9th Cir. 1995) (*citing Moore v. Permanente Medical Group*, 981 F.2d 443, 446 (9th Cir. 1992). There was a reasonable dispute concerning whether the complete preemption exception under ERISA § 502 applied to the claims. Therefore, the court declines to award attorney's fees to the plaintiffs.

. . .

. . .

IV. Conclusion

Accordingly,

IT IS HEREBY ORDERED, ADJUDGED, and DECREED that plaintiffs' amended motion to remand (ECF No. 49) be, and the same hereby is, GRANTED.

IT IS FURTHER ORDERED that the matter of *Fremont Emergency Services (Mandavia), Ltd. v. United Healthcare Insurance Company et al.*, case number 2:19-cv-00832-JCM-VCF, be, and the same hereby is, REMANDED to the Eighth Judicial District Court.

The clerk shall close the case accordingly.

DATED February 20, 2020.

James C. Mahan
UNITED STATES DISTRICT JUDGE

CLOSED

United States District Court
District of Nevada (Las Vegas)
CIVIL DOCKET FOR CASE #: 2:19-cv-00832-JCM-VCF

Fremont Emergency Services (Mandavia), Ltd. v. United Healthcare Insurance Company et al
Assigned to: Judge James C. Mahan
Referred to: Magistrate Judge Cam Ferenbach
Case in other court: District Court, Clark County, Nevada, A-19-792978-B
Cause: 29:1132 E.R.I.S.A.-Employee Benefits

Date Filed: 05/14/2019
Date Terminated: 02/20/2020
Jury Demand: Both
Nature of Suit: 791 Labor: E.R.I.S.A.
Jurisdiction: Federal Question

Plaintiff

Fremont Emergency Services (Mandavia), Ltd.

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Plaintiff

Team Physicians of Nevada-Mandavia, P.C.

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Patricia K Lundvall
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Plaintiff

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V.

Defendant

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Defendant

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Defendant

Health Plan Of Nevada, Inc. represented by **Brittany Maria Llewellyn**
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Defendant

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Colby Balkenbush
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Date Filed	#	Docket Text
05/14/2019	1	PETITION FOR REMOVAL from District Court, Clark County, Nevada, Case Number A–19–792978–B, (Filing fee $ 400 receipt number 0978–5548762) by Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., United Health Care Services Inc., UMR, Inc., Oxford Health Plans, Inc., Health Plan Of Nevada, Inc., United Healthcare Insurance Company. (Attachments: # 1 Exhibit, # 2 Civil Cover Sheet)(Roberts, D.) NOTICE of Certificate of Interested Parties requirement: Under Local Rule 7.1–1, a party must immediately file its disclosure statement with its first appearance, pleading,

		petition, motion, response, or other request addressed to the court. (Entered: 05/14/2019)
05/14/2019	2	CERTIFICATE of Interested Parties by Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. There are no known interested parties other than those participating in the case (Roberts, D.) (Entered: 05/14/2019)
05/14/2019		Case randomly assigned to Judge Jennifer A. Dorsey and Magistrate Judge Cam Ferenbach. (JM) (Entered: 05/15/2019)
05/15/2019	3	MINUTE ORDER IN CHAMBERS of the Honorable Judge Jennifer A. Dorsey on 5/15/2019. Statement regarding removed action is due by 5/30/2019. Joint Status Report regarding removed action is due by 6/14/2019. (Copies have been distributed pursuant to the NEF – JM) (Entered: 05/15/2019)
05/21/2019	4	MOTION to Dismiss by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. Responses due by 6/4/2019. (Attachments: # 1 Exhibit, # 2 Exhibit, # 3 Exhibit, # 4 Exhibit, # 5 Exhibit) (Balkenbush, Colby) (Entered: 05/21/2019)
05/24/2019	5	MOTION to Remand to State Court by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. Responses due by 6/7/2019. (Attachments: # 1 Declaration of Kristen T. Gallagher, Esq.) (Gallagher, Kristen) (Entered: 05/24/2019)
05/28/2019	6	CERTIFICATE OF SERVICE for 3 Minute Order Removal Case, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. (Balkenbush, Colby) (Entered: 05/28/2019)
05/29/2019	7	CERTIFICATE of Interested Parties by Fremont Emergency Services (Mandavia), Ltd.. There are no known interested parties other than those participating in the case (Gallagher, Kristen) (Entered: 05/29/2019)
05/30/2019	8	STATEMENT REGARDING REMOVAL by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. (Balkenbush, Colby) (Entered: 05/30/2019)
05/31/2019	9	RESPONSE to 8 Statement in Removal Case, by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2)(Gallagher, Kristen) (Entered: 05/31/2019)
06/03/2019	10	**VIEW 12 corrected image re** STIPULATION FOR EXTENSION OF TIME (First Request) re 4 Motion to Dismiss, 5 Motion to Remand to State Court by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Gallagher, Kristen) (Entered: 06/03/2019)
06/04/2019	11	CLERK'S NOTICE. Attorney Action Required to ECF No. 10 . Document is not in compliance with LR IA 6–2 as it does not contain a signature block for the Judge. Counsel is advised to correct the deficiency and file a *Notice of Corrected Image/Document* and link to 10 . **(no image attached)** (DKJ) (Entered: 06/04/2019)
06/04/2019	12	NOTICE of Corrected Image/Document re 10 Stipulation by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Service of corrected image is attached.) (Gallagher, Kristen) (Entered: 06/04/2019)
06/04/2019	13	ORDER granting 10 Stipulation; Re: 4 Motion to Dismiss, 5 Motion to Remand to State Court. Responses for 4 Motion due by 6/18/2019. Responses for 5 Motion due by 6/21/2019. Signed by Judge Jennifer A. Dorsey on 6/4/2019. (Copies have been distributed pursuant to the NEF – JM) (Entered: 06/05/2019)
06/05/2019	14	MOTION to Stay Case by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Attachments: # 1 Exhibit 1) (Gallagher, Kristen) (Entered: 06/05/2019)

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06/06/2019	15	RESPONSE to 14 Motion to Stay Case by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. Replies due by 6/13/2019. (Balkenbush, Colby) (Entered: 06/06/2019)
06/10/2019	16	REPLY to 15 Response **re 14 Motion to Stay Case**, by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Gallagher, Kristen) Modified docket entry relationship on 6/10/2019 (DKJ). (Entered: 06/10/2019)
06/11/2019	17	MINUTE ORDER IN CHAMBERS of the Honorable Judge Jennifer A. Dorsey on 6/11/2019. Re: 14 Motion to Stay Case. Plaintiff Fremont Emergency Services (Mandavia) Ltd. moves to stay all proceedings in this case except for its motion to remand 5 , which it seeks to have expedited. But Fremont just stipulated with defendants to extend the briefing schedule on its motion to remand [10, 12] and the court granted the requested extension 13 . Fremont has not shown good cause to now contract that briefing schedule. Accordingly, Fremont's motion to expedite the briefing schedule on its motion remand is DENIED and Fremont's motion to stay all proceedings in this case except for its remand motion is REFERRED to Magistrate Judge Ferenbach. (Copies have been distributed pursuant to the NEF – CH) (Entered: 06/11/2019)
06/14/2019	18	Joint STATUS REPORT by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Gallagher, Kristen) (Entered: 06/14/2019)
06/18/2019	19	RESPONSE to 4 Motion to Dismiss, by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. Replies due by 6/25/2019. (Perach, Amanda) (Entered: 06/18/2019)
06/19/2019	20	RESPONSE to 14 Motion to Stay Case by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. Replies due by 6/26/2019. (Attachments: # 1 Exhibit) (Balkenbush, Colby) (Entered: 06/19/2019)
06/21/2019	21	RESPONSE to 5 Motion to Remand to State Court by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. Replies due by 6/28/2019. (Attachments: # 1 Exhibit, # 2 Exhibit, # 3 Exhibit, # 4 Exhibit, # 5 Exhibit, # 6 Exhibit, # 7 Exhibit, # 8 Exhibit) (Balkenbush, Colby) (Entered: 06/21/2019)
06/24/2019	22	First MOTION to Extend Time (First Request) re 4 Motion to Dismiss, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. (Attachments: # 1 Exhibit, # 2 Exhibit) (Balkenbush, Colby) (Entered: 06/24/2019)
06/25/2019	23	CLERK'S NOTICE Regarding Local Rule IC 5−1(b). ECF No. 22 was not filed pursuant to LR IC 5−1(b). Please note the signatory must be the attorney or pro se party who electronically files the document. No further action is required concerning this document at this time. **(no image attached)** (DKJ) (Entered: 06/25/2019)
06/26/2019	24	REPLY to Response to 14 Motion to Stay Case by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Gallagher, Kristen) (Entered: 06/26/2019)
06/27/2019	25	ORDER denying 14 Motion to Stay Case; Discovery Plan/Scheduling Order due by 7/26/2019. Signed by Magistrate Judge Cam Ferenbach on 6/27/2019. (Copies have been distributed pursuant to the NEF – JM) (Entered: 06/28/2019)
06/28/2019	26	REPLY to Response to 5 Motion to Remand to State Court by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Attachments: # 1 Exhibit A, # 2 Exhibit B) (Perach, Amanda) (Entered: 06/28/2019)
07/01/2019	27	MINUTE ORDER IN CHAMBERS of the Honorable Judge Jennifer A. Dorsey on 7/1/2019. Re 22 Defendants' Motion for Extension of Time to File Reply. Good cause appearing, IT IS HEREBY ORDERED that the Defendants' Motion for Extension of Time to File Reply 22 is GRANTED. The deadline for the reply in support of the motion to dismiss 4 is extended to July 2, 2019.**(no image attached)** (Copies have

		been distributed pursuant to the NEF – CS) (Entered: 07/01/2019)
07/02/2019	28	REPLY to Response to 4 Motion to Dismiss, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. (Balkenbush, Colby) (Entered: 07/02/2019)
07/26/2019	29	PROPOSED Discovery Plan/Scheduling Order by Plaintiff Fremont Emergency Services (Mandavia), Ltd. (Gallagher, Kristen) (Entered: 07/26/2019)
10/21/2019	30	STIPULATION for Protective Order; filed by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Gallagher, Kristen) (Entered: 10/21/2019)
10/22/2019	31	ORDER granting 30 Stipulated Protective Order; Signed by Magistrate Judge Cam Ferenbach on 10/22/2019. (Copies have been distributed pursuant to the NEF – JM) (Entered: 10/22/2019)
10/30/2019	32	MOTION for Leave to File Amended Complaint; filed by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Attachments: # 1 Exhibit 1) (Gallagher, Kristen) Modified on 10/30/2019 (RFJ). (Entered: 10/30/2019)
11/11/2019	33	STIPULATION FOR EXTENSION OF TIME (First Request) *to Extend Deadline for Defendants to File Their Opposition and for Plaintiff to File Its Reply* re 32 Motion for Leave to File Document by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. (Balkenbush, Colby) (Entered: 11/11/2019)
11/12/2019	34	ORDER granting 33 Stipulation; Re: 32 Motion for Leave to File Document. Responses due by 11/20/2019. Replies due by 12/6/2019. Signed by Magistrate Judge Cam Ferenbach on 11/12/2019. (Copies have been distributed pursuant to the NEF – JM) (Entered: 11/12/2019)
11/20/2019	35	RESPONSE to 32 Motion for Leave to File Document by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. Replies due by 11/27/2019. (Balkenbush, Colby) (Entered: 11/20/2019)
12/06/2019	36	REPLY to Response to 32 Motion for Leave to File Document by Plaintiff Fremont Emergency Services (Mandavia), Ltd.. (Attachments: # 1 Exhibit 1, # 2 Exhibit 1–A, # 3 Exhibit 1–B) (Gallagher, Kristen) (Entered: 12/06/2019)
12/18/2019	37	ORDER Setting Hearing on 32 MOTION for Leave to File Amended Complaint. Motion Hearing set for 1/6/2020 at 03:00 PM in LV Courtroom 3D before Magistrate Judge Cam Ferenbach. Signed by Magistrate Judge Cam Ferenbach on 12/18/2019. (Copies have been distributed pursuant to the NEF – JM) (Entered: 12/18/2019)
01/03/2020	38	MOTION for Leave to File *Notice of Supplemental Authority in Support of Defendants' Arguments in Opposition to Plaintiff's Motion to Remand and in Support of Defendants' Motion to Dismiss* re 4 Motion to Dismiss, 5 Motion to Remand to State Court by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company. (Attachments: # 1 Exhibit 1) (Llewellyn, Brittany) (Entered: 01/03/2020)
01/06/2020	39	MINUTES OF PROCEEDINGS – Hearing re motion for leave to file amended complaint 32 held on 1/6/2020 before Magistrate Judge Cam Ferenbach. Crtrm Administrator: *J. Ries*; Pla Counsel: *Patricia Lundvall and Kristen Gallagher*; Def Counsel: *D. Roberts*; Recording start and end times: *2:50 – 3:58*; Courtroom: *3D*; The court canvasses and hears representations and arguments from the parties. ORDERED motion to dismiss 4 and motion to remand are both DENIED without prejudice; motion for leave to file amended complaint 32 is GRANTED; proposed discovery plan and scheduling order 29 is VACATED; and motion for leave to file supplemental authority 38 is DENIED as moot. FURTHER ORDERED amended complaint and new motion to remand are both due by 1/15/20. The parties are to submit a proposed discovery plan and scheduling order by 1/15/20. **(no image attached)** (Copies have been distributed pursuant to the NEF – JAR) (Entered: 01/07/2020)

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01/07/2020	40	First AMENDED COMPLAINT with Jury Demand against All Defendants by Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C., Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine. Adds new parties. Proof of service due by 4/6/2020. (Lundvall, Patricia) (Entered: 01/07/2020)
01/07/2020	41	PROPOSED SUMMONS to be issued *to UnitedHealth Group, Inc.* by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. (Lundvall, Patricia) (Entered: 01/07/2020)
01/07/2020	42	Summons Issued as to Unitedhealth Group, Inc. (JM) (Entered: 01/07/2020)
01/07/2020	43	MOTION for Extension of Time to Submit Responses and Objections to Plaintiff's Written Discovery Requests (First Requested Extension) by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. Responses due by 1/21/2020. (Attachments: # 1 Exhibit, # 2 Exhibit) (Balkenbush, Colby) (Entered: 01/07/2020)
01/07/2020	44	**VIEW 46 corrected image re** MOTION to Stay the Deadline to Respond to Plaintiff's Written Discovery Requests Pending the Court's Decision on Defendants' Motion for Extension of Time to Submit Responses and objections to Plaintiff's Written Discovery Requests re 43 Motion,, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. Responses due by 1/21/2020. (Attachments: # 1 Exhibit) (Balkenbush, Colby) Modified on 1/8/2020 (DKJ). (Entered: 01/07/2020)
01/08/2020	45	CLERK'S NOTICE. Attorney Action Required to ECF No. 44 . Page 8, the Certificate of Service, is not signed or dated. Counsel is advised to correct the deficiency and file a *Notice of Corrected Image/Document* and link to 44 . **(no image attached)** (DKJ) (Entered: 01/08/2020)
01/08/2020	46	NOTICE of Corrected Image/Document re 44 Motion,, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. (Service of corrected image is attached.) (Attachments: # 1 Exhibit) (Balkenbush, Colby) (Entered: 01/08/2020)
01/15/2020	47	TRANSCRIPT of Proceedings, 39 Motion Hearing, held on 1/6/2020, before Magistrate Judge Cam Ferenbach. Court (Reporter) Transcriber: Amber McClane, AM@nvd.uscourts.gov. Any Redaction Request is due by 2/5/2020. Redacted Transcript Deadline is set for 2/15/2020. Release of the Transcript Restriction is set for 4/14/2020. Before release date, the transcript may be viewed at the court public terminal or purchased through the court reporter. The Transcript Order Form is available on the court website. After that date, the transcript may be obtained through the court reporter or PACER. (AMM) (Entered: 01/15/2020)
01/15/2020	48	Joint Proposed Discovery Plan and Scheduling Order re 39 Miscellaneous Hearing,,, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. (Gallagher, Kristen) (Entered: 01/15/2020)
01/15/2020	49	Amended MOTION to Remand to State Court re 39 Miscellaneous Hearing,,, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. Responses due by 1/29/2020. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2) (Gallagher, Kristen) (Entered: 01/15/2020)
01/17/2020	50	STIPULATION FOR EXTENSION OF TIME (First Request) *to File Motion to Dismiss* by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. (Balkenbush, Colby) (Entered: 01/17/2020)

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01/17/2020	53	ORDER Setting Hearing on 48 Joint Proposed Discovery Plan and Scheduling Order. Motion Hearing set for 2/12/2020 at 03:00 PM in LV Courtroom 3D before Magistrate Judge Cam Ferenbach. Signed by Magistrate Judge Cam Ferenbach on 1/17/2020. (Copies have been distributed pursuant to the NEF – JM) (Entered: 01/21/2020)
01/21/2020	51	MINUTE ORDER IN CHAMBERS of the Honorable Judge Jennifer A. Dorsey on 1/21/2020. With good cause appearing, the Honorable Judge Jennifer A. Dorsey recuses herself in this action. IT IS ORDERED that this action is referred to the Clerk for random reassignment of this case for all further proceedings. **(no image attached)** (Copies have been distributed pursuant to the NEF – CS) (Entered: 01/21/2020)
01/21/2020	52	CLERK'S NOTICE that this case is randomly reassigned to Judge James C. Mahan for all further proceedings. All further documents must bear the correct case number **2:19–cv–00832–JCM–VCF. (no image attached)** (DKJ) (Entered: 01/21/2020)
01/21/2020	54	RESPONSE to 43 Motion,, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. Replies due by 1/28/2020. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3, # 4 Exhibit 4, # 5 Exhibit 5 and 5–A, # 6 Exhibit 6) (Gallagher, Kristen) (Entered: 01/21/2020)
01/21/2020	55	RESPONSE to 44 Motion,, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. Replies due by 1/28/2020. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2) (Gallagher, Kristen) (Entered: 01/21/2020)
01/21/2020	56	OBJECTION/APPEAL Magistrate Judge order or ruling under LR IB 3–1 re 39 Miscellaneous Hearing,,, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. Responses due by 2/4/2020. (Attachments: # 1 Exhibit 1) (Balkenbush, Colby) (Entered: 01/21/2020)
01/22/2020	57	CLERK'S NOTICE. Attorney Action Required to ECF No. 54 . Document was not filed pursuant to LR IC 2–2(b). For each type of relief requested or purpose, a separate document must be filed. Counsel is advised to file **ONLY** the Countermotion and any other requests located in ECF No. 54 as a separate entries to be in compliance with LR IC 2–2(b) and LR IC 2–2(c) by filing separate documents for each request or purpose. **DO NOT refile the response.** **(no image attached)** (DKJ) (Entered: 01/22/2020)
01/22/2020	58	Counter MOTION to Compel re 54 Response, 43 Motion,, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. Responses due by 2/5/2020. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3, # 4 Exhibit 4, # 5 Exhibit 5, # 6 Exhibit 6) (Gallagher, Kristen) (Entered: 01/22/2020)
01/23/2020	59	Unopposed MOTION for Leave to File Excess Pages re 40 Amended Complaint, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. (Balkenbush, Colby) (Entered: 01/23/2020)
01/24/2020	60	ORDER granting 59 Motion for Leave to File Excess Pages. Signed by Judge James C. Mahan on 1/24/2020.(Copies have been distributed pursuant to the NEF – JM) (Entered: 01/24/2020)
01/28/2020	61	REPLY to Response to 43 Motion,, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. (Balkenbush, Colby) (Entered: 01/28/2020)
01/28/2020	62	RESPONSE to 58 Motion to Compel, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. Replies due by 2/4/2020. (Balkenbush, Colby) (Entered: 01/28/2020)

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01/28/2020	63	REPLY to Response to 44 Motion,, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. (Balkenbush, Colby) (Entered: 01/28/2020)
01/29/2020	64	RESPONSE to 49 Motion to Remand to State Court, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. Replies due by 2/5/2020. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3, # 4 Exhibit 4, # 5 Exhibit 5, # 6 Exhibit 6, # 7 Exhibit 7, # 8 Exhibit 8) (Balkenbush, Colby) (Entered: 01/29/2020)
01/30/2020	65	ORDER re 43 Motion for Extension of Time, 44 Motion to Stay, 58 Countermotion to Compel. Motions Hearing set for 2/12/2020 at 03:00 PM in LV Courtroom 3D. Signed by Magistrate Judge Cam Ferenbach on 1/30/2020. (Copies have been distributed pursuant to the NEF – MR) (Entered: 01/30/2020)
02/03/2020	66	ORDER granting 50 Stipulation; Motion to Dismiss due by 2/4/2020. Signed by Judge James C. Mahan on 2/3/2020. (Copies have been distributed pursuant to the NEF – JM) (Entered: 02/03/2020)
02/04/2020	67	SUMMONS Returned Executed by Team Physicians of Nevada–Mandavia, P.C., Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd. re 42 Summons Issued. Unitedhealth Group, Inc. served on 1/15/2020. (Gallagher, Kristen) (Entered: 02/04/2020)
02/04/2020	68	REPLY to Response to 58 Motion to Compel, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2) (Gallagher, Kristen) (Entered: 02/04/2020)
02/04/2020	69	RESPONSE to 56 Objection/Appeal Magistrate Judge Order/Ruling LR IB 3–1, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. Replies due by 2/11/2020. (Perach, Amanda) (Entered: 02/04/2020)
02/04/2020	70	MOTION to Dismiss 40 Amended Complaint, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. Responses due by 2/18/2020. Discovery Plan/Scheduling Order due by 3/20/2020. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3, # 4 Exhibit 4, # 5 Exhibit 5, # 6 Exhibit 6) (Balkenbush, Colby) NOTICE of Certificate of Interested Parties requirement: Under Local Rule 7.1–1, a party must immediately file its disclosure statement with its first appearance, pleading, petition, motion, response, or other request addressed to the court. (Entered: 02/04/2020)
02/05/2020	71	REPLY to Response to 49 Motion to Remand to State Court, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. (Attachments: # 1 Exhibit 1) (Gallagher, Kristen) (Entered: 02/05/2020)
02/12/2020	73	MINUTES OF PROCEEDINGS – Hearing re motion for extension of time 43 , motion to stay 44 , joint proposed discovery plan and scheduling order 48 and counter motion to compel 58 held on 2/12/2020 before Magistrate Judge Cam Ferenbach. Crtrm Administrator: *J. Ries*; Pla Counsel: *Kristen Gallagher and Amanda Perach*; Def Counsel: *Colby Balkenbush and D. Roberts*; Recording start and end times: *3:02 – 4:02*; Courtroom: *3D*; The court canvasses and hears representations and arguments from the parties. ORDERED motion for extension of time 43 is GRANTED; motion to stay 44 is DENIED as moot; joint proposed discovery plan and scheduling order 48 is GRANTED IN PART to the extent the dispositive motions deadline will be 12/15/20 and the parties will submit another proposed discovery plan and scheduling order by 2/19/20; and counter motion to compel 58 is DENIED without prejudice. **(no image**

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		attached) (Copies have been distributed pursuant to the NEF – JAR) (Entered: 02/13/2020)
02/13/2020	72	CERTIFICATE of Interested Parties by Unitedhealth Group, Inc.. There are no known interested parties other than those participating in the case (Balkenbush, Colby) (Entered: 02/13/2020)
02/18/2020	74	TRANSCRIPT of Proceedings, 73 Motion Hearing held on 2/12/2020, before Magistrate Judge Cam Ferenbach. Court Reporter/Transcriber: Exceptional Reporting Services, Inc.. Recording start and end times: 3:02 p.m. to 4:01 p.m.. Any Redaction Request is due by 3/10/2020. Redacted Transcript Deadline is set for 3/20/2020. Release of the Transcript Restriction is set for 5/18/2020. Before release date, the transcript may be viewed at the court public terminal or purchased through the reporter/transcriber. Transcript Order form is available on court website. After that date it may be obtained through the court reporter or PACER. (AVB) (Entered: 02/18/2020)
02/18/2020	75	STIPULATION FOR EXTENSION OF TIME (First Request) *to File Response and Reply* re 70 Motion to Dismiss,,, by Defendants Health Plan Of Nevada, Inc., Oxford Health Plans, Inc., Sierra Health Care Options, Inc., Sierra Health and Life Insurance Company, Inc., UMR, Inc., United Health Care Services Inc., United Healthcare Insurance Company, Unitedhealth Group, Inc.. (Llewellyn, Brittany) (Entered: 02/18/2020)
02/19/2020	76	ORDER granting 75 Stipulation; Re: 70 Motion to Dismiss. Responses due by 2/25/2020. Replies due by 3/3/2020. Signed by Judge James C. Mahan on 2/19/2020. (Copies have been distributed pursuant to the NEF – JM) (Entered: 02/19/2020)
02/19/2020	77	First STIPULATION FOR EXTENSION OF TIME (First Request) re Discovery *Plan and Scheduling Order Submission* re 73 Miscellaneous Hearing,,,, by Plaintiffs Crum, Stefanko and Jones, Ltd., Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada–Mandavia, P.C.. (Gallagher, Kristen) (Entered: 02/19/2020)
02/20/2020	78	ORDER granting 49 Amended Motion to Remand to State Court. Signed by Judge James C. Mahan on 2/20/2020.(Copies have been distributed pursuant to the NEF, cc: Certified Docket to State Court – JM) (Entered: 02/20/2020)

I hereby attest and certify on 2-20-2020 that the foregoing document is a full, true and correct copy of the original on file in my legal custody.

CLERK, U.S. DISTRICT COURT
DISTRICT OF NEVADA

By _____ Deputy Clerk

CLERK, U.S. DISTRICT COURT
DISTRICT OF NEVADA
LLOYD D. GEORGE U.S. COURTHOUSE
333 LAS VEGAS BLVD. SO. – RM 1334
LAS VEGAS, NV 89101

OFFICIAL BUSINESS

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8th Judicial District Court
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89155

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Steven D. Grierson
CLERK OF THE COURT

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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: 27

NOTICE OF ENTRY OF ORDER RE: REMAND

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PLEASE TAKE NOTICE that an Order granting Plaintiffs' amended motion to remand was entered in the United States District Court, District of Nevada on February 20, 2020 (ECF No. 78), a copy of which is attached hereto as Exhibit 1.

DATED this 27th day of February, 2020.

McDONALD CARANO LLP

By: /s/ *Kristen T. Gallagher*

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Attorneys for Plaintiffs

000544

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 27th day of February, 2020, I caused a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER RE: REMAND** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Josephine E. Groh, Esq.
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EXHIBIT 1

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EXHIBIT 1

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

* * *

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., et al., Plaintiff(s), v. UNITEDHEALTH GROUP, INC., et al., Defendant(s).	Case No. 2:19-CV-832 JCM (VCF) ORDER

Presently before the court is plaintiffs' Fremont Emergency Services; Team Physicians of Nevada-Mandavia; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("plaintiffs") amended motion to remand. (ECF No. 49). Defendant United Healthcare Insurance Company ("United") filed a response (ECF No. 64), to which plaintiffs replied (ECF No. 71).

I. Background

Plaintiffs are professional emergency medical service groups that staff the emergency departments at hospitals and other facilities throughout Nevada. (ECF No. 40 at 5). Plaintiffs have been providing emergency services and care to patients in the emergency department, regardless of an individual's insurance coverage or ability to pay. *Id.*

United and plaintiffs have never had a written agreement governing the rates of reimbursement for emergency services rendered. *Id.* at 6. Nonetheless, plaintiffs have submitted claims to United seeking reimbursement for emergency care and United has routinely paid them.

Id. at 10. From 2008–2017, United normally paid plaintiffs at a range of 75–90%. *Id.* However, beginning in 2019, United continued to pay the claims submitted but reduced the rates of reimbursement to levels ranging from 12–60%, below the usual and customary rates. *Id.*

Plaintiffs' amended complaint asserts eight state law causes of action, all stemming from United's alleged underpayment of claims. *Id.* at 32–44. Plaintiffs originally brought suit against United in the Eighth Judicial District Court, and United timely removed the action. (ECF No. 1). Plaintiffs now move to remand the case. (ECF No. 49).

II. Legal Standard

Pursuant to 28 U.S.C. § 1441(a), "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a). "A federal court is presumed to lack jurisdiction in a particular case unless the contrary affirmatively appears." *Stock West, Inc. v. Confederated Tribes of Colville Reservation*, 873 F.2d 1221, 1225 (9th Cir. 1989).

Upon notice of removability, a defendant has thirty days to remove a case to federal court once he knows or should have known that the case was removable. *Durham v. Lockheed Martin Corp.*, 445 F.3d 1247, 1250 (9th Cir. 2006) (citing 28 U.S.C. § 1446(b)(2)). Defendants are not charged with notice of removability "until they've received a paper that gives them enough information to remove." *Id.* at 1251.

Specifically, "the 'thirty day time period [for removal] . . . starts to run from defendant's receipt of the initial pleading only when that pleading affirmatively reveals on its face' the facts necessary for federal court jurisdiction." *Id.* at 1250 (quoting *Harris v. Bankers Life & Casualty Co.*, 425 F.3d 689, 690–91 (9th Cir. 2005) (alterations in original)). "Otherwise, the thirty-day

clock doesn't begin ticking until a defendant receives 'a copy of an amended pleading, motion, order or other paper' from which it can determine that the case is removable. *Id*. (quoting 28 U.S.C. § 1446(b)(3)).

A plaintiff may challenge removal by timely filing a motion to remand. 28 U.S.C. § 1447(c). On a motion to remand, the removing defendant faces a strong presumption against removal, and bears the burden of establishing that removal is proper. *Sanchez v. Monumental Life Ins. Co.*, 102 F.3d 398, 403–04 (9th Cir. 1996); *Gaus v. Miles, Inc.*, 980 F.2d 564, 566–67 (9th Cir. 1992).

III. Discussion

As an initial matter, United bears the burden of proving that plaintiffs' complaint contains a cause of action within this court's jurisdiction. "In scrutinizing a complaint in search of a federal question, a court applies the well-pleaded complaint rule." *Ansley*, 340 F.3d at 861 (citing *Caterpillar Inc. v. Williams,* 482 U.S. 386, 392 (1987)). "For removal to be appropriate under the well-pleaded complaint rule, a federal question must appear on the face of a properly pleaded complaint." *Id.* (citing *Rivet v. Regions Bank of La.,* 522 U.S. 470, 475 (1998)).

The "well-pleaded complaint rule" governs federal question jurisdiction. This rule provides that district courts can exercise jurisdiction under 28 U.S.C. § 1331 only when a federal question appears on the face of a well-pleaded complaint. *See, e.g.*, *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). Thus, a plaintiff "may avoid federal jurisdiction by exclusive reliance on state law." *Id*. Moreover, "an anticipated or actual federal defense generally does not qualify a case for removal[.]" *Jefferson County v. Acker*, 527 U.S. 423, 431 (1999).

Although plaintiffs bring claims solely under state law, United argues that removal is proper under 28 U.S.C § 1441 based on the exception of complete preemption by § 502(a) of

ERISA. For the reasons set forth below, the court finds that defendant's asserted basis for removal is improper and grants plaintiffs' motion to remand.

"ERISA is one of only a few federal statutes under which two types of preemption may arise: conflict preemption and complete preemption." *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F. 3d 1337, 1343 (11th Cir. 2009). While conflict preemption is a defense to preempted state law claims, the doctrine does not normally allow for removal to federal court. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). On the other hand, complete preemption is a judicially recognized exception to the well-pleaded complaint rule that allows removal of claims within the scope of ERISA § 502(a) to federal court. *Davila* 542 U.S. at 209; *Marin General Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 945 (9th Cir. 2009).

In *Davila*, the Supreme Court established a two-pronged test to determine whether a state law claim is completely preempted by ERISA. *Davila*, 542 U.S. at 210. Complete preemption exists only when (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(b)," and (2) "there is no other independent legal duty that is implicated by a defendant's actions." *Id.* at 210. The test is conjunctive; a claim is completely preempted only if both prongs are satisfied. *Marin*, 581 F.3d at 947.

Under prong 1 of the *Davila* test, the Ninth Circuit has distinguished between claims involving the "right to payment" and claims involving the proper "amount of payment." *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc*., 187 F.3d 1045, 1051 (9th Cir. 1999). Claims involving the "right to payment" generally fall within the scope of § 502(a)(1)(b), while claims involving the "amount of payment" generally fall outside the scope of § 502(a)(1)(b). *Id.*

Although *Blue Cross* preceded *Davila*, the Ninth Circuit has expressly found that its analysis and holding are consistent with the *Davila* framework and remain good law. *Marin*, 581 F.3d at 948.

Here, plaintiffs allege claims disputing the amount of payment from United. (ECF No. 40). They do not contend they are owed an additional amount from the patients' ERISA plans. *See id.* Instead, they allege these claims arise from their alleged implied-in-fact contract with United. *Id.*

United attempts to distinguish the implied-in-fact contract from other types of contracts referenced in the case law. (ECF No. 64). However, Nevada courts have found that implied-in-fact agreements and express agreements have the same legal effects. *See Magnum Opes Constr. v. Sanpete Steel Corp.,* 2013 WL 7158997 (Nev. 2013); *Certified Fire Prot. Inc. v. Precision Constr*., 283 P. 3d 250, 256 (Nev. 2012).

Consequently, the court finds that plaintiffs' claims fall outside the scope of § 502(a) of ERISA, failing prong 1 of the *Davila* test. No further analysis under *Davila* is necessary. Plaintiffs' motion to remand is granted.

Additionally, while plaintiffs correctly indicate that 28 U.S.C § 1447(c) allows the court to impose attorney's fees and costs on a party who improperly removes a case to federal court, "Congress has unambiguously left the award of fees to the discretion of the district court." *Gotro v. R & B Realty Group*, 69 F.3d 1485, 1487 (9th Cir. 1995) (*citing Moore v. Permanente Medical Group*, 981 F.2d 443, 446 (9th Cir. 1992). There was a reasonable dispute concerning whether the complete preemption exception under ERISA § 502 applied to the claims. Therefore, the court declines to award attorney's fees to the plaintiffs.

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IV. Conclusion

Accordingly,

IT IS HEREBY ORDERED, ADJUDGED, and DECREED that plaintiffs' amended motion to remand (ECF No. 49) be, and the same hereby is, GRANTED.

IT IS FURTHER ORDERED that the matter of *Fremont Emergency Services (Mandavia), Ltd. v. United Healthcare Insurance Company et al.,* case number 2:19-cv-00832-JCM-VCF, be, and the same hereby is, REMANDED to the Eighth Judicial District Court.

The clerk shall close the case accordingly.

DATED February 20, 2020.

James C. Mahan

UNITED STATES DISTRICT JUDGE

23

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: 27 **HEARING REQUESTED** **DEFENDANTS' MOTION TO DISMISS**

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Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Co., Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants") hereby move to dismiss the claims asserted in Fremont's ("Plaintiff" or "Fremont") April 15, 2019 Complaint ("Complaint") with prejudice, pursuant to the doctrines of ERISA conflict preemption and complete preemption as well as pursuant to Nev. R. Civ. P. 12(b)(5) for failure to state a claim upon which relief can be granted.

I. INTRODUCTION[1]

Fremont is a for profit out-of-network medical provider. Defendants administer health plans whose members have received medical treatment from Fremont. Fremont alleges that the health plans have underpaid Fremont for medical services rendered to plan members, and seeks to compel the plans to pay Fremont at what it suggests is the "usual and customary rate"—without any regard to the explicit terms of the plans. To achieve its goal of forcing all of the plans to pay the same inflated rates, Fremont has brought a raft of deficient and improper state

[1] Defendants removed this case to federal court on May 14, 2019. While this case was in federal court, Fremont filed a motion to amend the complaint, which was granted. Fremont then filed a First Amended Complaint in federal court on January 7, 2020 that added two additional plaintiffs, one additional defendant and a Nevada RICO claim. On February 20, 2020, the federal court found that it lacked jurisdiction and remanded this matter to the Eighth Judicial District Court. "The issue of what effect is to be given to pleadings filed in federal court prior to a remand to state court is a determination for the state court." *Ayres v. Wiswall*, 112 U.S. 187, 190-91 (1884). While Nevada has not yet taken a position on this issue, logically the proceedings must now stand in the same posture they were in just prior to the filing of the May 14, 2019 Notice of Removal. As a result, all of the filings and actions taken by the federal court prior to the remand order should be deemed void, as that court found that it lacked jurisdiction all along. Other state courts who have addressed the issue agree. *See e.g., NCS Healthcare of Arkansas, Inc. v. W.P. Malone, Inc.*, 350 Ark. 520, 526, 88 S.W.3d 852, 856 (2002) ("[A]fter remand from federal court, a case stands as if it had never been removed from state court, and what happened in federal court has no bearing on the proceeding in state court."). Thus, since the only complaint on file with this Court is Fremont's April 15, 2019 Complaint, Defendants have responded to that Complaint only. However, if this Court disagrees that the actions taken by the federal court are void, Defendants request that they be given an opportunity to respond to the additional cause of action and allegations in Fremont's First Amended Federal Court Complaint and do not intend to waive any rights, arguments, counterclaims, and/or defenses by currently only responding to Fremont's April 15, 2019 State Court Complaint.

law claims.

However, all seven of Fremont's claims suffer from the same defect—they relate to employee benefit plans and are thus preempted by the Employee Retirement Income Security Act ("ERISA"). ERISA's comprehensive scheme regulates employee benefit plans and provides the exclusive civil enforcement mechanism to deal with disputes related to these plans. State law claims that relate to an ERISA plan or that supplement or duplicate a federal claim that could have been brought under ERISA are subject to dismissal based on ERISA's expansive preemption reach. Thus, as detailed in this Motion, Fremont's state law claims must be dismissed with prejudice.

There are two types of preemption under ERISA—conflict preemption and complete preemption. Under conflict preemption, a state law claim is subject to dismissal if it "relates to" an employee benefit plan governed by ERISA. ERISA's conflict preemption clause (29 U.S.C. § 1144(a)) has been called "one of the broadest preemption clauses ever enacted by Congress" and characterized as "clearly expansive." Under complete preemption, on the other hand, a state law claim is subject to dismissal if the plaintiff (1) could have brought a federal claim under ERISA and (2) no independent legal duty is implicated by the defendant's actions. Both types of preemption apply here, and both are fatal to Fremont's state law claims.

Allowing Fremont's state law claims to proceed would directly undermine the congressional intent behind ERISA—creating a uniform administrative scheme for all 50 states that guides the processing of claims and disbursement of benefits for employee health plans. Fremont is challenging the amount that it received on more than 10,000 separate health plan benefit claims it submitted to Defendants for payment, and is seeking to use state law claims to force the plans to pay more. But the health plans at issue—virtually all of which are governed by ERISA—independently set the benefit rates that each plan promises to pay. And ERISA's expansive preemptive reach does not permit a plaintiff to use state law claims to effectively rewrite the plans by superimposing on them some different, uniformly higher payment rate requirement that is inconsistent with plan terms. Such claims are conflict preempted because they directly "relate to" ERISA plans. And such claims are completely preempted because they

can and must be pursued as claims for benefits under ERISA Section 502(a)(1)(b), pursuant to which the Court can assess whether each challenged payment was consistent with the terms of the applicable plan.

Fremont will attempt to argue that its claims are not preempted because this is a "rate of payment" case rather than a "right to payment" case. However, Fremont's reliance on that purported distinction is wrong, as it only applies to situations where a plan or its agent *affirmatively promised* to pay some benefit rate that is different than the rates set by the plan, as may be the case with a network contract or oral promise that then serves as an independent source of legal obligation. This case does not fall into these categories: Fremont *admits* that it lacks a written contract, oral promise, or even a state statute setting benefit rates. The applicable employee benefit plans are the *only* documents that set forth the required rate of payment to Fremont, and ERISA does not permit Fremont to use state law claims to circumvent plan terms.

Moreover, to the extent a small number of the plans at issue, such as Affordable Care Act Exchange products, may not be governed by ERISA, such claims still must be dismissed as Fremont fails to allege viable state law claims for causes of actions under Rule 12(b)(5).

For all these reasons and those set forth below, Defendants request that the Court dismiss Fremont's state law claims in their entirety and with prejudice. However, Fremont should be given leave to replead its claims as statutory ERISA claims pursuant to 29 U.S.C. § 1132(a), subject to any defenses Defendants may have to such a claim.

II. NEARLY ALL OF FREMONT'S CLAIMS RELATE TO EMPLOYER SPONSORED ERISA PLANS AND ARE THUS SUBJECT TO PREEMPTION

When considering a motion to dismiss, the general rule is that a court is limited to reviewing the allegations in the Complaint and should not consider outside evidence. However, there is an exception to this rule where the defendant raises a defense of preemption. In that circumstance, the court may consider evidence outside the complaint showing that the claims relate to employee benefit plans governed by ERISA.[2] The purpose of this exception to the

[2] *Densmore v. Mission Linen Supply*, 164 F. Supp. 3d 1180, 1188, n. 2 (E.D. Cal. 2016).

general rule is to prevent plaintiffs, like Plaintiff here, from attempting to thwart congressional intent that ERISA provide the exclusive remedy for these types of claims through artful pleading.

Plaintiff's Complaint fails to identify any of the specific claims at issue, including failing to identify who was treated, on what date, and pursuant to which health plan. Instead,, all the Complaint identifies is the general time frame during which Plaintiff allegedly provided medical services to Defendants' members and submitted claims/requests for processing and adjudication to Defendants. *See* Compl. at ¶¶ 19-20, 25. Despite this, Defendants have determined that nearly all of the at-issue claims relate to ERISA-governed employee benefit plans and are thus conflict preempted.

During the time frames alleged in the Complaint, Plaintiff made claims/requests for payment to the following Defendants: UHIC, UHS, UMR, Oxford, SHL, HPN, and SHO. For the tens of thousands of claims that Plaintiff submitted to UHIC, UHS and UMR, based on the known information, all but one of the claims were made against ERISA-governed plans.[3] For the claims made against Oxford and SHO, all of the claims were made against ERISA governed plans.[4] For the claims made against SHL, approximately 72% of the claims were made against ERISA-governed plans.[5] For the claims made against HPN, approximately 84% of the claims were made against ERISA-governed plans.[6] In sum, over 90% of Plaintiff's claims in the relevant period were for services provided to members of ERISA-governed plans.

Furthermore, for all of the claims that Plaintiff is asserting in this litigation, Plaintiff represented that it received assignments of benefits from its patients that, if valid, would allow Plaintiff to sue under ERISA by standing in the shoes of each patient and asserting claims for

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[3] **Exhibit 1** at ¶ 7 (UHIC, UHS and UMR Declaration).

[4] **Exhibit 2** at ¶ 7 (Oxford Declaration); **Exhibit 3** at ¶ 7 (SHO Declaration).

[5] **Exhibit 4** at ¶ 7 (SHL and HPN Declaration).

[6] *Id.* at ¶ 8.

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benefits seeking additional reimbursement under the terms of the plans.[7] As discussed in more detail below, these assignments of benefits are critical because they render Plaintiff the type of party, under the *Davila* test discussed in Section IV, that can assert a claim under ERISA § 502(a)(1)(B), ERISA's civil enforcement statute, causing Plaintiff's state law claims to be completely preempted.

III. LEGAL STANDARD FOR CONFLICT PREEMPTION UNDER ERISA

A. The ERISA Preemption Clause, Saving Clause and Deemer Clause

The Employee Retirement Income Security Act ("ERISA") is a federal legislative scheme that "comprehensively regulates" employee benefit plans. 29 U.S.C. § 1001(b); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). ERISA comprehensively regulates, among other things, employee benefit plans that, "through the purchase of insurance or otherwise . . . [provide] medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, [or] death." 29 U.S.C. § 1002(1).

To ensure that plans and plan administrators would be subject to a uniform body of benefit laws, Congress capped off ERISA with three provisions relating to the preemptive effect of the federal legislation, which are set forth below:

1.) "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws[8] insofar as they may now or hereafter **relate to** any employee benefit plan . . .". 29 U.S.C. § 1144(a) (pre-emption clause) (emphasis added).[9]

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[7] *See* **Exhibit 1** at ¶ 7 (UHIC, UHS and UMR Declaration), **Exhibit 4** at ¶¶ 7-8 (SHL and HPN Declaration); **Exhibit 2** at ¶ 7 (Oxford Declaration); **Exhibit 3** at ¶ 7 (SHO Declaration); *See also* **Exhibit 5** (sample claims forms to UMR during the 2017-2019 time period showing Box 27 "Accept Assignment" checked "YES"); **Exhibit 6** (sample claim forms to SHO during the same time period). Defendants have reviewed claim forms and related data for the claims that were made to the other entities in this lawsuit and confirmed that Fremont also received an assignment of benefits for those claims but have not attached those claim forms to avoid overburdening the Court. However, those claim forms can be produced if necessary.

[8] Under ERISA, the term "state law" is defined as "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1). Thus, ERISA preempts not only state statutes but also the common law of each state.

[9] In cases discussing conflict preemption, this section is also commonly referred to as § 514(a) of ERISA.

2.) "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (saving clause).

3.) Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

The U.S. Supreme Court summarized how the above clauses work together as follows: "If a state law 'relate[s] to . . . employee benefit plan[s],' it is pre-empted. [29 U.S.C § 1144(a)] The saving clause excepts from the pre-emption clause laws that 'regulat[e] insurance.' [29 U.S.C § 1144(b)(2)A)]. The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company. [29 U.S.C. § 1144(b)(2)(B)]." *Pilot Life Ins. Co.*, 481 U.S. at 45.

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B. ERISA's "Relates to" Preemption Clause is Broad and Preempts any State Law Claim that Requires a Plan to Deviate from Plan Terms. Fremont's Claims Conflict with the Plan Documents and Would Require the Court to Essentially Rewrite Them.

The Ninth Circuit has repeatedly stated that ERISA's preemption clause is "one of the broadest preemption clauses ever enacted by Congress." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990); *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001) (calling the ERISA preemption clause "clearly expansive.").[10] "[A] state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Pilot Life Ins. Co.*, 481 U.S. at 47. "[T]o determine whether a state law has the forbidden connection, we

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[10] Fremont may argue in its response that the federal court has already rejected these preemption arguments when it granted Fremont's motion to remand. Such an argument would be misplaced. Although the federal court found that complete preemption did not apply when it remanded this case, the defense of conflict preemption under § 514(a) of ERISA (aka 29 U.S.C. § 1144(a)) is broader than complete preemption and thus even more likely to apply to Fremont's state law claims. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1492 (7th Cir. 1996) ("the defense of 'conflict preemption' is much broader because § 514 [of ERISA] is much broader than § 502(a).").

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look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147.

ERISA commands that a plan shall "specify the basis on which payments are made to and from the plan," 29 U.S.C. § 1102(b)(4), and that the fiduciary shall administer the plan "in accordance with the documents and instruments governing the plan," 29 U.S.C. § 1104(a)(1)(D) (emphasis added). Thus, any state law claim that would run counter to these ERISA requirements by, for example, requiring a plan administrator to make payments that are different than the payments required to be paid pursuant to the plan documents, is preempted. *Egelhoff*, 532 U.S. at 147.

Here, that is exactly what Fremont's state law claims attempt to do. Fremont is an out-of-network medical provider that alleges it provided treatment to more than 10,800 patients who were members of Defendants' health plans administered by Defendants. Compl. at ¶ 25. Fremont further alleges that the Defendants failed to adequately reimburse Fremont for these services and it seeks a judgment requiring the Defendants to "reimburse Fremont at the usual and customary rate. . . or alternatively for the reasonable value of the services provided." *Id.* at ¶¶ 23, 26, 27, 29, and subparagraphs C and D of Fremont's Request for Relief. However, each health plan at issue already provides for a particular rate of reimbursement to plan members for services received from out-of-network providers like Fremont. Thus, the remedy Fremont seeks via its seven state law claims is nothing less than a complete rewriting of the health plans at issue. Fremont is essentially asking this Court to insert the terms "usual and customary rate" and "reasonable value" into each of the controlling health plans implicated by the 10,800 at-issue claims. As explained more fully below, courts have repeatedly found that ERISA does not permit a plaintiff to use a state law claim to rewrite and/or avoid a plan's payment terms. Fremont's state law claims unquestionably "relate to" ERISA-governed health plans issued and/or administered by Defendants and are thus conflict preempted by ERISA.

C. Fremont's State Law Claims Do Not Fall Within ERISA's Saving Clause

Once it is determined that a state law claim "relates to" a benefit plan, which all of Fremont's claims do, the next question is whether the state laws at issue "regulate insurance." If they do, they are exempted from ERISA preemption under the ERISA saving clause. 29 U.S.C. § 1144(b)(2)(A).

The U.S. Supreme Court has held that two criteria should be considered in determining whether a state law falls within ERISA's saving clause. First, a court should consider whether, as a matter of "common sense," the state law is one that "regulates insurance." *Pilot Life Ins. Co.*, 481 U.S. at 48-49. Second, a court should use the McCarran-Ferguson[11] test to determine whether the state law (1) is limited to the insurance industry, (2) has the effect of transferring or spreading a policyholder's risk, and (3) involves an integral part of the relationship between the insurer and the insured. *Id.* The Nevada Supreme Court has adopted the U.S. Supreme Court's framework for assessing whether the ERISA saving clause applies and held that all three elements of the McCarran-Ferguson test must be met for the ERISA saving clause to apply. *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1082, 864 P.2d 288, 293 (1993).[12]

Here, none of Fremont's state law claims fall within the ERISA saving clause. As to Fremont's common law claims for (1) Breach of Implied-in-Fact Contract, (2) Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing, and (3) Unjust Enrichment, none of these claims can be said to regulate insurance or to be "limited to the insurance industry." Rather, such claims are applicable to a wide variety of non-insurance related commercial disputes. *See e.g., Pilot Life Ins. Co.*, 481 U.S. at 48–49 (1987) (holding that a claim for tortious breach of contract and the Mississippi law of bad faith did not "regulate insurance" and was thus

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[11] The McCarran-Ferguson Act generally permits states to regulate the "business of insurance." 15 U.S.C. § 1012(a). In determining what constitutes the "business of insurance," courts have come up with the three part McCarran-Ferguson test.

[12] Although the Nevada Supreme Court did not expressly reference Pilot Life's "Common Sense Test," other Nevada courts applying Nevada law have applied both the Common Sense Test and the McCarran-Ferguson Test. *See Brandner v. UNUM Life Ins. Co. of Am.*, 152 F. Supp. 2d 1219, 1226 (D. Nev. 2001)

preempted because "[a]ny breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages.").

In regard to Fremont's statutory claims for (1) Violation of NRS 686A.020 and 686A.310 (Nevada Unfair Trade Practices Act), (2) Violation of Nevada Prompt Pay Statutes, (3) Violation of Consumer Fraud and Deceptive Trade Practices Acts and (4) Declaratory Judgment, all of these claims fail the McCarran-Ferguson test. While the Nevada Unfair Trade Practices Act is specifically aimed at insurance companies, the Nevada Supreme Court has found that the law does not have the effect of spreading a policyholder's risk and thus does not fall within ERISA's saving clause. *Villescas*, 109 Nev. at 1083, 864 P.2d at 293.

The Nevada Prompt Pay Act does not fall under the saving clause for the same reason. "Riskspreading . . . is the pooling or averaging of policyholder's risks." *Id.* at 1082, 864 P.2d at 293; *see also* BLACK'S LAW DICTIONARY (11th ed. 2019) (defining "Risk" in the insurance context as "[t]he chance or degree of probability of loss to the subject matter of an insurance policy."). The Prompt Pay Act simply subjects an insurer to fines by the Nevada Insurance Commissioner if the insurer does not process/pay claims within a specified time frame. NRS 683A.0879(8). This does nothing to pool or average a policyholder's risks.

Finally, Nevada's Deceptive Trade Practices Act and Uniform Declaratory Judgments Act are laws of general applicability and not limited to the insurance industry. *See* NRS 598.0915 (stating that any "person" with a "business or occupation" can be liable under the Act); NRS 30.040 (allowing a declaratory judgment claim to be brought for any "deed, written contract or other writings constituting a contract."). Thus, these claims also do not fall under the ERISA saving clause and, as a result, are conflict preempted.

D. In the Alternative, ERISA's Deemer Clause also Bars Fremont's State Law Claims

Even if this Court were to find that some of Fremont's claims fall within ERISA's saving clause, *which they do not*, the claims would still be preempted by ERISA's "deemer clause." 29 U.S.C. § 1144(b)(2)(B). This clause bars enforcement of any state insurance law against self-

funded ERISA plans by mandating that these plans be "deemed" to not be insurance companies for purposes of state insurance laws and regulations. As with ERISA's "relates to" preemption clause, the U.S. Supreme Court has construed the "deemer clause" broadly, stating:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause. By forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws 'purporting to regulate insurance.' As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans . . . State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990). Here, the only state laws at issue that even purport to regulate insurance are Fremont's claims for violation of (1) the Nevada Unfair Trade Practices Act and (2) the Nevada Prompt Pay Statutes. However, even assuming, *arguendo*, that these laws would otherwise fall within ERISA's saving clause, the deemer clause prohibits them being enforced against any ERISA plans that are self-funded, which must be deemed not to be in the business of insurance. In sum, ERISA conflict preemption presents an insurmountable barrier to Fremont's state law claims.

IV. LEGAL STANDARD FOR COMPLETE PREEMPTION UNDER ERISA

A. The Doctrine of Complete Preemption and the Consequences of a Finding of Complete Preemption

The doctrine of complete preemption applies when a federal statute so completely dominates a particular area that any state law claims are converted into an action arising under federal law. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63–64, 107 S. Ct. 1542, 1546 (1987). One area where this doctrine applies is with certain claims related to employee benefit plans, such as employer-sponsored health insurance. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

As part of ERISA's comprehensive scheme, Congress created a special civil enforcement mechanism to deal with all claims related to employee benefit plans. That mechanism is set

forth in 29 U.S.C. § 1132(a)[13] and permits a "participant or beneficiary" to bring a special statutory ERISA claim over which state and federal courts have concurrent jurisdiction.[14] The statute reads as follows:

> A civil action may be brought—(1) by a participant or beneficiary— . . . (B) 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.

29 U.S.C. § 1132(a)(1)(B). The U.S. Supreme Court has found that this statute evidences congressional intent to completely preempt state law claims related to ERISA plans.

A finding of complete preemption means that the plaintiff's state law claims are barred and subject to dismissal, as the plaintiff will only be permitted to assert a statutory cause of action under 29 U.S.C. § 1132(a)(1)(B). *See Davila*, 542 U.S. at 209 ("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.").

B. Pursuant to the *Davila* Test, Plaintiff's State Law Claims Are Completely Preempted

Davila sets forth a two-prong test for determining whether a state law claim is completely preempted by ERISA's civil enforcement provision. A state law cause of action is completely preempted if (1) the plaintiff, "at some point in time, could have brought [the] claim under ERISA § 502(a)(1)(B)," and (2) "there is no other independent legal duty that is implicated by [the] defendant's actions." *Davila*, 542 U.S. at 210, 124 S. Ct. at 2496.

The *Davila* test would be undisputedly met if a plan member paid for a covered medical treatment herself, received only partial reimbursement from the plan, and then brought suit

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[13] This section is also commonly referred to as § 502(a) of ERISA.

[14] 29 U.S.C. § 1132(e)(1) (providing that a statutory ERISA claim may be brought in state or federal court).

000564

against the plan administrator seeking additional reimbursement. *Id.* at 211. This would be a clear example of a "beneficiary or participant" seeking to recover benefits under an employee benefit plan (see 29 U.S.C. § 1132(a)(1)(B)), and ERISA flatly does not permit state law claims, however labeled, to be used as a mechanism to seek additional reimbursement from a plan outside the plan's terms. The employee's exclusive remedy for seeking additional payments from an ERISA plan is a statutory ERISA claim for benefits.

The result is the same if the employee plan member assigns her claim to the medical provider and the medical provider then brings suit against the plan administrator seeking reimbursement for medical services. The Ninth Circuit has held that ERISA preempts the state law claims of a medical provider suing as the assignee of an employee's rights under an employee benefit plan governed by ERISA. *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374 (9th Cir. 1986) (upholding the dismissal of various state tort law claims and a claim under the California Unfair Insurance Practices Act as preempted by ERISA since the provider had accepted an assignment from the patients and thus had standing to bring an ERISA claim itself).

Here, just like the provider in *Misic*, Fremont is an out-of-network medical provider that provided medical services to members of health plans administered by Defendants. Compl. at ¶¶ 17-19. Fremont then requested payments from Defendants, representing that it had received assignments of the patients' plan benefits. *Id.* at ¶¶ 20, 25-26. As in *Misic*, Defendants here paid a portion of the amounts requested, but not the entire amount. *Id.*; *Misic*, 789 F.2d at 1376 ("The trust paid a portion of the amount billed, but less than the full 80%."). Fremont has now brought suit seeking additional reimbursements from the applicable health plans and, in doing so, stands in the shoes of Defendants' members.

Both elements of the *Davila* test are therefore met. The first element is met because Fremont obtained assignments that give it standing to bring ERISA claims. The fact that Fremont now self-servingly disclaims that it is suing as the assignee of Defendants' plan members is not relevant to a *Davila* analysis. The only question is whether Fremont "*could*" have brought an ERISA claim, and Fremont clearly could have done so.

Element 2 of the *Davila* test is met because Fremont is an out-of-network provider who lacks a written contract with Defendants that sets forth an agreed upon rate of payment. Compl. at ¶ 17. Thus, the only legal duties owed to Fremont (if any) flow from the terms of the applicable ERISA plans. Regardless of the labels used and Fremont's attempt at artful pleading, all of Fremont's claims are completely preempted.

V. LEGAL STANDARD FOR RULE 12(B)(5) MOTION TO DISMISS

Under NRCP 12(b)(5), this Court must dismiss a claim where the plaintiff can "prove no set of facts that would entitle him or her to relief." *Cohen v. Mirage Resorts, Inc.*, 119 Nev. 1, 22, 62 P.3d 720, 734 (2003); *see Hay v. Hay*, 100 Nev. 196, 198, 678 P.2d 672, 674 (1984) (providing that Nevada is a notice-pleading jurisdiction). A claim that fails as a matter of law on the face of the pleading warrants dismissal under NRCP 12(b)(5). *See Harrison v. Roitman*, 131 Nev. Adv. Op. 92, 362 P.3d 1138, 1139 (2015). In evaluating a motion to dismiss for failure to state a claim, the court must accept all factual allegations in the complaint as true, construe the complaint's allegations liberally, and draw all inferences in favor of the plaintiff. *See Simpson v. Mars Inc.*, 113 Nev. 188, 190, 929 P.2d 966, 967 (1997).

VI. FREMONT'S CLAIM FOR BREACH OF IMPLIED-IN-FACT CONTRACT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Courts regularly find this type of implied-in-fact contract claim subject to conflict preemption. *See Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000) (internal citation omitted) ("We have held that ERISA preempts common law theories of breach of contract implied in fact, promissory estoppel, estoppel by conduct, fraud and deceit and breach of contract.") (emphasis added); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356 (9th Cir. 1984) (breach of implied-in-fact contract claim was conflict preempted) (abrogated on other grounds in *Dytrt v. Mountain States Tel. & Tel. Co.*, 921 F.2d 889, 894, n. 4 (9th Cir. 1990); *Parlanti v. MGM Mirage*, No. 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (breach of contract claim was both conflict preempted and completely preempted).

This is supported not only by law, but by common sense. Fremont is attempting to compel thousands of different ERISA-governed plans administered by the Defendants to pay Fremont the same rate—an inflated "usual and customary rate"—without regard to the specific benefit rates established by the terms of each controlling health plan, and without any of the plans ever having agreed to pay anything other than their plan benefit rates. If, for example, a plan expressly provided that it would pay all medical claims at 150% of the benefit rate paid by Medicare, Fremont would ask the Court to apply its implied-in-fact contract logic to compel that plan to instead pay it a higher "usual and customary rate." That is a textbook case of the kind of claim that is conflict preempted. ERISA requires the Defendants to "specify the basis on which payments are made to and from [their plans]" and to administer their plans "in accordance with the documents and instruments governing the plan[s]," 29 U.S.C. § 1102(b)(4); 29 U.S.C. § 1104(a)(1)(D). Fremont's implied-in-fact contract claim "relates to" employee benefit plans and is preempted as it seeks to have this Court conduct a wholesale rewriting of those plans' payment terms. To the extent Fremont is entitled to any additional reimbursement, the amount of that reimbursement depends entirely on the rate of payment that is established by the plan documents.

B. This Claim is Subject to Complete Preemption

The *Davila* test for complete preemption is met here as (1) Fremont has standing to bring a statutory § 502(a) ERISA claim due to the assignments of benefits it received from Defendants' plan members and (2) there is no legal obligation owed by Defendants other than those created by the ERISA benefit plans since Fremont is an out-of-network provider. Compl. at ¶ 17. The case law is in accord. *Melamed v. Blue Cross of California, 557 F. App'x 659, 661 (9th Cir. 2014)* ("Melamed's breach of implied contract claim is completely preempted because through that claim, Melamed seeks reimbursement for benefits that exist "only because of [the defendant's] administration of ERISA-regulated benefit plans."); *In Re Managed Care Litig.*, 298 F. Supp. 2d at 1292 (out-of-network providers' implied-in-fact contract claim was completely

preempted); *Torrent & Ramos, M.D., P.A. v. Neighborhood Health Partnerships, Inc.*, No. 04-20858-CIV, 2004 WL 7320735, at *4 (S.D. Fla. July 1, 2004) (same).[15]

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

An implied-in-fact contract exists where the conduct of the parties demonstrates that they (1) intended to contract, (2) exchanged bargained-for promises, and (3) the terms of the bargain are sufficiently clear. *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379–80, 283 P.3d 250, 256 (2012); *Magnum Opes Const. v. Sanpete Steel Corp.*, No. 60016, 2013 WL 7158997, at *2 (Nev. Nov. 1, 2013) (unpublished).

Here, Fremont fails to state a claim as it has not sufficiently alleged any of the above three elements. Nowhere in the Complaint is there an allegation that the Defendants "intended to contract" with Fremont. Nor is there any explanation of what "promises" were exchanged between the Parties and what the terms of those promises were. Reading the Complaint in the light most favorable to Fremont, there is instead an allegation that (1) Fremont provided medical services to members of Defendants' health plans, (2) Fremont requested full reimbursement for these services from Defendants and (3) on some occasions Defendants obliged, and on other occasions Defendants did not. Compl. at ¶¶ 35, 37-40. In essence, Fremont argues that payments for some past services constitute a promise by Defendants to pay for all future services. *Id.*

The Nevada Supreme Court's decision in *Recrion Corp.* forecloses such a theory. There the Court refused to find an implied-in-fact contract where an employee provided unsolicited

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[15] Fremont may argue in response that the Nevada Federal District Court found that complete preemption does not apply to Fremont's Breach of Implied-in-Fact Contract claim in its February 20, 2020 order remanding this case to state court. However, the federal court erroneously relied on an inapplicable distinction between claims involving the "right to payment" vs. the "amount of payment." Remand Order at 4:24-28. Further, the federal court's remand order relies heavily on the "strong presumption against removal [to federal court]." *Id.* at 3:5-8. Here, unlike in the federal court proceeding, there is no presumption against complete preemption applying to Fremont's claims. Further, this Court is not required to defer to the federal court's reasoning as all orders made by the federal court are now void since it found that it lacked jurisdiction all along. *See e.g., NCS Healthcare of Arkansas, Inc. v. W.P. Malone, Inc.*, 350 Ark. 520, 526, 88 S.W.3d 852, 856 (2002) ("[A]fter remand from federal court, a case stands as if it had never been removed from state court, and what happened in federal court has no bearing on the proceeding in state court.").

000568

services to a hotel prior to having a discussion about compensation. The Court noted that its ruling would have been the same even if, after the services were provided, the hotel had promised the employee compensation. The Court held that "[p]ast consideration is the legal equivalent to no consideration" and that services cannot be subject to an implied-in-fact contract unless the contract was created "before" the services were provided. *Smith v. Recrion Corp.*, 91 Nev. 666, 669, 541 P.2d 663, 665 (1975) (emphasis added).

Here, just like in *Recrion Corp*, Fremont is attempting to force the Defendants to compensate it for unsolicited[16] services that were provided without any contract in place. Further, Fremont relies only on the past consideration of prior payments to create the alleged implied-in-fact contract—a theory that *Recrion Corp* expressly disapproved. Thus, Fremont has failed to state a claim for implied-in-fact contract and this claim should be dismissed.

Alternatively, if Fremont is attempting to rely on a state or federal statute to create the implied-in-fact contract, this theory also fails. The Complaint cites to the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, and NRS 439B.410. Compl. at ¶¶ 15, 33. However, these statutes only relate to requirements *that hospitals provide* emergency services to *patients* regardless of the patients' ability to pay. They do not require payment by *insurers* to out-of-network providers, or say anything about a required rate of payment. Thus, Fremont has failed to state a claim for implied-in-fact contract and this claim should be dismissed.

VII. FREMONT'S CLAIM FOR TORTIOUS BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Tortious breach claims are subject to conflict preemption. *Pilot Life Ins. Co.* 481 U.S. at 48–49 (claim for tortious breach of contract and the Mississippi law of bad faith were conflict preempted); *Bayona*, 223 F.3d at 1034 ("Here, Castro asserted counterclaims for breach of

[16] The Complaint does not allege that the Defendants did anything to solicit or induce Fremont to provide emergency medical services to their plan members.

000569

contract, tortious breach of the covenant of good faith and fair dealing, and fraud—all were based on common law and state causes of action, and all were preempted.") (emphasis added) (internal citation omitted); *Thrall v. Prudential Insurance Company of America*, 2005 WL 8161321, at *2 (D. Nev. Aug. 11, 2005) (finding claim for breach of duty of good faith and fair dealing preempted under ERISA). In *Pilot Life*, the U.S. Supreme Court found that (1) such a claim is subject to conflict preemption under ERISA's "relates to" preemption clause and (2) a state's tortious breach common law does not seek to "regulate insurance" and thus does not fall within ERISA's saving clause. *Pilot Life*, 481 U.S. at 48–49. There is no reason for this Court to deviate from the reasoning in that case.

B. This Claim is Subject to Complete Preemption

Like Fremont's other state law claims, this claim seeks to recover money for medical services provided to members of employee benefit plans governed by ERISA. Compl. at ¶¶ 24-26. Thus, reference to the plan is required to determine both coverage and the amount of reimbursement. This claim also attempts to "duplicate" or "supplement" the ERISA civil enforcement mechanism by seeking punitive damages against a plan administrator. Compl. at ¶ 55 and p. 16:12-13. Such claims are completely preempted. *Estate of Burgard v. Bank of America, N.A.*, 2017 WL 1273869 (D. Nev. March 31, 2017) ("[I]t is well established that breach of contract claims—whether contractual or tortious—fall within section 502(a)."); *see also Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1009 (9th Cir. 1998) ("Extracontractual, compensatory and punitive damages are not available under ERISA.") (limitation on other grounds recognized in *A.F. v. Providence Health Plan*, 157 F. Supp. 3d 899, 916 (D. Or. 2016); *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1146-47 (9th Cir. 2003) ("claim processing causes of action" which seek state law damages are "clearly" preempted under 29 U.S.C. § 1132(a)(1)(B) of ERISA).

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

The implied covenant of good faith and fair dealing only arises if a valid contract exists between Fremont and Defendants. *A.C. Shaw Const., Inc. v. Washoe Cty.*, 105 Nev. 913, 914, 784 P.2d 9, 10 (1989). Thus, as an initial matter, if the Court agrees that Fremont has failed to

allege an enforceable implied-in-fact contract it should end its analysis there and dismiss this claim.

In the alternative, even assuming that an implied-in-fact contract exists, this claim still fails. Nevada has only recognized this cause of action in two discrete circumstances—(1) a suit by an insured against its insurer where an insurer acts in bad faith in denying coverage and (2) bad faith wrongful discharge by an employer where the employee has a special relationship of trust, reliance and dependency with the employer. *U.S. Fid. & Guar. Co. v. Peterson*, 91 Nev. 617, 620, 540 P.2d 1070, 1071 (1975) (recognizing bad faith tort in insurance context); *D'Angelo v. Gardner*, 107 Nev. 704, 717, 819 P.2d 206, 215 (1991) (recognizing bad faith tort in employment context).

Critically, the Nevada Supreme Court has refused to expand this tort to contracts between sophisticated parties in the commercial realm.[17] *Aluevich v. Harrah's*, 99 Nev. 215, 216, 660 P.2d 986, 986 (1983) (holding that claim for tortious breach of the implied covenant does not extend to commercial leases between two sophisticated parties). The tort is only meant for situations where there is a "special relationship" between the parties, such as in the insured-insurer or employer-employee context. *Id.*

Here, while Fremont has alleged that there was "[a] special element of reliance or trust between Fremont and the [Defendants]," this is an entirely conclusory allegation, Compl. at ¶ 50, which is not entitled to the assumption of truth typical of more specific allegations. Nor does the Complaint contain any other allegations explaining why there would be a "special relationship" between two sophisticated parties (Fremont and Defendants) who do not even have an express written contractual relationship. *See* Compl. at ¶ 17 (admitting no written agreement exists); *see also* Compl. at ¶¶ 2, 14 (admitting that Fremont is a sophisticated "professional practice group of emergency medicine physicians" that runs major emergency rooms across the Las Vegas

[17] In addition, there is no reason to predict that the Nevada Supreme Court will expand the tort to the commercial realm anytime soon. The vast majority of jurisdictions have refused to do so. *Tort Remedies for Breach of Contract: The Expansion of Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing into the Commercial Realm*, 86 COLUM. L. REV. 377, 390 (1986) ("Most jurisdictions have refused to apply the bad faith tort to the commercial context, limiting the tort to its application in the insurance context.").

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Moreover, as explained above, even if Fremont had made more specific allegations to support this claim, it would still be subject to dismissal, as the Nevada Supreme Court has found as a matter of law that this tort does not apply to commercial contracts. *Aluevich*, 99 Nev. at 216, 660 P.2d at 986. Thus, Fremont has failed to state a plausible claim for tortious breach and this claim should be dismissed.

VIII. FREMONT'S CLAIM FOR UNJUST ENRICHMENT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Fremont's unjust enrichment claim "relates to" employee benefit plans governed by ERISA because to determine the appropriate benefit rate, the Court would need to refer to the rate of payment terms in the plans at issue. Notably, Fremont's allegations supporting its unjust enrichment claim specifically reference health plans. Compl. at ¶ 61. Courts regularly find such claims to be preempted. *Alcalde v. Blue Cross & Blue Shield of Fla., Inc.*, 62 F. Supp. 3d 1360, 1365 (S.D. Fla. 2014) (medical provider's unjust enrichment claim against plan found to be conflict preempted); *Lab. Physicians, P.A. v. AvMed, Inc.*, No. 8:08-CV-1726-T-26EAJ, 2009 WL 2486328, at *2 (M.D. Fla. Aug. 10, 2009) (same). ERISA requires that plans be administered "in accordance with the documents and instruments governing the plan[s]," 29 U.S.C. § 1104(a)(1)(D), yet Fremont seeks to use this claim to recover a different amount than it would be owed pursuant to the each plans' rate of payment terms for out-of-network providers. Thus, this claim clearly conflicts with ERISA and is preempted. Moreover, Nevada law on unjust enrichment would not fall within the ERISA saving clause as it is a law of general applicability that is not specifically aimed at regulating insurance companies.

B. This Claim is Subject to Complete Preemption

Courts have specifically held that a plaintiff-providers' unjust enrichment claims seeking to require health plans to pay amounts in excess of plan terms are subject to complete preemption. *Torrent & Ramos, M.D., P.A.*, 2004 WL 7320735, at *4 (out-of-network providers' unjust enrichment claim was completely preempted); *Hill v. Opus Corp.*, 841 F. Supp. 2d 1070, 1086 (C.D. Cal. 2011) (unjust enrichment claim was subject to ERISA preemption); *Lodi Mem'l*

Hosp. Ass'n v. Tiger Lines, LLC, No. 2:15-CV-00319-MCE, 2015 WL 5009093, at *8 (E.D. Cal. Aug. 20, 2015) (quantum meruit claim was subject to ERISA preemption); *Hill Country Emergency Medical Associates, P.A., et al. v. United HealthCare Insurance Company, et al.*, Civil Action No. 19-cv-00548-RP, Dkt. No. 18 (W.D. Tex. Dec. 10, 2019) (medical providers' quantum meruit claim held to be completely preempted).[18]

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

"Unjust enrichment exists when the plaintiff [1] confers a benefit on the defendant, [2] the defendant appreciates such benefit, and there is [3] acceptance and retention by the defendant of such benefit under circumstances such that it would be inequitable for him to retain the benefit without payment of the value thereof." *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 381, 283 P.3d 250, 257 (2012). "[A] pleading of quantum meruit for unjust enrichment does not discharge the plaintiff's obligation to demonstrate that the defendant received a benefit from services provided." *Id.*

Here, Fremont's claim fails as courts around the country routinely hold that providing medical services to a participant or beneficiary of a health plan does not benefit the insurer/administrator. Rather, courts have found that the medical provider is providing a benefit only to the patient (i.e. the insured/plan member). *See Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc.*, No. 14-81271-CV, 2015 WL 2198470, at *5 (S.D. Fla. May 11, 2015) ("a healthcare provider who provides services to an insured does not benefit the insurer."); *Adventist Health Sys./Sunbelt Inc. v. Med. Sav. Ins. Co.*, No. 6:03-CV-1121-ORL-19, 2004 WL 6225293, at *6 (M.D. Fla. Mar. 8, 2004) ("as a matter of commonsense, the benefits of healthcare treatment flow to patients, not insurance companies"); *Encompass Office Solutions, Inc. v. Ingenix, Inc.*, 775 F.Supp.2d 938, 966 n. 11 (E.D. Tex. 2011) (dismissing quantum meruit claim because benefit of medical treatment flowed only to insured, not insurer); *Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.*, 962 F. Supp. 2d 887, 898–99 (S.D. Tex. 2013) (same) (reversed in part

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[18] A copy of the *Hill Country* order, which was against TeamHealth affiliated medical providers, is attached hereto as **Exhibit 7**.

on other grounds in, 614 F. App'x 731 (5th Cir. 2015); *Travelers Indem. Co. of Connecticut v. Losco Grp., Inc.*, 150 F. Supp. 2d 556, 563 (S.D.N.Y. 2001) ("It is counterintuitive to say that services provided to an insured are also provided to its insurer. The insurance company derives no benefit from those services; indeed, what the insurer gets is a ripened obligation to pay money to the insured—which hardly can be called a benefit."); *Joseph M. Still Burn Ctrs., Inc. v. AmFed Nat'l Ins. Co.*, 702 F.Supp.2d 1371, 1377 (S.D. Ga. 2010) (dismissing quantum meruit causes of action because the medical provider provided services to a patient, not the insurer, "and no cognizable, let alone measurable, benefit or value to [the insurer was] identified by [the provider]"); *Sinai Med. Ctr. v. Mid–West Nat. Life Ins. Co. of Tenn.*, 118 F.Supp.2d 1002, 1013 (C.D.Cal. 2000) (stating that a medical provider's claim for quantum meruit lacked merit because it did not treat the patient at the insurance company's request).

Since the only benefit that Fremont alleges it conferred on the Defendants is the medical treatment the Defendants' plan members, this claim fails as a matter of law and should be dismissed. *See* Compl. at ¶ 62.

IX. FREMONT'S CLAIM FOR VIOLATION OF NRS 686A.020 AND 686A.310 SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

The Nevada Supreme Court has found that claims under the Nevada Unfair Trade Practices Act are preempted by ERISA. *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1084, 864 P.2d 288, 294 (1993) ("We add Nevada's voice to the growing body of case law holding state unfair insurance practice claims to be preempted by ERISA and conclude that Chapter 686A of the Nevada Insurance Code is preempted by ERISA when applied to a valid ERISA plan."); *see also Thrall*, 2005 WL 8161321, at *2 (claim for violation of Nevada Unfair Claim Practices was preempted). The *Villescas* decision is directly on point and found not only that claims such as Fremont's "relate to" an ERISA plan, but also that these claims do not fall within the ERISA saving clause. *Villescas*, 109 Nev. at 1083, 864 P.2d at 294. So, too, here. At bottom, Fremont's claim under the Nevada Unfair Trade Practices Act is conflict preempted, as it relates to the processing of claims under ERISA-governed plans.

B. This Claim is Subject to Complete Preemption

Based on the Nevada Supreme Court's decision in *Villescas*, this claim is also subject to complete preemption under the *Davila* test. Fremont has standing to bring a statutory ERISA claim against Defendants due to the assignments of benefits it received, and Defendants do not owe any duty to Fremont independent of the ERISA plans at issue.

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

Fremont asserts that the Defendants violated the Nevada Unfair Insurance Practices Act by not paying more on Fremont's claims. Fremont specifically cites to NRS 686A.310(1)(e), which prohibits "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." Compl. ¶ 70.

Fremont's claim fails as a matter of law because the Act only gives a private right of action to "insureds," not to third party claimants like Fremont. NRS 686A.310(2) ("In addition to any rights or remedies available to the Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.") (emphasis added) In fact, The Nevada Supreme Court has specifically held on multiple occasions that the Act does not create a private right of action against insurers in favor of third party claimants like Fremont. *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992) ("we conclude that [plaintiff] has no private right of action as a third-party claimant under NRS 686A.310."). The Court recently reaffirmed *Gunny's* central holding, stating as follows:

> NRS 686A,310(1)(e) provides that it is an unfair practice to '[f]ail[ ] to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear.' NRS 686A.310 expressly grants insureds a private right of action against insurance companies engaged in this unfair practice. This statute, however, does not provide a private right of action to third-party claimants.

Fulbrook v. Allstate Ins. Co., No. 61567, 2015 WL 439598, at *4 (Nev. Jan. 30, 2015) (citing to *Gunny*) (emphasis added) (unpublished). Case law out of the Nevada federal district court is in accord. *See Tweet v. Webster*, 614 F. Supp. 1190, 1195 (D. Nev. 1985) ("we do not find any facts or evidence presented by plaintiffs to persuade us that a Nevada court would grant a third

party claimant a cause of action directly against an insurer for bad faith refusal to settle a reasonably clear claim, based on statute, implied contract, or common law tort, under Nevada law as it stands today."); *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1376 (D. Nev. 1989) ("We have no reason to disagree with [the] conclusion that the Act created no private right of action in favor of third party claimants against the insurer.").

Here, Fremont is undisputedly a third party medical provider who provided medical services to participants of plans administered by Defendants. Fremont is not an "insured" but rather a "third party claimant" with no contractual relationship with Defendants. Therefore, this claim should be dismissed, as Fremont lacks standing to bring it.

X. FREMONT'S CLAIM FOR VIOLATIONS OF NEVADA'S PROMPT PAY STATUTES AND REGULATIONS SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Plaintiff alleges that Defendants violated the Nevada prompt pay statutes, including NRS 683A.0879, NRS 689A.410, NRS 689B.255, NRS 689C.485, NRS 695C.185, and NAC 686A.675, by failing to reimburse Fremont within 30 days of Fremont's requests for payment. Compl. at ¶ 78. As a remedy for this alleged violation, Fremont seeks to recover Nevada statutory penalties. *Id.* at ¶¶ 78, 81.

Plaintiffs' prompt pay claim unquestionably "has a connection with or reference to" an ERISA plan, as the claim is based on Defendants' alleged failure to cause the plans at issue to "pay Fremont the usual and customary rate within 30 days of receipt of the claim." *Id.*. at ¶ 77. To determine whether the challenged plan benefit payments violated the statute, the Court would have to reference the ERISA plans at issue to determine whether or not Defendants complied with the rate of payment terms for out-of-network providers. Further, this claim conflicts with the aforementioned ERISA requirement that Defendants comply with plan's payment terms (29 U.S.C. § 1102(b)(4) and 29 U.S.C. § 1104(a)(1)(D)) by seeking to have the Court superimpose a "usual and customary rate" term into each plan. Thus, this claim should be dismissed as conflict preempted. *See e.g., N. Jersey Brain & Spine Ctr. v. CIGNA Healthcare of NJ, Inc.*, No. CV 09-2630 (JAG), 2010 WL 11594901, at *6 (D.N.J. Jan. 12, 2010) (out-of-network providers' New

Jersey prompt pay statute claims found to be conflict preempted); *Am.'s Health Ins. Plans v. Hudgens*, 915 F. Supp. 2d 1340, 1359–60 (N.D. Ga. 2012) (Georgia prompt pay statute found to be conflict preempted since it "interfere[d] with nationally uniform administration of ERISA plans.").

B. This Claim is Subject to Complete Preemption

This claim is completely preempted for several reasons. First, ERISA already provides a remedy for a plan administrator's failure to promptly pay claims. A plan participant or beneficiary may seek an injunction to force immediate payment. 29 U.S.C. § 1132(a)(1)(B) (action can be brought to "enforce his rights under the terms of the plan"); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 272 (3d Cir. 2001) (claims related to delay in processing claims were completely preempted, as a plan participant or beneficiary can accelerate the plan's approval of a claim by seeking an injunction under 29 U.S.C. § 1132(a)(1)(B) to enforce the benefits to which they are entitled.). Nevada's prompt pay statute seeks to supplement this remedy and is thus completely preempted.

Second, courts have repeatedly found similar state "prompt pay" statutes preempted, unless the claim for payment specifically arises from an independent agreement between the provider and plan. *Compare Schoedinger v. United Healthcare of Midwest, Inc.*, 557 F.3d 872, 875–76 (8th Cir. 2009) (finding provider's claim, pursuant to an assignment of benefits from participant, for interest under Missouri prompt pay statute pre-empted by ERISA); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F.Supp.2d 901, 938 (M.D. Tenn. 2013) (finding Tennessee Prompt Pay Act claim pre-empted because provider brought it as assignee of plan participant) *with In re Managed Care Litig.*, 298 F.Supp.2d 1259, 1294 (S.D. Fla. 2003) (finding no pre-emption of providers' prompt pay claims arising from "a separate relationship between the provider and plan administrator," rather than an assignment from plan participants). *See also America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) (Georgia's prompt-pay provision was preempted as applied to self-funded ERISA plans because the provision interfered with uniform administration of benefits.); *Zipperer v. Premera Blue Cross Blue Shield of Alaska*, 2016 WL 4411490 (D. Alaska, August 16, 2016) (Alaska prompt pay statute was preempted);

Houston Methodist Hosp. v. Humana Ins. Co., 266 F. Supp. 3d 939 (S.D. Tex. 2017) (Texas Prompt Payment of Physicians and Providers Act was preempted); *OSF Healthcare Sys. v. Contech Constr. Prod. Inc.Group Comprehensive Health Care*, No. 1:13-CV-01554-SLDJEH, 2014 WL 4724394, at *7 (C.D. Ill. Sept. 23, 2014) (Illinois prompt-pay statute preempted by ERISA as having an "impermissible connection to an ERISA plan."). There is no significant distinction between Nevada's prompt pay statute and those of other states that have been found to be preempted. These statutes seek to regulate the processing of claims under employee benefit plans, which infringes on the field occupied by ERISA. The Court should adopt the above courts' reasoning and find that Nevada's prompt pay statute is preempted as well.

Third, Fremont's claim is also preempted because it seeks to recover Nevada statutory penalties which are not available under ERISA. *See e.g., Elliot*, 337 F.3d at 1147 (holding claim processing causes of action under state law which seek non-ERISA damages are preempted by ERISA).

XI. FREMONT'S CLAIM FOR VIOLATIONS OF NEVADA'S CONSUMER FRAUD & DECEPTIVE TRADE PRACTICES ACTS SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Through this claim, Fremont seeks to hold Defendants liable for making false representations and engaging in coercion, duress or intimidation in relation to Defendants' processing of claims on employee benefit plans. Compl. at ¶¶ 85, 87. As part of this claim, Fremont alleges that Defendants are refusing to pay for "covered emergency services." *Id.* at ¶ 87. This claim is conflict preempted because (1) the Court would need to reference the ERISA plans at issue to determine whether the services Fremont provided were in fact "covered," as well as whether any misrepresentations were made regarding the plan payment terms, and (2) the state law Fremont relies on impermissibly "relates to" the processing of claims under an employee benefit plan. There is no reason for this Court to deviate from other courts' decisions on this issue. *Pachuta v. Unumprovident Corp.*, 242 F. Supp. 2d 752, 764 (D. Hawaii, March 19, 2002) (holding that plaintiff's Hawaii Deceptive Trade Practices Act claim "related to" an ERISA plan and did not fall within the ERISA saving clause) ("Plaintiff's breach of contract and

unfair and deceptive trade practices [claims] are obviously preempted under ERISA . . . Plaintiff's claim for deceptive trade practices is a statutory cause of action that by its very terms is not specifically directed at insurance companies."); *Pilot Life Ins. Co.*, 481 U.S. at 57 (finding fraud claims based on the improper processing of a benefits claim were conflict preempted); *Davidian v. S. Cal. Meat Cutters Union*, 859 F.2d 134, 135 (9th Cir. 1988) (claims against an ERISA plan for bad faith, fraud, deceit and breach of fiduciary duty were conflict preempted); *Olson v. General Dynamics Corp.*, 960 F.2d 1418, 1422–23 (9th Cir. 1991) (claim challenging oral misrepresentation regarding the level of benefits provided by a plan is conflict preempted).

B. This Claim is Subject to Complete Preemption

This claim is completely preempted because, as discussed previously, the *Davila* test is met. Fremont could have brought its challenge to the payment amounts that it received through a statutory ERISA claim pursuant to the assignments of benefits it received from Defendants' plan members. Defendants do not owe any independent legal obligation to Fremont beyond that set forth in the ERISA plan documents since Fremont is an out-of-network provider.

Moreover, this claim seeks punitive treble damages and a disgorgement of profits against Defendants. Compl. at ¶ 89. All claims seeking such damages against an ERISA plan administrator are completely preempted. *Davila*, 542 U.S. at 209 ("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."); *Bast*, 150 F.3d at 1009 ("Extracontractual, compensatory and punitive damages are not available under ERISA."); *Elliot*, 337 F.3d at 1146-47 ("claim processing causes of action" which seek state law damages are "clearly" preempted under 29 U.S.C. § 1132(a)(1)(B) of ERISA).

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

1. Fremont Has Failed to Plead this Claim with Particularity

When a claim sounds in fraud, it must be pled with particularity. *See* Nev. R. Civ. P. 9(b) ("In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake."). The Nevada Supreme Court has held that a claim for violation of the Nevada Deceptive Trade Practices Act sounds in fraud and thus is subject to the pleading

requirements of Nev. R. Civ. P. 9(b). *Davenport v. Homecomings Fin.*, LLC, No. 56322, 2014 WL 1318964, at *3 (Nev. Mar. 31, 2014); *see also Sommers v. Cuddy*, No. 2:08-CV-78-RCJ-RJJ, 2012 WL 359339, at *4 (D. Nev. Feb. 2, 2012) ("a plaintiff must plead a deceptive trade practices claim with Rule 9(b) particularity.").

To plead a fraud claim with particularity under Rule 9(b), "[t]he circumstances that must be detailed include averments to the time, the place, the identity of the parties involved, and the nature of the fraud or mistake." *Brown v. Kellar*, 97 Nev. 582, 583–84, 636 P.2d 874, 874 (1981). The "allegations of fraud must be specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud charged so that they can defend against the charge and not just deny that they have done anything wrong." *Swartz v. KPMG LLP*, 476 F.3d 756, 764 (9th Cir. 2007) (internal citation omitted).[19]

For a fraud claim against multiple defendants, "Rule 9(b) does not allow a complaint to merely lump multiple defendants together but requires plaintiffs to differentiate their allegations when suing more than one defendant . . . and inform each defendant separately of the allegations surrounding his alleged participation in the fraud. In the context of a fraud suit involving multiple defendants, a plaintiff must, at a minimum, identify the role of each defendant in the alleged fraudulent scheme." *Id.* at 764-765 (internal quotations and citations omitted).

Here, Fremont's fraud allegations are formulaic, conclusory and entirely inadequate. *See* Compl. at ¶¶ 84-90. Fremont has not set forth the time, place, or specific content of *any* false representations by the Defendants. Fremont has also failed to allege the identity of a single individual employed by Defendants who made a false representation, broke a state or federal law or engaged in coercion, duress or intimidation. Fremont then compounds this error by doing exactly what the Nevada Supreme Court has prohibited—lumping all the Defendants in this case together and failing to identify the role each Defendant played in the alleged fraudulent scheme. *Id.* (referring only to the "UH Parties" generally in each allegation). For all these reasons,

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[19] Federal case law on this issue is strong persuasive authority as Fed. R. Civ. P. 9(b) is identical to Nev. R. Civ. P. 9(b).

Fremont has not pled this claim with particularity and it should be dismissed.

2. Fremont is Not "Victim" Within the Meaning of NRS 41.600 and Thus Lacks Standing to Bring a Claim

An action under the Nevada Deceptive Trade Practices Act may be brought by any person who is a "victim" of consumer fraud. NRS 41.600(1). The term "victim" in section 41.600 is not defined, and the Nevada Supreme Court has not yet offered a definition. Nonetheless, the Nevada Supreme Court has defined "victim" as that term is used in NRS 176.033(c), which authorizes restitution for a crime victim.

The court addressed the issue in *Igbinovia v. State*, 111 Nev. 699, 895 P.2d 1304 (1995), where it held that the Las Vegas Metropolitan Police Department was not a "victim" that could receive restitution for money used to purchase illegal drugs in a sting operation. *Id.* at 706, 895 at 1308. While noting the term was undefined, the court found that "the word 'victim' has commonly-understood notions of passivity, where the harm or loss suffered is generally unexpected and occurs without the voluntary participation of the person suffering the harm or loss." *Id.*

At least two Nevada federal district court decisions have found that it is appropriate to use the definition of "victim" proposed by the *Igbinovia* decision when determining whether a claimant has standing to bring a claim under the Nevada Deceptive Trade Practices Act. *Winnemucca Farms, Inc. v. Eckersell*, No. 3:05-CV-385-RAM, 2010 WL 1416881, at *7 (D. Nev. Mar. 31, 2010); *Weaver v. Aetna Life Ins. Co.*, No. 308-CV-00037-LRH-VPC, 2008 WL 4833035, at *5 (D. Nev. Nov. 4, 2008). Further, in a pre-*Igbinovia* decision, a Nevada federal district court found that business competitors are not "victims" within the meaning of NRS 41.600 and thus lack standing to sue under the Act (i.e. again accepting the distinction between passive and active involvement in a scheme). *Rebel Oil Co. v. Atl. Richfield Co.*, 828 F. Supp. 794, 797 (D. Nev. 1991). Thus, significant persuasive authority exists indicating that, if forced to address the issue, the Nevada Supreme Court would adopt the definition of "victim" set forth in *Igbinovia* and only confer standing on individuals who were "passive" victims of a deceptive trade practice and did not "voluntarily" participate in the scheme that caused them harm.

Here, Fremont's claim fails as it admits in the Complaint that it is not a passive victim of Defendants' alleged scheme, but rather was an active and knowing participant in the events in dispute. Fremont admits that it entered into contract negotiations with Defendants beginning in 2017, that Defendants fully informed Fremont during those negotiations of the rates it should expect to be paid for all future services rendered, and that Fremont nonetheless thereafter willingly provided medical services to the Defendants' members. Compl. at ¶¶ 18-19, 25-26, 87. As such, Fremont does not qualify as a passive "victim" under NRS 41.600 and lacks standing to bring this claim.

XII. FREMONT'S CLAIM FOR DECLARATORY JUDGMENT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Fremont's declaratory judgment claim seeks a judicial declaration requiring Defendants to cause the plans they administer to pay Fremont amounts of reimbursement set without regard to the terms of the plans. Compl. at ¶¶ 98-99. But it would be impossible for this Court to determine the correct amount of reimbursement, if any, for Fremont's medical services without referring to and interpreting the terms and conditions of the members' ERISA plans. At bottom, the relief sought by Fremont—a declaration that it is entitled to receive the "usual and customary rate" for its services—would require this Court to alter or rewrite the ERISA plans altogether. This Court simply cannot issue the declaratory relief sought by Fremont without consulting the language in the ERISA plans. Therefore, Fremont's claim for declaratory judgment is preempted because it "relates to" these ERISA plans. *See, e.g., Brandner v. UNUM Life Ins. Co. of Am.*, 152 F. Supp. 2d 1219, 1225 (D. Nev. 2001) (declaratory relief claim related to an ERISA plan, did not fall within ERISA saving clause and was preempted); *Bland v. Fiatallis N. Am., Inc.*, No. 02 C 0069, 2003 WL 1895429, at *2 (N.D. Ill. Apr. 15, 2003) (stating "ERISA preempts state claims for declaratory relief that relate to an ERISA benefits plan").

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B. This Claim is Subject to Complete Preemption

ERISA's civil enforcement statute specifically authorizes actions for declaratory judgment, providing that a plan participant or beneficiary can bring a civil action to "clarify any of his rights to future benefits." 29 U.S.C. § 1132(a)(1)(B); *see also Franchise Tax Board of California v. Construction Laborers Vacation Trust for S. California*, 463 U.S. 1, 27 n.31 (1983) ("ERISA has been interpreted as creating a cause of action for a declaratory judgment"). Fremont seeks a declaratory judgment under state law regarding the correct amount of reimbursement for the medical services that it performed on Defendants' members. Compl. at ¶¶ 98-99. Such a claim clearly duplicates the relief provided by 29 U.S.C. § 1132(a)(1)(B) of ERISA and therefore is completely preempted. *Davila*, 542 U.S. at 209 ("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.").

XIII. CONCLUSION

For all the above reasons, Defendants request that this Court dismiss Fremont's state law claims with prejudice, but give Fremont leave to attempt to plead a statutory claim under 29 U.S.C. § 1132(a)(1)(B) of ERISA.

Dated this 12th day of March, 2020.

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CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of March, 2020, a true and correct copy of the foregoing **DEFENDANTS' MOTION TO DISMISS** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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EXHIBIT 1

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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation: UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10: ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF JANE STALINSKI IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND**

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I, Jane Stalinski, declare under penalty of perjury as follows:

1. I am an adult resident of Cuyahoga County in the state of Ohio, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am a Legal Service Specialist for UnitedHealthcare Insurance Company ("UHIC") and its affiliates.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendants UnitedHealthcare Insurance Company's ("UHIC"), United HealthCare Services, Inc.'s ("UHS"), and UMR, Inc.'s ("UMR") plan members from July 2017 to present and that Defendants failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to UHIC, UHS and UMR. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002.

7. In regard to the thousands of claims that Fremont sent to Defendants UHIC, UHS,

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and UMR during the time period of July 2017 to present, all but one of the claims were made against employee benefit plans. Further, for all of Fremont's claims against UHIC, UHS, and UMR, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

8. In addition, I have reviewed the nature of the claims Fremont has asserted against UHIC, UHS and UMR and determined that some of the claims were denied in full and no partial payment was issued.

9. I declare under penalty of perjury under the laws of the State of Nevada and the United States that the foregoing is true and correct.

DATED this 20th day of June, 2019.

Jane Stalinski

Jane Stalinski

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EXHIBIT 2

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EXHIBIT 2

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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation. Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF MARYANN BRITTO IN SUPPORT OF OPPOSITION TO MOTION TO REMAND**

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I, Maryann Britto, declare under penalty of perjury as follows:

1. I am an adult resident of Fairfield County, Connecticut, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am a Legal Case Information Analyst for United Healthcare Services, Inc.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendant Oxford Health Plans, Inc.'s ("Oxford") plan members from July 2017 to present and that Oxford failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to Oxford. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002.

7. In regard to the claims that Fremont sent to Defendant Oxford during the time period of July 2017 to present, all of the claims were made against employee benefit plans. Further, for all of Fremont's claims against Oxford, the claim submission data indicates that

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Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

8. In addition, I have reviewed the nature of the claims Fremont has asserted against Oxford and determined that some of the claims were denied in full and no partial payment was issued.

9. I declare under penalty of perjury under the laws of the State of Nevada and the United States that the foregoing is true and correct.

DATED this 21 day of June, 2019.

Maryann Britto

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EXHIBIT 3

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EXHIBIT 3

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF SHAWNA REED IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND**

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I, Shawna Reed, declare under penalty of perjury as follows:

1. I am an adult resident of Clark County, Nevada, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am the general manager for Sierra Health-Care Options, Inc. ("SHO") operations.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendant SHO's plan members from July 2017 to present and that SHO failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to SHO. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002.

7. In regard to the claims that Fremont sent to Defendant SHO during the time period of July 2017 to present, all of the claims were made against employee benefit plans.

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Further, for all of Fremont's claims against SHO, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

8. I declare under penalty of perjury under the laws of the State of Nevada and the United States that the foregoing is true and correct.

DATED this ___ day of June, 2019.

Shawna Reed

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EXHIBIT 4

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EXHIBIT 4

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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF ELLEN SINCLAIR IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND**

000598

I, Ellen Sinclair, declare under penalty of perjury as follows:

1. I am an adult resident of Clark County, Nevada, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am a Healthcare Economics Consultant for HPN/SHL.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendants Sierra Health and Life Insurance Co.'s ("SHL") and Health Plan of Nevada, Inc.'s ("HPN") plan members from July 2017 to present and that Defendants failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to SHL and HPN. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002.

7. In regard to the claims that Fremont sent to Defendant SHL during the time period of July 2017 to present, approximately 72 percent of the claims were made against employee

benefit plans. Further, for all of Fremont's claims against SHL, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

8. In regard to the claims that Fremont sent to Defendant HPN during the time period of July 2017 to present, approximately 84 percent of the claims were made against employee benefit plans. Further, for all of Fremont's claims against HPN, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

9. In addition, I have reviewed the nature of the claims Fremont has asserted against SHL and HPN and determined that some of the claims were denied in full and no partial payment was issued.

10. I declare under penalty of perjury under the laws of the State of Nevada and the United States that the foregoing is true and correct.

DATED this 20 day of June, 2019.

Ellen Sinclair

Ellen Sinclair

EXHIBIT 5

000601

000601

EXHIBIT 5

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

Claim TPA ID : [redacted]
Claim Total : $883.00

Patient's Acct# : [redacted]
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#)
						X

[redacted]

8. RESERVED FOR NUCC USE

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)

[redacted]

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.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/01/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY: 06 28 17 QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. 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.

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 Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 07 01 17	07 01 17	23		99284		A,B,C,D	883 00	1			1063778611
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN: 880262438 ☐ ☒

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT For govt. claims, see back: ☒ YES ☐ NO

28. TOTAL CHARGE $ 883 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.)

RIVAS, JULIE
1063778611
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

SOUTHERN HILLS HOSPITAL AND ME
9300 W SUNSET RD

LAS VEGAS,NV 89148-4844

a. 1457306359 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

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

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

000602

000602

000602

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,295.00

Patient's Acct# : [redacted]
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#)
						X

[redacted]

8. RESERVED FOR NUCC USE

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? ☐ YES ☐ NO PLACE (State)

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. CLAIM CODES(Designated by NUCC)

[redacted]

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.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/02/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY: 07 02 17 QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. S098XXA B. S0083XA C. F10129 D. W228XXA
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. EPSDT Family Plan	I. ID. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	X	[redacted]	X YES ☐ NO	$ 1,295 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.)
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

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

000603

000603

000603

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $505.00

Patient's Acct# : [redacted]
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 [X] (ID#)

[redacted]

8. RESERVED FOR NUCC USE

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? [ ] YES [ ] NO PLACE (State)

c. OTHER ACCIDENT? [ ] YES [ ] NO

10d. CLAIM CODES(Designated by NUCC)

[redacted]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/03/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

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.

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 Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER I.D. #
1	07 03 17	07 03 17	23		99283		A	463 00	1			1104011527
2	07 03 17	07 03 17	23		99053		A	42 00	1			1104011527
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT For govt. claims, see back [X] YES [ ] NO

28. TOTAL CHARGE $ 505 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.)
LEONG, JOEANN
1104011527
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

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

000604

000604

000604

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

Claim TPA ID : [redacted]
Claim Total : $1,787.00

Patient's Acct# : [redacted]
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#)
						X

[redacted]

8. RESERVED FOR NUCC USE

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? ☐ YES ☐ NO PLACE (State)

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. CLAIM CODES(Designated by NUCC)

[redacted]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/06/17

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

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.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. R42	B. R55	C. E860	D. I959
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
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	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	X	[redacted]	X YES ☐ NO	$ 1,787 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.)

HIXSON, MICHAEL
1568656213
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

ST ROSE DOMINICAN HOSPITALS-SI
3001 ST ROSE PKWY

HENDERSON,NV 89052-3839

a. 1770626426 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

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

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

000605

000605

000605

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,295.00

Patient's Acct# : [redacted]
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#)
						X [redacted]

[redacted]

a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/09/17

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R1031 B. N200 C. N3001 D. R112 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. EPSDT Family Plan	I. I.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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,295 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SLAUGHTER, KEVIN 1558317354 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 102 E LAKE MEAD PKWY HENDERSON,NV 89015-5575 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

909000

000606

000606

Submitter : COBA (MEDICARE COBA MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,681.00

Patient's Acct# : [redacted]
Batch Number :
CCN# :
HIC Number :

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 X (ID#)

[redacted]

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? ☐ 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)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/10/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate 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.

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 Family Plan	I. I.D. QUAL	J. RENDERING. PROVIDER I.D. #
1 07 10 17 07 10 17	23		99291	DESC: CRITICAL CARE	A,B,C,D	1,681 00	1			1023391026
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,681 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
ALBEKORD, ARASH 1023391026 SIGNED DATE	SOUTHERN HILLS HOSPITAL AND ME 9300 W SUNSET RD LAS VEGAS,NV 89148-4844 a. 1457306359 b.	FREMOT EMER SVCMANDAVIA LTD PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : COBA (MEDICARE COBA MEDICAL)

000607

000607

000607

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,295.00

Patient's Acct# : [redacted]
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#)
						X

[redacted]

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? YES NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/12/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R0789 B. R0600 C. R042 D. R918 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. EPSDT 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 I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X	$ 1,295 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
MACEDO, MARK 1114286077 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LASVEGAS,NV 89128-0436 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

809000

809000

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,295.00

Patient's Acct# : [redacted]
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#)	X (ID#)

[redacted]

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	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/15/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HA=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. N200 B. N289 C. R1031 D. 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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 07 15 17 07 15 17	23		99285		A,B,C	1,295 00	1			1215138086
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,295 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
MENES, KEVIN 1215138086 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 9300 W SUNSET RD LASVEGAS,NV 89148-4844 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

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

609000

000609

000609

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

Claim TPA ID : [redacted]
Claim Total : $1,295.00

Patient's Acct# : [redacted]
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 [X] (ID#)

[redacted]

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? ☐ 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)

e. 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.
READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.
SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/17/17

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. R1084 B. K529 C. D72829 D. R030
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	07 17 17	07 17 17	23		99285		A,B,C,D	1,295 00	1			1972505675
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ [X]	[redacted]	[X] YES ☐ NO	$ 1,295 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
DUNAGAN, CLARENCE 1972505675 207P00000X SIGNED DATE	MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. 1104870187 b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

000610

000610

000610

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

1500

Claim TPA ID : [redacted]
Claim Total : $463.00

Patient's Acct# : [redacted]
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 X (ID#)

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/29/17

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 29 17 QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. S0502XA B. R030 C. W228XXA D. E. F. G. H. I. J. K. L.		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 Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 07 29 17 07 29 17	23		99283		A,B,C	463 00	1			1104060169
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 463 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
ROOZENDAAL, SUZANNE 1104060169 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000611

000611

000611

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

1500

Claim TPA ID : [redacted]
Claim Total : $463.00

Patient's Acct# : [redacted]
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#)
						X

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 08/14/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. M5412	B. R030	C. F419	D.
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. EPSDT 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 463 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
ANDERSON, ERIC 1619979028 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 9300 W SUNSET RD LASVEGAS,NV 89148-4844 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org UNOFFICIAL/NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

000612
000612
000612

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

1500

Claim TPA ID : [redacted]
Claim Total : $64.00

Patient's Acct# : [redacted]
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#)

[redacted]

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? ☐ 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)

[redacted]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 08/26/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. R4182 B. I509 C. R7989 D. N289 E. F. G. H. I. J. K. L.		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 Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER I.D. #
1	08 26 17	08 26 17	23		93010		B	64 00	1			1629049945
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	X	[redacted]	X YES ☐ NO	$ 64 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
MCBRIDE, DANIEL 1629049945 207P00000X	FREMONT EMERGENCY SERVICES MAN 3001 ST ROSE PKWY HENDERSON,NV 89052-3839	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772
SIGNED DATE	a. b.	a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000613

000613

000613

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

1500

Claim TPA ID : [redacted]
Claim Total : $883.00

Patient's Acct# : [redacted]
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#)	X (ID#)

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S DATE OF BIRTH MM DD YY / SEX
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 11/10/17

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

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.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. O200 B. R030 C. Z3A01 D. E. F. G. H. I. J. K. L.		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 Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	11 10 17	11 10 17	23		99284	SA	A,B,C	883 00	1			1336566579
2												
3												
4												
5												
6												

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
880262438	☐	X	[redacted]	X YES ☐ NO	$ 883 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
LI, TERRY 1336566579 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 102 E LAKE MEAD PKWY HENDERSON,NV 89015-5575 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000614

000614

000614

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,295.00

Patient's Acct# : [redacted]
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#)

[redacted]

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? ☐ 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)

	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 11/11/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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. 17b.
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. E860 B. R1110 C. N289 D. R197 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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	11 11 17	11 11 17	23		99285		A,B,C,D	1,295 00	1			1285898049
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	X	[redacted]	X YES ☐ NO	$ 1,295 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
CRAVEN, IAN 1285898049 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000615

000615

000615

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

1500

Claim TPA ID : [redacted]
Claim Total : $883.00

Patient's Acct# : [redacted]
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#)
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[X]

[redacted]

ZIP CODE	TELEPHONE (Include Area Code)
79119	

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? [ ] YES [ ] NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 12/08/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

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

A.	B.	C.	D.
O200	O2341	R102	Z3A01
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 12 08 17	12 08 17	23		99284		A,B,C,D	883 00	1			1720375322
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	[ ]	[X]	[redacted]	[X] YES [ ] NO	$ 883 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH#
KATZ, JASON 1720375322 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000616

000616

000616

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

1500

Claim TPA ID : [redacted]
Claim Total : $463.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

PICA

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/01/18

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 QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. N390 B. R030 C. D. 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. EPSDT Family Plan	I. ID. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 463 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
ZAHAROFF, NATALIE 1578786877 207P00000X SIGNED DATE	ER AT THE LAKES 3325 SOUTH FORT APACHE LAS VEGAS,NV 89117-6360 a. 9999999995 b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000617

000617

000617

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

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. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY: 08 27 74 SEX M F X

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID(Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES(Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/04/18

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 QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? YES NO $ CHARGES

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 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 Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 01 04 18	01 04 18	23		99285		A,B,C	1,360 00	1			1720375322
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN: 880262438 EIN X

26. PATIENT ACCOUNT NO.: [redacted]

27. ACCEPT ASSIGNMENT YES X 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.

NUCC Instruction Manual at: www.nucc.org

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

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

000618

000618

000618

Submitter : 133068979 (MULTIPLAN 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $927.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)	X (ID#)

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/08/18

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 QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. K625 B. K8590 C. I10 D. 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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	01 08 18	01 08 18	23		99284		A,B,C	927 00	1			1073933057
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 927 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
TANG, MICHAEL 1073933057 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 133068979 (MULTIPLAN 837 MEDICAL)

000619

000619

000619

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ 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.
READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.
SIGNED AUTHORIZED SIGNATURE ON FILE DATE 01/16/18

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: 01 16 18 QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. S91301A B. S91302A C. Y9389 D. E. F. G. H. I. J. K. L.		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 Family Plan	I. I.D. QUAL	J. RENDERING. PROVIDER I.D. #
1	01 16 18	01 16 18	23		99285		A,B,C	1,360 00	1			1326294844
2												
3												
4												
5												
6												

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
880262438	☐	☒	[redacted]	☒ YES ☐ NO	$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
INGLISH, DANIEL 1326294844 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org
UNOFFICIAL\NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

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

000620
000620
000620

Submitter : 383384800 (HOVS MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)

[redacted]

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) ☐ YES ☐ NO	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/19/18

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: 01 19 18 QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. R531 B. R001 C. I452 D. I10 E. F. G. H. I. J. K. L.		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 Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 01 19 18	01 19 18	23		99285		A,B,C,D	1,360 00	1			1518387885
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,360 00	$ 1,324 87	

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 #
NUSSBAUM, CHRISTIN 1518387885	MOUNTAINVIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436	FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI,OH 45263-8972
SIGNED DATE	a. 1104870187 b.	a. 1366429821 b.

000621
000621
000621

Submitter : 752297429-10144 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 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 QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF#= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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.
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. EPSDT Family 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	1			1548425259
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back ☒ YES ☐ NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ ☒	[redacted]		$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
CHAN, STEPHANIE 1548425259 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 9300 W SUNSET RD LASVEGAS,NV 89148-4844 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

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 : 752297429-10144 (UHC 837 MEDICAL)

000622

000622

000622

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

1500

Claim TPA ID : [redacted]
Claim Total : $929.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X [redacted]

[redacted]

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? ☐ 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)

a. INSURED'S DATE OF BIRTH MM DD YY / SEX 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.	

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 AUTHORIZED SIGNATURE ON FILE DATE 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.

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY: 01 26 18 QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. S61217A B. Z23 C. W228XXA D. 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. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1	01 26 18	01 26 18	23		99283	25	A,B,C	486 00	1			1972690592
2	01 26 18	01 26 18	23		12002		A	443 00	1			1972690592
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 880262438 ☐ X	26. PATIENT ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT (For govt. claims, see back) X YES ☐ NO	28. TOTAL CHARGE $ 929 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.) NEVAREZ, CHRISTOPHER 1972690592 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.

000623
000623
000623

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

1500 Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)	☒ (ID#)

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	b. OTHER CLAIM ID(Designated by NUCC)
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.
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 AUTHORIZED SIGNATURE ON FILE DATE 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.
SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. R1011	B. K8050	C. E6601	D.
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	02 22 18	02 22 18	23		99285		A,B,C	1,360 00	1			1558317354
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	☒	[redacted]	☒ YES ☐ NO	$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SLAUGHTER, KEVIN 1558317354 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 9300 W SUNSET RD LASVEGAS,NV 89148-4844 a. / b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 / b.

NUCC Instruction Manual at: www.nucc.org
UNOFFICIAL\NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

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

000624
000624
000624

Submitter : COBA (MEDICARE COBA MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
HIC Number : [redacted]

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#)

PICA

[redacted]

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? ☐ 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)

[redacted]	
	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/23/18

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 QUAL. MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0	22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. R0789 B. I2510 C. E876 D. R000 E. F. G. H. I. J. K. L.	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 Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER I.D. #
1	03 23 18	03 23 18	23		99285	GC	A,B,C,D	1,360 00	1			1336574250
2												
3												
4												
5												
6												

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
880262438	☐	X	[redacted]	X YES ☐ NO	$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
WRIGHT, BROOKS E 1336574250	MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436	FREMOT EMER SVC MANDAVIA LTD PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772
SIGNED DATE	a. 1104870187 b.	a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : COBA (MEDICARE COBA MEDICAL)

000625

000625

000625

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,404.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a. and 9d.

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authonze 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 03/31/18

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 QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. F10129 B. R4182 C. R739 D. 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. EPSDT 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 SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,404 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
LOVINGER, AARON 1063462364 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

000626
000626
000626

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,956.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a. and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 04/26/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. K0889 B. K047 C. L03211 D. R030 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. EPSDT Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER I.D. #
1	04 26 18	04 26 18	23		99284	25	A,B,C,D	927 00	1			1558599050
2	04 26 18	04 26 18	23		40800		B	1,029 00	1			1558599050
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,956 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
TRANCHELL, NATHAN 1558599050 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3001 ST ROSE PKWY HENDERSON,NV 89052-3839 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000627

000627

000627

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

1500

Claim TPA ID : [redacted]
Claim Total : $927.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 05/16/18

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	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
05 16 18 QUAL.	QUAL.	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HI=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. S32511A	B. R262	C. W0110XA	D.
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING. PROVIDER I.D. #
1 05 16 18	05 16 18	23		99284		A,B,C	927 00	1			1194131854
2											
3											
4											
5											
6											

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
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 927 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
LIN, CHARLES 1194131854 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000628

000628

000628

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $927.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

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	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 06/07/18

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: 06 07 18 QUAL.	15. OTHER DATE MM DD YY QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF# H/L#		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. S80211A	B. S80212A	C. M542	D. R1011
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. EPSDT Family Plan	I. ID. QUAL	J. RENDERING. PROVIDER I.D. #
1 06 07 18	06 07 18	23		99284	SA	A,B,C,D	927 00	1			1255799227
2											
3											
4											
5											
6											

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
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 927 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SONDRUP, LOGAN 1255799227 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 8280 W WARM SPRINGS RD LASVEGAS,NV 89113-3612 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1689013161 b.

000629
000629
000629

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,803.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

PICA

[redacted]

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	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a. and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 07/15/18

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	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 15 18 QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. S098XXA B. S0101XA C. R55 D. R030 E. F. G. H. I. J. K. L.		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 Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	07 15 18	07 15 18	23		99285	25	A,B,C,D	1,360 00	1			1790787497
2	07 15 18	07 15 18	23		12002		B	443 00	1			1790787497
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,803 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
CLARK, RUSSELL 1790787497 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

000630
000630
000630

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $927.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
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#)
						X

[redacted]

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	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 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 FILE

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 MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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.

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 Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	07 25 18	07 25 18	23		99284		A,B,C	927 00	1			1013357102
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	X	[redacted]	X YES ☐ NO	$ 927 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
KUO, TIM 1013357102 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3001 ST ROSE PKWY HENDERSON,NV 89052-3839 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

000631

000631

000631

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,353.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
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#)

[redacted]

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? ☐ 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)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/01/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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. 17b.
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R002 B. C. D. E. F. G. H. I. J. L.	22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

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

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

	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. #
1	01 01 19	01 01 19	23		99285		A	1,353 00	1			1588653125
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	X	[redacted]	X YES ☐ NO	$ 1,353 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SPENCE, ROBERT 1588653125 207P00000X SIGNED DATE	ER AT ALIANTE 7207 N ALIANTE PKWY LAS VEGAS,NV 89084-2502 a. 9999999995 b.	PREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1316488141 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000632

000632

000632

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

Claim TPA ID : [redacted]
Claim Total : $530.00

Patient's Acct# : [redacted]
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#)

PICA

[redacted]

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	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/02/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. J069 B. R05 C. D. 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. EPSDT 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												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 530 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
WRIGHT, BROOKS 1336574250 207P00000X SIGNED DATE	MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. 1104870187 b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

000633

000633

000633

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $927.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

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) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes. complete items 9, 9a. and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/12/19

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

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.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. R509	B. J09X2	C. J3489	D.
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING. PROVIDER I.D. #
1 01 12 19 01 12 19	23		99284		A,B,C	927 00	1			1508055765
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims. see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 927 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
RUSHTON, JOHN 1508055765 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

000634

000634

000634

Submitter : COBA (MEDICARE COBA MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number :
CCN# :
HIC Number :

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#)
						X

PICA

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 01/14/19

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

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.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HA=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. I2699	B. E1165	C. J90	D.
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 01 14 19 01 14 19	23		99285	DESC: EMERGENCY DEPT VISIT	A,B,C	1,360 00	1			1811395718
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
FORSMAN, ROBYN R 1811395718 SIGNED DATE	SUNRISE HOSPITAL AND MEDICAL C 3186 S MARYLAND PKWY LAS VEGAS,NV 89109-2317 a. 1861439952 b.	PREMONT EMERGENCY SERVICES PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : COBA (MEDICARE COBA MEDICAL)

000635

000635

000635

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)

[redacted]

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	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE 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.

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. R569	B. R4182	C.	D.
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING. PROVIDER I.D. #
1	02 25 19	02 25 19	23		99285		A,B	1,360 00	1			1104087287
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back ☒ YES ☐ NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ ☒	[redacted]		$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
FLORES, PATRICK 1104087287 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org UNOFFICIAL\NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

000636
000636
000636

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/04/19

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

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.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HI/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. R0602	B. R1900	C. D649	D.
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. EPSDT 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	SSN	EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	☐	X	[redacted]	X YES ☐ NO	$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
GOMEZ, ADRIAN 1235431388 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

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 : 752297429-10036 (UHC 837 MEDICAL)

000637

000637

000637

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
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#)

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/05/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. K5900 B. R339 C. N390 D. 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. EPSDT Family Plan	I. ID. QUAL	J. RENDERING. PROVIDER I.D. #
1	03 05 19	03 05 19	23		99285		A,B,C	1,360 00	1			1548425259
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
CHAN, STEPHANIE 1548425259 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 9300 W SUNSET RD LAS VEGAS,NV 89148-4844 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

000638

000638

000638

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

1500

Claim TPA ID : [redacted]
Claim Total : $1,360.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	b. OTHER CLAIM ID(Designated by NUCC)
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	c. INSURANCE PLAN NAME OR PROGRAM NAME
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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 AUTHORIZED SIGNATURE ON FILE DATE 03/06/19

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

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.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R1011 B. R1013 C. D. 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. EPSDT Family Plan	I. ID. 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.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	[redacted]	X YES NO	$ 1,360 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
DUNAGAN, CLARENCE 1972505675 207P00000X SIGNED DATE	MOUNTAIN VIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. 1104870187 b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

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

000639

000639

000639

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,337.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

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	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a. and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/09/19

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

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.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. R1013	B. K529	C.	D.
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. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	03 09 19	03 09 19	23		99285		A,B	1,295 00	1			1366865206
2	03 09 19	03 09 19	23		99053		A,B	42 00	1			1366865206
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT For govt. claims, see back	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,337 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
LUNDBERG, MICHAEL 1366865206 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3325 SOUTH FORT APACHE LAS VEGAS,NV 89117-6360 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

000640

000640

000640

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $484.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[X]

[redacted]

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? [ ] YES [ ] NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/11/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

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

A. M25562	B. M25462	C.	D.
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. EPSDT 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 [ ] [X]	[redacted]	[X] YES [ ] NO	$ 484 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
MACEDO, MARK 1114286077 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 7207 ALIANTE PKWY NORTH LAS VEGAS,NV 89084-2373 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1316488141 b.

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 : 752297429-10036 (UHC 837 MEDICAL)

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Submitter : 133068979 (PHCS ROUTED 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,428.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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	OTHE
(Medicare#)	(Medicaid#)	(ID#/DoD#)	(Member ID#)	(ID#)	(ID#)	X (ID#)

PICA

[redacted]

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? ☐ 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)

	c. INSURANCE PLAN NAME OR PROGRAM NAME
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/18/19

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

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.
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. J189 B. R0600 C. R05 D.	
E. F. G. H.	
I. J. K. L.	

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO	
20. OUTSIDE LAB? ☐ YES ☐ NO	$ CHARGES
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 Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	03 18 19	03 18 19	23		99285		A,B,C	1,428 00	1			1194131854
2												
3												
4												
5												
6												

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
880262438	☐	X	[redacted]	X YES ☐ NO	$ 1,428 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
LIN, CHARLES 1194131854 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

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Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,474.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)

[redacted]

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? ☐ YES ☐ NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/19/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. J189 B. R0902 C. J45901 D. E. F. G. H. I. J. K. L.		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 Family Plan	I. I.D. QUAL	J. RENDERING. PROVIDER I.D. #
1	03 19 19 03 19 19	23		99285		A,B,C	1,428 00	1			1851592497
2	03 19 19 03 19 19	23		99053		A,B,C	46 00	1			1851592497
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,474 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
WALKER, JAMES 1851592497 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

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Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $964.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
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#)

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/24/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] 17b.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=	20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. H6691 B. B974 C. D. 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. EPSDT 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.	27. ACCEPT ASSIGNMENT For govt. claims, see back X YES ☐ NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]		$ 964 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
ZAHAROFF, NATALIE 1578786877 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 7207 ALIANTE PKWY NORTH LAS VEGAS,NV 89084-2373 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1316488141 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

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Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,853.00

Patient's Acct# : [redacted]
Batch Number : [redacted]
CCN# : [redacted]
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#)
						X

[redacted]

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? YES NO PLACE (State)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 03/28/19

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

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.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? YES NO $ CHARGES

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

A. K5900	B. E860	C. N451	D.
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. EPSDT Family Plan	I. ID. QUAL	J. RENDERING. PROVIDER I.D. #
1 03 28 19	03 28 19	23		99291		A,B,C	1,853 00	1			1609253103
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X YES NO	$ 1,853 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
CHANG, WILLIS 1609253103 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org UNOFFICIAL\NOT YET APPROVED BY N.U.C. FORM CMS-1500 (02/12)

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Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $927.00

Patient's Acct# : [redacted]
Batch Number :
CCN# : [redacted]
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 [X] (ID#)

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)	b. OTHER CLAIM ID(Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES(Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a and 9d.

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 AUTHORIZED SIGNATURE ON FILE DATE 04/18/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. M25511 B. M62838 C. D. 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. EPSDT Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER I.D. #
1	04 18 19 04 18 19	23		99284		A,B	927 00	1			1790981462
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 [ ] [X]	26. PATIENT ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT [X] YES [ ] 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.) RAY, ROBERT 1790981462 207P00000X SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FREMONT EMERGENCY SERVICES MAN 3325 SOUTH FORT APACHE LAS VEGAS,NV 89117-6360 a. 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

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

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EXHIBIT 6

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EXHIBIT 6

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

[redacted] 8/1/13

1. MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | X | OTHER (ID#)

[redacted]

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 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.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
08 26 17 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 26 17 TO 08 26 17

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0
A. R03.0 B. 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) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 26 17	08 26 17	23	X	99285	223.00		A	1295 00	1		NPI	1336574250
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER: 88-0262438 SSN EIN X
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO
28. TOTAL CHARGE $ 1295 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.)
WRIGHT DO, BROOKS
SIGNATURE ON FILE
DATE 12/28/17

32. SERVICE FACILITY LOCATION INFORMATION
SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS, NV 89109-2317
a. 1861439952

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1518120971 b. ZZ207P00000X

SRS 5231 Manual available at www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)
44 OUTSOURCED BILLIN
VIC NC 1500 S-12

SIERRA HEALTHCARE OPTIONS%\

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE DATE 01/02/18

SIGNED SIGNATURE ON FILE

01 14 17 431

17a.

17b. NPI

FROM 01 14 17 TO 01 14 17

I21.3

ICD Ind 0

DATE(S) OF SERVICE From MM DD YY	To MM DD YY	PLACE OF SERVICE	EMG	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID QUAL	RENDERING PROVIDER ID. #
1 01 14 17	01 14 17	23	X	99291		A	1601 00	1		NPI	1104168293
2											
3											
4											
5											
6											

88-0262438 X [redacted] X YES NO $ 1601 00 $ 0 00

BAILEY MD,JAMES
SIGNATURE ON FILE
01/02/18

MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS,NV 89128-0436
1104870187

FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI,OH 45263-8972
800-562-2945
1366429821 ZZ207P00000X

MOA 5230 PLEASE PRINT OR TYPE SZR 60 COMMNPI FORM

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

HEALTH INSURANCE CLAIM FORM

[redacted]

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 01/08/18
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: 05 14 17 QUAL. 431
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 05 14 17 TO 05 14 17
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind. 0
A. K56.69 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	PLACE OF SERVICE	EMG	B. CPT/HCPCS	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER	D. DIAGNOSIS POINTER	E. $ CHARGES	F. DAYS OR UNITS	G. EPSDT Family Plan	H. ID. QUAL.	I. RENDERING PROVIDER ID. #
1 05 14 17	05 14 17	23	X	99285	25	A	1233	001		NPI	1366766099
2 05 14 17	05 14 17	23	X	99053		A	40	001		NPI	1366766099
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]
[redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE $ 1273 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.)
TRUAX DO,GREG FERMIN
SIGNATURE ON FILE
01/08/18
DATE

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

SEE 32601

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

VCMS 1500CS 12

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

HEALTH INSURANCE CLAIM FORM

[redacted]

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 DATE 01/18/18

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 15 17 QUAL. 431

15. OTHER DATE QUAL MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 15 17 TO 08 15 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. R07.89 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. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 08 15 17	08 15 17	23	X	99285		A	1295 00	1		NPI	1629294004
2 08 15 17	08 15 17	23	X	93010		A	64 00	1		NPI	1629294004
3										NPI	
4										NPI	
5										NPI	
6										NPI	

22.00

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE $ 1359 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.)
SONDRUP MD,LOGAN COL
SIGNATURE ON FILE
DATE 01/18/18

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
8280 W WARM SPRINGS RD
LAS VEGAS,NV 89113-3612
a. 1528101284 b.

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1689013161 b. ZZ207P00000X

SRD [illegible] must be available at www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NUCC 08/05 (02-12)

[redacted]

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

HEALTH INSURANCE CLAIM FORM

[redacted]

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 01/19/18

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 (LMP) MM DD YY: 08 19 17 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 19 17 TO 08 19 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

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

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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 19 17	08 19 17	23	X	99291	22.00	ABC	1681 00	1		NPI	1740625946
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X] EIN

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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.)
BRIA MD,CARLEY
SIGNATURE ON FILE
SIGNED 01/19/18 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. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. ZZ207P00000X

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

SIERRA HEALTH OPTIONS
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

[redacted]

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 01/25/18
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: 07 18 17 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY: 07 18 17

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 07 18 17 TO 07 18 17

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. 0
A. S72.121A B. R03.0 C. Y93.89 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	18	17	07	18	17	23	X	99285		ABC	1295 00	1		NPI CJ2642 1104087287
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 ☐ ☒
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO
28. TOTAL CHARGE $ 1295 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.)
FLORES DO,PATRICK H
SIGNATURE ON FILE
SIGNED 01/25/18 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. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. VWCHDG207P00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

[redacted]

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

[redacted]

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 01/26/18

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

11. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 11 22 17 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

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

A. I48.3 B. I50.9 C. R79.89 D. F17.200 E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 22 17	11 22 17	23	X	99291	25	ABCD	1681	001		NPI	1366555708
2 11 22 17	11 22 17	23	X	92960		A	925	001		NPI	1366555708
3 11 22 17	11 22 17	23	X	93010		A	256	004		NPI	1366555708
4 11 22 17	11 22 17	23	X	99152		A	93	001		NPI	1366555708
5										NPI	
6										NPI	

223.50

25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438 [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 2955 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.)
PENDLETON MD, DANIEL
SIGNATURE ON FILE
01/26/18
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
8280 W WARM SPRINGS RD
LAS VEGAS,NV 89113-3612
a. 1528101284 b.

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1689013161 b. ZZ207P00000X

SBD 52600

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

44 OUTSOURCED BILLIN

WCMS 1500C9 12

000654
000654
000654

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

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S SIGNATURE I authorize the release of any medical or other information necessary ... I request payment of government benefits either to myself or to the party who accepts assignment
SIGNATURE ON FILE 02/01/18
DATE

13. INSURED'S OR AUTHORIZED ... payment of medical benefits ... services described below
SIGNATURE ON FILE
SIGNED

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
08 06 17 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
FROM 08 06 17 TO 08 06 17

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
YES [X] NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. I47.2 B. R00.2 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE
ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 06 17	08 06 17	23	X	99285	25	AB	1295 00	1		NPI	1063462364
2 08 06 17	08 06 17	23	X	99053		AB	42 00	1		NPI	1063462364
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN
88-0262438 [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE
$ 1337 00

29. AMOUNT PAID
$ 0 00

30. BALANCE DUE
$ 1337 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.)
LOVINGER MD,AARON VI
SIGNATURE ON FILE
DATE 02/01/18

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 # (800) 562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. ZZ207P00000X

SRS 5231 Form available at www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NUCC 08/05

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

PICA

[redacted]

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 02/22/18
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
09 29 17 QUAL 431

15. OTHER DATE MM DD YY
QUAL

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. I21.3 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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 29 17	09 29 17	23	X	99291		AB	1681 00	1		NPI	1285898049
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX ID NUMBER SSN EIN
88-0262438 X

[redacted]

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

28. TOTAL CHARGE $ 1681.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $

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 MD,IAN ANDREW
SIGNATURE ON FILE
02/22/18
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 # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a 1518120971 b ZZ207P00000X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

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

CARRIER

HEALTH INSURANCE CLAIM FORM

[redacted]

SIGNATURE ON FILE 02/26/18	SIGNATURE ON FILE
12 28 17 431	FROM 12 28 17 TO 12 28 17
R07.89 R51 R94.31	ORIGINAL REF NO

	DATE(S) OF SERVICE	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	EPSDT FAMILY PLAN	ID QUAL	RENDERING PROVIDER ID #
1	12 28 17 12 28 17	23	X	99284		ABC	927 00	1	NPI	I649569583
2	12 28 17 12 28 17	23	X	99053		ABC	44 00	1	NPI	I649569583
3									NPI	
4									NPI	
5									NPI	
6									NPI	

88-0262438	X	[redacted]	X YES NO	971 00	0 00

MARTIN DO,JARED T
SIGNATURE ON FILE
02/26/18

SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS,NV 89109-2317
1861439952

FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
(800)562-2945
1518120971 ZZ207P000000X

NRS 52.31

PLEASE PRINT OR TYPE

PHYSICIAN OR SUPPLIER INFORMATION

000657

000657

000657

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

HEALTH INSURANCE CLAIM FORM

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

CARRIER

[redacted]

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.
SIGNED SIGNATURE ON FILE DATE 03/06/18

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 12 16 17 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 16 17 TO 12 16 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. R53.1 B. I63.9 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G DAYS OR UNITS	H. (EPSDT Family Plan)	I ID. QUAL.	J. RENDERING PROVIDER ID #
12 16 17	12 16 17	23	X	99285		AB	1360 00	1		NPI	1003869504
12 16 17	12 16 17	23	X	93010		A	67 00	1		NPI	1003869504
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1427 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.)
KARKAVANDIAN DO,HABI
SIGNED SIGNATURE ON FILE 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

NOTE: Instruction manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM 1500 (02-12)

WCMS-1500CS-12

SIERRA HEALTHCARE OPTIONS%\

[redacted]

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

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED SIGNATURE ON FILE DATE 04/19/18

SIGNED SIGNATURE ON FILE

08 17 17 QUAL 431

08 17 17 08 17 17

I21.3 G51.0 I16.0

24.A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ Charges	G. Days or Units	H. EPSDT Family Plan	I. ID. Qual.	J. Rendering Provider ID. #
08 17 17	08 17 17	23	X	99291		ABC	1681 001				1972505675

88-0262438 X [redacted] YES NO 1681 00 0 00

MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS,NV 89128-0436
1104870187

DUNAGAN MD,CLARENCE
SIGNATURE ON FILE
04/19/18

FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI,OH 45263-8972
1366429821 77207P00000X

800-562-2945

MOA 5200 CKK 80 COMM NPI FORM

PLEASE PRINT OR TYPE

KAISER PPO
PO BOX 14392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

[redacted]

PICA

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 04/30/18
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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 13 18 QUAL. 431

15. OTHER DATE QUAL. 439 04 13 18

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____

17b. NPI _____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 13 18 TO 04 13 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

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

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.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
1	04	13	18	04	13	18	23	X	99291		ABCD	1765	001		NPI	1073933057
2	04	13	18	04	13	18	23	X	99053		ABCD	44	001		NPI	1073933057
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438 [X]

[redacted]

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

28. TOTAL CHARGE $ 1809.00

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.)
TANG DO,MATCHED
SIGNATURE ON FILE
SIGNED 04/30/18 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. # 800 562 2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. 2Z207P00000X
44 OUTSOURCED BILLIN

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

FIRST FOLD WHCF-10-BW / WHCF-10-BW-SS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

000660

[redacted]

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

PICA

[redacted]

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06/05/18

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 17 17 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 17 17 TO 06 17 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. M46.1 B. A41.9 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 17 17	06 17 17	23	X	99291		AB	1681 00	1		NPI	1205940756
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [ ] [X]

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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
a) 1770626426

33. BILLING PROVIDER INFO & PH. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a) 1689013161 b) 2220Z00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

WCMS-1500CS-12

SIERRA OUTSOURCED BILLING

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECURE FOLD

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

000661

000661

000661

[redacted]

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06/12/18

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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 19 17 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 19 17 TO 11 19 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

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

A. I46.9 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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 19 17	11 19 17	23	X	99291	25	A	1681 00	1		NPI	1508055765
11 19 17	11 19 17	23	X	31500		A	1022 00	1		NPI	1508055765
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]
26. PATIENT'S ACCOUNT NO.: [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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 (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
RUSHTON MD,JOHN MATT
SIGNATURE ON FILE
SIGNED 06/12/18

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. # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. ZZ207P00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED BY AMA COUNCIL ON ... FORM 1500 (02-12)

WCMS-1500CS-12

SRS 5291 41 OUTSOURCED BILLIN

[redacted]

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

[redacted]

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.
SIGNED SIGNATURE ON FILE 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.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 05 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 05 18 TO 06 05 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. J96.90 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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06 05 18	06 05 18	23	X	99291		A	1765 00	1		NPI	1194131854
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [ ] [X]

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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. 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. # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. ZZ207P00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NUCC 02/12

WCMS-1500CS-12

[redacted]

KAISER
POB 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

PICA

[redacted]

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.
SIGNED: SIGNATURE ON FILE DATE: 08/10/18

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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 09 18 QUAL: 431

15. OTHER DATE QUAL: MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 09 18 TO 02 09 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. R07.2 B. R79.89 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
02 09 18	02 09 18	23	X	99285		AB	1360 00	1		NP	1114212743
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 88-0262438 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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.)
KIM MD,ANGELO
SIGNATURE ON FILE
SIGNED 08/10/18

32. SERVICE FACILITY LOCATION INFORMATION
SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS,NV 89148-4844
a. 1457306359 b.

33. BILLING PROVIDER INFO & PH # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1679550149 b. ZZ207P00000X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

WCMS-1500CS-12

[redacted]

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

PICA

[redacted]

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 — DATE 08/16/18

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) MM DD YY: 11 17 17 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY: 11 17 17

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 17 17 TO 11 17 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO

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

A. S09.8XXA B. S03.2XXA C. S00.83XA D. Y93.89

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 17 17	11 17 17	23	X	99285		ABCD	1295 00	1		NPI	1285898049
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 EIN X

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1295 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE

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 MD, IAN ANDREW
SIGNATURE ON FILE
SIGNED 08/16/18

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 # (800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1518120971 b. ZZ207P00000X

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

44 OUTSOURCED BILLIN

WCMS-1500CS-12

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

000665
000665

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

HEALTH INSURANCE CLAIM FORM

[redacted]

SIGNED SIGNATURE ON FILE DATE 09/25/18

SIGNED SIGNATURE ON FILE

02 17 18 431

02 17 18 02 17 18

X

R06.00 J18.1 E87.2

DATE(S) OF SERVICE FROM	DATE(S) OF SERVICE TO	PLACE OF SERVICE	EMG	PROCEDURES, SERVICES OR SUPPLIES (CPT/HCPCS)	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID QUAL	RENDERING PROVIDER ID #
02 17 18	02 17 18	23	X	99285		ABC	1360	001			1437398476

88-0262438 X [redacted] X YES NO 1360 00 0 00

800-562-2945

LO DO, JOSEPH
SIGNATURE ON FILE
09/25/18

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 ZZ207P00000X

SRD In... material available at www.nucc.org PLEASE PRINT OR TYPE DRR ...CLAIM FORM

999000
999000

KAISER
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

[redacted]

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 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 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. [redacted]

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

28. TOTAL CHARGE $ 1427 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.)
LO DO,JOSEPH
SIGNATURE ON FILE
SIGNED 10/04/18 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
8280 W WARM SPRINGS RD
LAS VEGAS,NV 89113-3612
a. 1528101284 b.

33. BILLING PROVIDER INFO & PH. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1689013161 b. 2220TP00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-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

[redacted]

PICA

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 10/09/18

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 SIGNATURE ON FILE

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 MM DD YY FROM TO

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 22 18 TO 04 22 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 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 SSN EIN: 88-0262438 [X]
26. PATIENT'S ACCOUNT NO. [redacted]
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.)
ANDERSON MD,ERIC JOH
SIGNATURE ON FILE
SIGNED 10/09/18

32. SERVICE FACILITY LOCATION INFORMATION
SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS,NV 89148-4844
a. 1457306359 b.

33. BILLING PROVIDER INFO & PH. # (800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1679550149 b. ZZ207P00000X

NSV Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (02-12)

WCMS-1500CS-12

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

[redacted]

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 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) MM DD YY: 07 13 18 QUAL 431

15. OTHER DATE QUAL ____ MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. ____
17b. NPI ____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 07 13 18 TO 07 13 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. 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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 13 18	07 13 18	23	X	99285		AB	1360 00	1		NPI	1619979028
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 ☐ ☒
26. PATIENT'S ACCOUNT NO. [redacted]
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
SIGNED 10/26/18 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. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a 5181209710 b 2207P000000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-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

[redacted]

PICA — 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.
SIGNED: SIGNATURE ON FILE DATE: 11/13/18

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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 10 16 QUAL: 431

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 10 16 TO 11 10 16

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. 0

A. I20.8 B. R00.2 C. E11.65 D. I99.8
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 10 16	11 10 16	23	X	99285		ABCD	1233 00	1		NPI	1760458053
2 11 10 16	11 10 16	23	X	99053		ABCD	40 00	1		NPI	1760458053
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE: $ 1273 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.)
BEHL DO,ANDREW
SIGNATURE ON FILE
SIGNED 11/13/18

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. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1366429821 b. ZZ207P00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

FIRST FOLD WHCF-10-BW / WHCF-10-BW-SS

000670

000670

000670

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

[redacted]

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 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
07 29 18 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY 07 29 18

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____
17b. NPI _____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 07 29 18 TO 07 29 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. 0

A. S72.012A B. W01.0XXA C. _____ D. _____
E. _____ F. _____ G. _____ H. _____
I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER _____

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 29 18	07 29 18	23	X	99285		AB	1360 00	1		NPI	1194131854
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

[redacted]

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.)
LIN MD,CHARLES
SIGNATURE ON FILE
SIGNED 12/27/18 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 # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. 2220TP00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

[redacted]

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

[redacted]

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. 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: 03 29 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 03 29 18 TO 03 29 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

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

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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. (EPSDT Family Plan)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 29 18	03 29 18	23	X	99291		AB	1765 00	1		NPI	1023138245
2 03 29 18	03 29 18	23	X	93010		B	67 00	1		NPI	1023138245
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [ ] [X]

[redacted]

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

28. TOTAL CHARGE $ 1832 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.)
FERGUSON MD,SCOTT RI
SIGNATURE ON FILE
SIGNED 01/16/19 DATE

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

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197-FORM 1500 (02-12)

WCMS-1500CS-12

SIERRA HEALTHCARE OPTIONS-NV P

[redacted]

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

PICA

[redacted]

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 03 18 TO 10 03 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. 0
A. I48.91 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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 03 18	10 03 18	23	X	99291		A	1765 00	1		NPI	1548425259
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ 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.)
CHAN MD, STEPHANIE
SIGNATURE ON FILE
SIGNED 01/30/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION
SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS, NV 89148-4844
a 1457306359 b

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a 1679550149 b ZZ207P00000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

000673

000673

000673

000673

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

7990-0116 (02-12) (OCR 1PT)

[redacted]

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

PICA

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 01/30/19

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 18 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. K85.90 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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 18 18	08 18 18	23	X	99285		AB	1360 00	1		NPI	1831518406
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X] EIN
26. PATIENT'S ACCOUNT NO. [redacted]
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.)
HUNT MD, STEPHEN M
SIGNATURE ON FILE
SIGNED 01/30/19 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 # (800) 562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a 1518120971 b ZZ207P00000X

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE GMS APPROVED BY NUCC 02/12 FORM 1500 (02-12)

[redacted]

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

[redacted]

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 DATE 01/30/19
SIGNED

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 26 18 QUAL 431

15. OTHER DATE QUAL 439 MM DD YY 08 26 18

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
FROM 08 26 18 TO 08 26 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. 0
A. S72.012A B. W07.XXXA C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 26 18	08 26 18	23	X	99285		AB	1360 00	1		NPI	1588653125
2 08 26 18	08 26 18	23	X	99053		AB	44 00	1		NPI	1588653125
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1404 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.)
SPENCE MD, ROBERT LEW
SIGNATURE ON FILE
SIGNED 01/30/19 DATE

32. SERVICE FACILITY INFORMATION
SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS, NV 89109-2317
a f861439952 b

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a f518120971 b ZZ207P00000X

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE GMS APPROVED BY NUCC 02/12 FORM 1500 (02-12)

1500-0116 (02-12) (OCR) 1PT.

[redacted]

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

[redacted]

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
11 24 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 24 18 TO 11 24 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. I69.320 B. I69.351 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 11 24 18	11 24 18	23	X	99285		AB	1360 00	1		NPI	1962883280
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
88-0262438 [ ] [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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.)
GRUNSETH MD, AARON
SIGNATURE ON FILE
SIGNED 01/30/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION
SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS, NV 89109-2317
a 1861439952

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a 1518120971 b ZZ207P00000X

PHYSICIAN OR SUPPLIER INFORMATION

790-0116 (02-12) (OCR 1PT)

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE GMS APPROVED BY NUCC 02/12 FORM 1500 (02-12)

[redacted]

KAISER
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

[redacted]

SIGNATURE ON FILE 02/15/19 SIGNATURE ON FILE

08 19 18 431 08 19 18 08 19 18

X

K74.60	E87.1	R18.8	0 R74.0

08 19 18	08 19 18	23 X	99285	ABCD	1360 001	1437413549

88-0262438 X [redacted] X 1360 00 0 00
800-562-2945

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

FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI,OH 45263-8972
1689013161 ZZ207P00000X

SRD 52600 PLEASE PRINT OR TYPE MMB 00 CMS NPI FORM

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SIERRA HEALTH
PO BOX 15392
LAS VEGAS NV 89114

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 below.
SIGNED SIGNATURE ON FILE DATE 02/21/19

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 26 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 26 18 TO 10 26 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

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

A. I61.9 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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 26 18	10 26 18	23	X	99291	25	AB	1765 00	1		NPI	1932529609
2 10 26 18	10 26 18	23	X	31500		A	1073 00	1		NPI	1932529609
3 10 26 18	10 26 18	23	X	99053		AB	44 00	1		NPI	1932529609
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [ ] [X]

26. PATIENT'S ACCOUNT NO.

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

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. # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1518120971 b. ZZ207P00000X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

[redacted]

KAISER-CA
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

CARRIER

[redacted]

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 02/25/19
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 13 18 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY: 10 13 18

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 13 18 TO 10 13 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. S22.41XA B. S32.018A C. S22.028A 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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 13 18	10 13 18	23	X	99291		ABCD	1765 00	1		NPI	1730169111
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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 02/25/19 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. # (800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. ZZ207P000000X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

[redacted]

KAISER
POB 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

CARRIER

[redacted]

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 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 (LMP) MM DD YY
10 17 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. I48.91 B. F10.129 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 17 18	10 17 18	23	X	99291		AB	1765 00	1		NPI	1205063286
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
88-0262438 [ ] [X]

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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.)
PHILLIPS DO,HEBER SA
SIGNATURE ON FILE
SIGNED 03/29/19 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. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. ZZ207P00000X

PHYSICIAN OR SUPPLIER INFORMATION

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

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

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

[redacted]

PICA

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) MM DD YY 09 11 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 09 11 18 TO 09 11 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. 0

A. K92.2 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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 11 18	09 11 18	23	X	99285		AB	1360 00	1		NPI	1326294844
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. [redacted]

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.)
ENGLISH DO, DANIEL JO
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
a. 1861439952 b.

33. BILLING PROVIDER INFO & PH. # (800) 562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1518120971 b. ZZ207P00000X
44 OUTSOURCED BILLIN

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

[redacted]

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

HEALTH INSURANCE CLAIM FORM

[redacted]

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 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) MM DD YY 12 06 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 06 18 TO 12 06 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [X] NO $ CHARGES

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

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 MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 06 18	12 06 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 SSN EIN
88-0262438 [ ] [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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.)
ANDERSON MD, ERIC YOH
SIGNATURE ON FILE
04/02/19
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. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1366429821 b. ZZ207P00000X
44 OUTSOURCED BILLING

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WCMS-1500CS-12

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

[redacted]

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SIGNED _____ DATE _____

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SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 08 04 18 QUAL 431

15. OTHER DATE QUAL _____ MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____

17b. NPI _____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 04 18 TO 08 04 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

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

A. I48.91 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 MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08	04	18	08	04	18	23	X	99285		AB	1360 00	1		NPI	1467536854
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 88-0262438 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ Ø 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.)
SABESHI MD, NIKK
SIGNATURE ON FILE
04/04/19
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS, NV 89148-4844
a. 1457306359 b.

33. BILLING PROVIDER INFO & PH # (800) 562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1679550149 b. ZZ207P00000X

890-0116 (02-12) (OCR) 1PT

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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

[redacted]

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SIGNED _____ DATE _____

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 02 18 QUAL 431

15. OTHER DATE QUAL _____ MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____

17b. NPI _____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 02 18 TO 06 02 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES _____

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

A. I21.4 B. R56.9 C. R73.9 D. G92
E. _____ F. _____ G. _____ H. _____
I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER _____

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 06 02 18	06 02 18	23	X	99291		ABCD	1765 00	1		NPI	1073933057
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 88-0262438

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] 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.)
TANG DO, MICHAEL
SIGNATURE ON FILE
SIGNED 04/04/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION
SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS, NV 89109-2317
a. 1861439952

33. BILLING PROVIDER INFO & PH # (800) 562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1518120971 b. ZZ207P00000X

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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

[redacted]

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SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 17 18 QUAL 431

15. OTHER DATE QUAL _____ MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____

17b. NPI _____

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES _____

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

A. R07.2 B. R73.9 C. I10 D. _____
E. _____ F. _____ G. _____ H. _____
I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER _____

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10	17	18	10	17	18	23	X	99285		ABC	1360 00	1		NPI	1972505675
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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.)
DUNAGAN MD, CLARENCE
SIGNED SIGNATURE ON FILE DATE 04/04/19

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 # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1366429821 b. ZZ207P00000X

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ATTN: KAISER CLAIMS
LAS VEGAS, NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

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SIGNED SIGNATURE ON FILE

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15. OTHER DATE QUAL MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 02 18 TO 08 02 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. I50.9 B. I48.91 C. R09.02 D. R06.00
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 02 18	08 02 18	23	X	99285		ABCD	1360 00	1		NPI	1790787497
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [ ] [X]
26. PATIENT'S ACCOUNT NO.
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.)
CLARK MD, RUSSELL PAT
SIGNATURE ON FILE
SIGNED 04/16/19 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# 800-582-2945
FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
a 1366429821 b ZZ207P00000X

790-0116 (02-12) (OCR) 1PT.

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EXHIBIT 7

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000687

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.	§	1:19-CV-548-RP
UNITEDHEALTHCARE INSURANCE COMPANY and UNITEDHEALTHCARE OF TEXAS, INC.,	§	
Defendants.	§	

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.

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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.").

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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.

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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).

24

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: 27

NOTICE OF INTENT TO TAKE DEFAULT AS TO:

(1) DEFENDANT UNITEDHEALTH GROUP, INC. ON ALL CLAIMS; AND

(2) ALL DEFENDANTS ON THE FIRST AMENDED COMPLAINT'S EIGHTH CLAIM FOR RELIEF

000699

McDONALD CARANO
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Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") is a professional emergency medicine services group practice that staffs the emergency departments at hospitals located throughout Clark County, Nevada. This case arises from the United Defendants' improper business strategy to artificially reduce payments to Fremont, Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); and Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively, the "Health Care Providers") through a multi-front assault: negotiations aimed at trying to leverage an in-network agreement at unsubstantiated low reimbursement rates; concurrent pressure by United on hospital facilities in order to put pressure on hospitals who have contractual relationships with the Health Care Providers; and the organized plan between United and third-party Data iSight to artificially reduce reimbursement rates for emergency medicine services. Part of this plan is to delay payment of reasonable and customary reimbursement rates provided to United's members to continue the economic squeeze on the Health Care Providers. As a result, Fremont initiated this action on April 15, 2019 alleging it has been improperly underpaid for emergency services by the United defendants and claims for breach of implied-in-fact contract, tortious breach of the implied covenant of good faith and fair dealing unjust enrichment (alternative claim), violation of NRS 686A.020 and 686.020, violation of Nevada's Prompt Pay Statutes and Regulations, Consumer Fraud and Deceptive Trade Practices Acts, and seeking a declaratory judgment.

On May 14, 2019, defendants United Healthcare Insurance Company; United Health Care Services Inc. dba UnitedHealthcare; UMR, Inc., dba United Medical Resources; Oxford Health Plans, Inc.; Sierra Health And Life Insurance Company, Inc.; Sierra Health-Care Options, Inc., Health Plan Of Nevada, Inc. (collectively, the "Removing Defendants") removed the action to the United States District Court, District of Nevada, Case No. 2:19-cv-00832-JCM-VCF.

During the pendency of the action in federal court, Fremont moved to remand the action and moved for leave to amended its complaint. After a contested hearing, the federal court granted leave to amend and the Health Care Providers filed a First Amended Complaint adding (1) plaintiffs Team Physicians and Ruby Crest; (2) defendant UnitedHealth Group, Inc.; and (3) a claim for violation of Nevada civil racketeering statute, NRS 207.350 *et seq.* **Exhibit 1**, First

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