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

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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

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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.

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161. This reimbursement is dictated by Defendants, to the financial detriment of the Health Care Providers.

The Enterprise's False Statements: Geographic Adjustment

162. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

163. Indeed, on its provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

164. Data iSight's parent company, MultiPlan, further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

165. Contrary to those statements, however, claims from providers in different geographic locations show that Data iSight does not adjust for geographic differences but instead, works with Defendants to cut uniformly out-of-network provider payments across geographic locations.

166. For example, Member WY was treated in Wyoming on January 21, 2019. The provider billed Defendants $779 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

167. Four days later, on January 25, 2019, Member AZ in Arizona and billed Defendants $1,212.00 for CPT Code 99284 and Defendants, via Data iSight, allowed exactly $413.39.

…

…

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168. On the same date, Member NH was treated on the other side of the country in New Hampshire. The provider billed Defendants $1,047 for procedure 99284, and Defendants, via Data iSight, again allowed $413.39.

169. On February 8, 2019, Member OK was treated in Oklahoma. The provider billed Defendants $990 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

170. Two days later, Members KS and NM were treated in Kansas and New Mexico, respectively. The providers billed Defendants $778.00 and $895.00, respectively, for procedure code 99284, but for both of these claims, Defendants, via Data iSight, allowed exactly $413.39.

171. One month later, Member CA was treated in California and Member NV was treated in Nevada. The CA provider billed Defendants $937.00 for procedure code 99284. Defendants, via Data iSight, yet again allowed exactly $413.39. A Health Care Provider billed Defendants $763.00 for procedure code 99284 and, via Data iSight, Defendants again allowed exactly $413.39.

172. Two months later, on May 20, 2019, a provider treated Member PA in Pennsylvania and billed Defendants $1,094 for procedure code 99284, and Defendants, via Data iSight, allowed exactly $413.39.

Patient	Location	Date of Service	Billed Amount	CPT Code	Allowed Amount – "DataiSight™ Reprice"
WY	Wyoming	1/21/19	$779 .00	99284	$413.39
AZ	Arizona	1/25/19	$1,212.00	99284	$413.39
NH	New Hampshire	1/25/19	$1047.00	99284	$413.39
OK	Oklahoma	2/8/19	$990.00	99284	$413.39
KS	Kansas	2/10/19	$778.00	99284	$413.39
NM	New Mexico	2/10/19	$895.00	99284	$413.39
CA	California	3/25/19	$937.00	99284	$413.39
NV	Nevada	3/30/19	$763.00	99284	$413.39
PA	Pennsylvania	5/20/19	$1,094.00	99284	$413.39

173. Defendants falsely claim on their website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

174. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but also all be higher than the allowed $413.39:

Location	CPT Code	80th Percentile of Fair Health Benchmark
Wyoming	99284	$1,105.00
New Hampshire	99284	$753.00
Oklahoma	99284	$1,076.00
Kansas	99284	$997.00
New Mexico	99284	$1,353.00
California	99284	$795.00
Pennsylvania	99284	$859.00
Arizona	99284	$1,265.00
Nevada	99284	$927.00

The Enterprise's Predicate Acts

175. To perpetuate the scheme and conceal it from the Health Care Providers, in or around 2018, Defendants and Data iSight entered into written agreements with each other that are consistent with Data iSight's agreements with similar health insurance companies.

176. Under those contracts, Data iSight would handle claims determinations for services rendered to Defendants' Members under pre-agreed thresholds set by Defendants.

177. By no later than 2019, Defendants and Data iSight then coordinated and effectuated the posting of false statements on websites and the communication of false statements to providers, including the Health Care Providers, in furtherance of the scheme.

178. These statements include Data iSight and its parent company posting that it would provide a transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment process for providers.

179. Data iSight communicated to the Health Care Providers' representatives by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United [HealthCare]."

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180. Finally, after weeks of pressure, Data iSight informed the Health Care Providers' representative by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

181. In short, the Enterprise perpetuated its scheme by communicating threats regarding reimbursement cuts to the Health Care Providers in late 2017 and 2018.

182. Then, after making good on those threats, the Enterprise communicated false and misleading information to the Health Care Providers and falsely denied that it had information requested by the Health Care Providers about the basis for the drastically-cut and unreasonable reimbursement rates that Defendants sought to impose.

183. In addition, since at least January 1, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to the Health Care Providers at rates that were far below usual and customary rates and/or reasonable rates for the services provided.

184. For example, Defendants sent Fremont, a Remittance for emergency services provided to Members under multiple procedure codes, including the following for CPT Codes 99284 and 99285:

d. Member #17 was treated on May 14, 2019 at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

e. Member #18 was treated on May 18, 2019, at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

f. Yet, Member #19 was treated on March 25, 2019, at a billed charge of $973.00 (CPT Code 99285), for which Defendants, via MultiPlan, allowed $875.00 which is 90% of billed charges. This a reasonable rate, in line with the reasonable rates historically paid by Defendants to Fremont for non-participating provider services.

g. Further, for professional services provided by Team Physicians between January and June 2019, Defendants allowed and approved payments ranging from $294.60 (27% of billed charges in the amount of $1,084.00) up to 100%, or $1,084.00.

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185. Defendants and Data iSight expected that those unreasonable payments would be accepted in full satisfaction of the Health Care Providers' claims.

186. Defendants and Data iSight have received, and continue to receive, financial gains from their scheme to defraud the Health Care Providers.

187. For the services that the Health Care Providers provided to Defendants' Members in 2019, only 13% of the non-participating claims have, to date, been reimbursed at reasonable rates, resulting in millions of dollars in financial loss to the Health Care Providers.

188. The purpose of, and the direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to unlawfully reimburse the Health Care Providers at unreasonable rates, to the harm of the Health Care Providers, and to the benefit of the Enterprise.

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract)

189. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

190. At all material times, the Health Care Providers were obligated under federal and Nevada law to provide emergency medicine services to all patients presenting at the emergency departments they staff, including Defendants' Patients.

191. At all material times, Defendants were obligated to provide coverage for emergency medicine services to all of its Members.

192. At all material times, Defendants knew that the Health Care Providers were non-participating emergency medicine groups that provided emergency medicine services to Patients.

193. From July 1, 2017 to the present, Fremont has undertaken to provide emergency medicine services to UH Parties' Patients, and the UH Parties have undertaken to pay for such services provided to UH Parties' Patients. And from prior to May 2015 to the present, Team Physicians and Ruby Crest have undertaken to provide emergency medicine services to UH

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Parties' Patients, and the UH Parties have undertaken to pay for such services provided to UH Parties' Patients.

194. From approximately March 1, 2019 to the present Fremont has undertaken to provide emergency medicine services to the Sierra Affiliates' and HPN's Patients, and Sierra Affiliates and HPN have undertaken to pay for such services provided to their Patients. And from prior to May 2015 to the present, Team Physicians and Ruby Crest have undertaken to provide emergency medicine services to Sierra Affiliates' and HPN's Patients, and Sierra Affiliates and HPN have undertaken to pay for such services provided to their Patients.

195. At all material times, Defendants were aware that the Health Care Providers were entitled to and expected to be paid at rates in accordance with the standards established under Nevada law.

196. At all material times, Defendants have received the Health Care Providers' bills for the emergency medicine services the Health Care Providers have provided and continue to provide to Defendants' Patients, and Defendants have consistently adjudicated and paid, and continue to adjudicate and pay, the Health Care Providers directly for the non-participating claims, albeit at amounts less than usual and customary.

197. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by the Health Care Providers to Defendants' Patients, the parties implicitly agreed, and the Health Care Providers had a reasonable expectation and understanding, that Defendants would reimburse the Health Care Providers for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates Defendants pay for other substantially identical claims also submitted by the Health Care Providers.

198. Under Nevada common law, including the doctrine of quantum meruit, the Defendants, by undertaking responsibility for payment to the Health Care Providers for the services rendered to Defendants' Patients, impliedly agreed to reimburse the Health Care Providers at rates, at a minimum, equivalent to the reasonable value of the professional emergency medical services provided by the Health Care Providers.

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199. Defendants, by undertaking responsibility for payment to the Health Care Providers for the services rendered to the Defendants' Patients, impliedly agreed to reimburse the Health Care Providers at rates, at a minimum, equivalent to the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services provided by the Health Care Providers.

200. In breach of its implied contract with the Health Care Providers, Defendants have and continue to unreasonably and systemically adjudicate the non-participating claims at rates substantially below both the usual and customary fees in the geographic area and the reasonable value of the professional emergency medical services provided by the Health Care Providers to the Defendants' Patients.

201. The Health Care Providers have performed all obligations under the implied contract with the Defendants concerning emergency medical services to be performed for Patients.

202. At all material times, all conditions precedent have occurred that were necessary for Defendants to perform their obligations under their implied contract to pay the Health Care Providers for the non-participating claims, at a minimum, based upon the "usual and customary fees in that locality" or the reasonable value of the Health Care Providers' professional emergency medicine services

203. The Health Care Providers did not agree that the lower reimbursement rates paid by Defendants were reasonable or sufficient to compensate the Health Care Providers for the emergency medical services provided to Patients.

204. The Health Care Providers have suffered damages in an amount equal to the difference between the amounts paid by Defendants and the usual and customary fees professional emergency medicine services in the same locality, that remain unpaid by Defendants through the date of trial, plus the Health Care Providers' loss of use of that money; or in an amount equal to the difference between the amounts paid by Defendants and the reasonable value of their professional emergency medicine services, that remain unpaid by the Defendants through the date of trial, plus the Health Care Providers' loss of use of that money.

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205. As a result of the Defendants' breach of the implied contract to pay the Health Care Providers for the non-participating claims at the rates required by Nevada law, the Health Care Providers have suffered injury and is entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

206. The Health Care Providers have been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

SECOND CLAIM FOR RELIEF

(Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing)

207. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

208. The Health Care Providers and Defendants had a valid implied-in-fact contract as alleged herein.

209. A special element of reliance or trust between the Health Care Providers and the Defendants, such that, Defendants were in a superior or entrusted position of knowledge.

210. That the Health Care Providers performed all or substantially all of their obligations pursuant to the implied-in-fact contract.

211. By paying substantially low rates that did not reasonably compensate the Health Care Providers the usual and customary rate or alternatively for the reasonable value of the services provide, Defendants performed in a manner that was unfaithful to the purpose of the implied-in-fact contract, or deliberately contravened the intention and sprit of the contract.

212. That Defendants' conduct was a substantial factor in causing damage to Fremont.

213. As a result of Defendants' tortious breach of the implied covenant of good faith and fair dealing, the Health Care Providers have suffered injury and is entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

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214. The acts and omissions of Defendants as alleged herein were attended by circumstances of malice, oppression and/or fraud, thereby justifying an award of punitive or exemplary damages in an amount to be proven at trial.

215. The Health Care Providers have been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

THIRD CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment)

216. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

217. The Health Care Providers rendered valuable emergency services to the Patients.

218. Defendants received the benefit of having their healthcare obligations to their plan members discharged and their members received the benefit of the emergency care provided to them by the Health Care Providers.

219. As insurers or plan administrators, Defendants were reasonably notified that emergency medicine service providers such as the Health Care Providers would expect to be paid by Defendants for the emergency services provided to Patients.

220. Defendants accepted and retained the benefit of the services provided by the Health Care Providers at the request of the members of its Health Plans, knowing that the Health Care Providers expected to be paid a usual and customary fee based on locality, or alternatively for the reasonable value of services provided, for the medically necessary, covered emergency medicine services it performed for Defendants' Patients.

221. Defendants have received a benefit from the Health Care Providers' provision of services to its Patients and the resulting discharge of their healthcare obligations owed to their Patients.

222. Under the circumstances set forth above, it is unjust and inequitable for Defendants to retain the benefit they received without paying the value of that benefit; i.e., by paying the Health Care Providers at usual and customary rates, or alternatively for the reasonable value of services provided, for the claims that are the subject of this action and for all

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emergency medicine services that the Health Care Providers will continue to provide to Defendants' Members.

223. The Health Care Providers seek compensatory damages in an amount which will continue to accrue through the date of trial as a result of Defendants' continuing unjust enrichment.

224. As a result of the Defendants' actions, the Health Care Providers have been damaged in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

225. The Health Care Providers sue for the damages caused by the Defendants' conduct and is entitled to recover the difference between the amount the Defendants' paid for emergency care the Health Care Providers rendered to its members and the reasonable value of the service that the Health Care Providers rendered to Defendants by discharging their obligations to their plan members.

226. As a direct result of the Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FOURTH CLAIM FOR RELIEF

(Violation of NRS 686A.020 and 686A.310)

227. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

228. The Nevada Insurance Code prohibits an insurer from engaging in an unfair settlement practices. NRS 686A.020, 686A.310.

229. One prohibited unfair claim settlement practice is "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e).

230. As detailed above, Defendants have failed to comply with NRS 686A.310(1)(e) by failing to pay the Health Care Providers' medical professionals the usual and customary rate

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for emergency care provided to Defendants' members. By failing to pay the Health Care Providers' medical professionals the usual and customary rate Defendants have violated NRS 686A.310(1)(e) and committed an unfair settlement practice.

231. The Health Care Providers are therefore entitled to recover the difference between the amount Defendants paid for emergency care the Health Care Providers rendered to their members and the usual and customary rate, plus court costs and attorneys' fees.

232. The Health Care Providers are entitled to damages in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

233. Defendants have acted in bad faith regarding their obligation to pay the usual and customary fee; therefore, the Health Care Providers are entitled to recover punitive damages against Defendants.

234. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FIFTH CLAIM FOR RELIEF

(Violations of Nevada Prompt Pay Statutes & Regulations)

235. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

236. The Nevada Insurance Code requires an HMO, MCO or other health insurer to pay a healthcare provider's claim within 30 days of receipt of a claim. NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), NRS 695C.185 (HMO), NAC 686A.675 (all insurers) (collectively, the "NV Prompt Pay Laws"). Thus, for all submitted claims, Defendants were obligated to pay the Health Care Providers the usual and customary rate within 30 days of receipt of the claim.

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237. Despite this obligation, as alleged herein, Defendants have failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of the submission of the claim. Indeed, Defendants failed to reimburse the Health Care Providers at the usual and customary rate at all. Because Defendants have failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of submission of the claims as the Nevada Insurance Code requires, Defendants are liable to the Health Care Providers for statutory penalties.

238. For all claims payable by plans that Defendants insure wherein it failed to pay at the usual and customary fee within 30 days, Defendants are liable to the Health Care Providers for penalties as provided for in the Nevada Insurance Code.

239. Additionally, Defendants have violated NV Prompt Pay Laws, by among things, only paying part of the subject claims that have been approved and are fully payable.

240. The Health Care Providers seek penalties payable to it for late-paid and partially paid claims under the NV Prompt Pay Laws.

241. The Health Care Providers are entitled to damages in an amount in excess of $15,000.00 to be determined at trial, including for its loss of the use of the money and its attorneys' fees.

242. Under the Nevada Insurance Code and NV Prompt Pay Laws, the Health Care Providers are also entitled to recover their reasonable attorneys' fees and costs.

SIXTH CLAIM FOR RELIEF

(Consumer Fraud & Deceptive Trade Practices Acts)

243. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

244. The Nevada Deceptive Trade Practices Act (DTPA) prohibits the UH Parties from engaging in "deceptive trade practices," including but not limited to (1) knowingly making a false representation in a transaction; (2) violating "a state or federal statute or regulation relating to the sale or lease of goods or services"; (3) using "coercion, duress or intimidation in a

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transaction"; and (4) knowingly misrepresent the "legal rights, obligations or remedies of a party to a transaction." NRS 598.0915(15), 598.0923(3), 598.0923(4), NRS 598.092(8), respectively.

245. The Nevada Consumer Fraud Statute provides that a legal action "may be brought by any person who is a victim of consumer fraud." NRS 41.600(1). "Consumer fraud" includes a deceptive trade practice as defined by the DTPA.

246. Defendants have violated the DTPA and the Consumer Fraud Statute through their acts, practices, and omissions described above, including but not limited to (a) wrongfully refusing to pay the Health Care Providers for the medically necessary, covered emergency services the Health Care Providers provided to Members in order to gain unfair leverage against the Health Care Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Health Care Providers to accept lower amounts than it is entitled for its services; and (b) engaging in systematic efforts to delay adjudication and payment of the Health Care Providers' claims for its services provided to UH Parties' members in violation of their legal obligations

247. As a result of Defendants' violations of the DTPA and the Consumer Fraud Statute, the Health Care Providers are entitled to damages in an amount in excess of $15,000.00 to be determined at trial.

248. Due to the willful and knowing engagement in deceptive trade practices, the Health Care Providers are entitled to recover treble damages and all profits derived from the knowing and willful violation.

249. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers is thus entitled to an award of attorneys' fees and costs of suit incurred herein.

SEVENTH CLAIM FOR RELIEF

(Declaratory Judgment)

250. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

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251. This is a claim for declaratory judgment and actual damages pursuant to NRS 30.010 *et seq.*

252. As explained above, pursuant to federal and Nevada law, Defendants are required to cover and pay the Health Care Providers for the medically necessary, covered emergency medicine services the Health Care Providers have provided and continue to provide to Defendants' members.

253. Under Nevada law, Defendants are required to pay the Health Care Providers the usual and customary rate for that emergency care. Instead of reimbursing the Health Care Providers at the usual and customary rate or for the reasonable value of the professional medical services, Defendants have reimbursed them at reduced rates with no relation to the usual and customary rate.

254. Beginning in or about July 2017, Fremont became out-of-network with the UH Parties; and Team Physicians and Ruby Crest have never been in-network with the UH Parties. Since then, the UH Parties have demonstrated their refusal to timely settle insurance claims submitted by the Health Care Providers and have failed to pay the usual and customary rate based on this locality in violation of UH Parties' obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

255. Beginning in or about March 2019, Fremont became out-of-network with the Sierra Affiliates and HPN and Physicians and Ruby Crest have never been in-network with the Sierra Affiliates or HPN. Upon information and belief, the Sierra Affiliates and HPN are failing to timely settle insurance claims submitted by the Health Care Providers and to pay the usual and customary rate based on this locality in violation of the Sierra Affiliates' and HPN's obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

256. An actual, justiciable controversy therefore exists between the parties regarding the rate of payment for the Health Care Providers' emergency care that is the usual and customary rate that Defendants are obligated to pay.

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257. Pursuant to NRS 30.040 and 30.050, the Health Care Providers therefore request a declaration establishing the usual and customary rates that they are entitled to receive for claims between July 1, 2017 and trial, as well as a declaration that the UH Parties are required to pay to the Health Care Providers at a usual and customary rate for claims submitted thereafter.

258. Pursuant to NRS 30.040 and 30.050, Team Physicians and Ruby Crest therefore request a declaration establishing the usual and customary rates that they are entitled to receive for claims between July 1, 2017 and trial, as well as a declaration that the Sierra Affiliates and HPN are required to pay to Team Physicians and Ruby Crest at a usual and customary rate for claims submitted thereafter.

259. Pursuant to NRS 30.040 and 30.050, Fremont therefore request a declaration establishing the usual and customary rates that Fremont is entitled to receive for claims between March 1, 2019 and trial, as well as a declaration that the Sierra Affiliates and HPN are required to pay to Fremont at a usual and customary rate for claims submitted thereafter.

260. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

EIGHTH CLAIM FOR RELIEF

(Violation of NRS 207.350 *et seq.*)

261. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

262. Nevada RICO allows a private cause of action for racketeering. NRS 207.470 provides in pertinent part that:

> Any person who is injured in his or her business or property by reason of any violation of NRS 207.400 has a cause of action against a person causing such injury for three times the actual damages sustained. An injured person may also recover attorney's fees in the trial and appellate courts and costs of investigation and litigation reasonably incurred.

263. This claim arises under NRS 207.400(b), (c), (d) and (j).

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264. The Defendants committed the following crimes of racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude).

265. The Defendants engaged in racketeering enterprises as defined by NRS 207.380 involving their fraudulent misrepresentations to the Health Care Providers, and failing to pay and retaining significant sums of money that should have been paid to them for emergency medicine services provided to the Defendants' Members, but instead were directed to themselves and/or Data iSight.

266. As set forth above, since at least January 2019, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of NRS 207.380, comprised of at least Defendants and Data iSight, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce and/or committed preparatory acts in furtherance thereof.

267. Each of the Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

268. Defendants and Data iSight had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates for their own pecuniary gain, by defrauding the Health Care Providers and preventing them from obtaining reasonable payment for the services they provided to Defendants' Members, in retaliation for the Health Care Providers' lawful refusal to agree to Defendants' massively discounted and unreasonable proposed contractual rates.

269. Since at least January 2019, the Defendants, have been and continue to be, engaged in preparations and implementation of a scheme to defraud the Health Care Providers by committing a series of unlawful acts designed to obtain a financial benefit by means of false or fraudulent pretenses, representations, promises or material omissions which constitute predicate unlawful activity under NRS 207.390 involving multiple instances of obtaining possession of money or property valued at $650 or more; multiple transactions involving fraud or deceit in course of enterprise or occupation and involuntary servitude in violation of NRS

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200.463. The Defendants have engaged in more than two related and continuous acts amounting to racketeering activity in violation of NRS 207.400(1)(a)-(d), (1)(f), (1)(h)-(i) pursuant to a scheme or artifice to defraud and to which the Defendants have committed for financial benefit and gain to the detriment of the Health Care Providers. The Defendants, on more than two occasions, have schemed with Data iSight to artificially and, without foundation, substantially decrease non-participating provider reimbursement rates while continuing to represent that the reimbursement rates are based on legitimate cost data or paid data.

270. The foregoing acts establish racketeering activity and are related to each other in that they further the joint goal of unfairly and illegally retaining financial benefit to the detriment of the Health Care Providers. In each of the examples provided herein, the acts alleged to establish a pattern of unlawful activity are related because they have the same or similar pattern, intents, results, accomplices, victims or methods of commission, or are otherwise interrelated by distinguishing characteristics and are not isolated incidents.

271. Each Defendant provides benefits to insured members, processes claims for services provided to members, and/or issues payments for services and knows and willingly participates in the scheme to defraud the Health Care Providers.

272. As a direct and proximate result of Defendants' violations of NRS 207.360(28), (35) and (36), the Health Care Providers have sustained a reasonably foreseeable injury in their business or property by a pattern of racketeering activity, suffering substantial financial losses, in an amount to be proven at trial, in violation of NRS 207.470.

273. Pursuant to NRS 207.470, the Health Care Providers are entitled to damages for three times the actual damages sustained, recovery of attorneys' fees in the trial and appellate courts and costs of investigation and litigation reasonably incurred.

REQUEST FOR RELIEF

WHEREFORE, the Health Care Providers request the following relief:

A. For awards of general and special damages in amounts in excess of $15,000.00, the exact amounts of which will be proven at trial;

B. Judgment in their favor on the First Amended Complaint;

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C. Awards of actual, consequential, general, and special damages in an amount in excess of $15,000.00, the exact amounts of which will be proven at trial;

D. An award of punitive damages, the exact amount of which will be proven at trial;

E. A declaratory judgment that Defendants' failure to pay the Health Care Providers a usual and customary fee or rate for this locality or alternatively, for the reasonable value of their services violates the Nevada law, breaches the parties' implied-in-fact contract, is a tortious breach of the implied covenant of good faith and fair dealing, and violates Nevada common law;

F. An order permanently enjoining Defendants from paying rates that do not represent usual and customary fees or rates for this locality or alternatively, that do not compensate the Health Care Providers for the reasonable value of their services; and enjoining Defendants and enjoining Defendants from engaging in acts or omissions that are violative of Nevada law;

G. Judgment against the Defendants and in favor of the Health Care Providers pursuant to the Eighth Claim for Relief in an amount constituting treble damages resulting from Defendants' underpayments to the Health Care Providers for the reasonable value of the emergency services provided to Defendants' Members and reasonable attorneys' fees and costs incurred in bringing this action;

H. The Health Care Providers costs and reasonable attorneys' fees pursuant to NRS 207.470;

I. Reasonable attorneys' fees and court costs;

J. Pre-judgment and post-judgment interest at the highest rates permitted by law; and

K. Such other and further relief as the Court may deem just and proper.

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JURY DEMAND

The Health Care Providers hereby demand trial by jury on all issues so triable.

DATED this 7th day of January, 2020.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 7th day of January, 2020, I caused a true and correct copy of the foregoing **FIRST AMENDED COMPLAINT** to be served via the U.S. District Court's Notice of Electronic Filing system ("NEF") in the above-captioned case, upon the following:

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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.

/s/ *Marianne Carter*
An employee of McDonald Carano LLP

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 15th day of May, 2020, I caused a true and correct copy of the foregoing **FIRST AMENDED COMPLAINT** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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Steven D. Grierson
CLERK OF THE COURT

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA) LTD., Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, Defendant.	CASE#: A-19-792978-B DEPT. XXVII

BEFORE THE HONORABLE NANCY L. ALLF, DISTRICT COURT JUDGE

FRIDAY, MAY 15, 2020

RECORDER'S TRANSCRIPT OF HEARING
ALL PENDING MOTIONS

Appearing via Videoconference:

For the Plaintiff: PATRICIA LUNDVALL, ESQ.
AMANDA PERACH, ESQ.

For the Defendant: D. LEE ROBERTS, ESQ.
COLBY BALKENBUSH, ESQ.

RECORDED BY: BRYNN WHITE, COURT RECORDER

Las Vegas, Nevada, Friday, May 15, 2020

[Case called at 3:02 p.m.]

THE COURT: All right. Calling the case of Fremont Emergency versus United Healthcare, A792978. Appearances, please.

MS. LUNDVAL: I believe the Court asked for appearances, notwithstanding the fact that --

THE COURT: Yeah.

MS. LUNDVAL: -- it seemed to be a little bit broken up. This is Pat Lundvall with McDonald Carano, here on behalf of the Plaintiffs, Emergency Services -- Fremont Emergency Services, et. all.

THE COURT: Thank you.

MR. ROBERTS: Good afternoon --

THE COURT: Are there any --

MR. ROBERTS: -- Your Honor, Lee Roberts, appearing for the Defendants.

THE COURT: Thank you. Are there other appearances?

MS. PERACH: Good afternoon --

MR. BALKENBUSH: [indiscernible] Your Honor.

MS. PERACH: -- Your Honor.

MR. BALKENBUSH: I apologize --

MS. PERACH: Good afternoon, Your Honor --

MR. BALKENBUSH: -- Your Honor. Colby Balkenbush, for Defendants, as well.

MS. PERACH: -- Amanda Perach appearing.

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THE COURT: Ms. Perach and Mr. Balkenbush are also present. Were there any --

MS. PERACH: Thank you, Your Honor.

THE COURT: -- appearances?

All right. So, about 10 minutes ago I got the e-mail with your stipulation that said this hearing wouldn't be necessary. I thank you for appearing regardless. Does anyone have anything to add for the record? Because it looks like you'll need a hearing set after June 5th.

MS. LUNDVAL: I don't believe that there's anything else that we need to put on the record. The stipulation is in the hopes that the Court will have time for us on June 5th or as soon thereafter then, as the Court may have the time by which then to continue this hearing.

The other thing I would like to add is I would thank Mr. Roberts for his cooperation in being able to assist and get his client's agreement in to the stipulation and it was proposed.

THE COURT: Thank you. Is there a response?

MR. ROBERTS: I'd also like to note, that the stipulation has days in it that are a little bit longer for us than the ones that were provided to the Court yesterday and so, I similarly would like to thank Ms. Lundvall for working with us to give us the time we needed to -- to get this in front of the Court.

THE COURT: Thank you, both. The day of June 5th is fine with me, and we can do it at 1:00 pm. I'm kind of waiting to see what the governor is going to say today. Our chief judge is encouraging to do everything remotely through [indiscernible]. I'm hopeful that -- I can tell

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you that, at least I will be in the courtroom, which may make it a little easier for you guys, if you go by BlueJeans. Though -- the place to be determined, but we can do the hearing on the June 5th, 1:00 pm.

MS. LUNDVAL: We thank the Court --

THE COURT: Is there anything --

MS. LUNDVAL: We would thank the Court for your cooperation in that regard, as well as your staff.

THE COURT: Actually, my staff is - - they're rock stars. I thank you all if you took the time to my law clerk and extern, because I don't really want to know about those conversations, if you guys were able to do that yesterday, I thank you both for that as well.

All right, is there anything further?

MS. LUNDVAL: No, Your Honor.

THE COURT: No.

MR. ROBERTS: Nothing --

THE COURT: Then congratulations --

MR. ROBERTS: -- for the Defendants, Your Honor.

THE COURT: Professional courtesy goes a long way. Thank you, both. See you in June.

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MS. LUNDVAL: Thank you, Your Honor.

MR. ROBERTS: Thank you, Your Honor.

[Hearing concluded at 3:06 p.m.]

* * * * * * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.

Brynn White

Brynn White
Court Recorder/Transcriber

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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

DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT

Hearing Date: June 5, 2020

Hearing Time: 1:00 PM

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Defendants UnitedHealth Group, Inc., 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 Plaintiffs' First Amended 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]

Plaintiffs are for profit out-of-network medical providers. Defendants administer health plans whose members have received medical treatment from Plaintiffs. Plaintiffs allege that the health plans have underpaid Plaintiffs for medical services rendered to plan members, and seek to compel the controlling plans to pay Plaintiffs at what they suggest is the "usual and customary rate"—without any regard to the explicit terms of the plans. To achieve the goal of forcing all of the plans (with varying terms) to pay the same inflated amounts not afforded under the plans, Plaintiffs have brought a raft of deficient and improper state law claims.

However, all of Plaintiffs' claims are subject to dismissal because they 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

[1] Defendants removed this case to federal court on May 14, 2019. While this case was in federal court, Fremont Emergency Services (Mandavia), Ltd. ("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 subject matter jurisdiction and remanded this matter to the Eighth Judicial District Court. The Parties then stipulated to allow Plaintiffs to refile their First Amended Complaint in this Court, which Plaintiffs did on May 15, 2020. At Plaintiffs' request, Defendants are responding to Plaintiffs' first seven claims through this filing and responding to Plaintiffs' eighth cause of action, a Nevada RICO claim, through a separate supplemental filing. *See* Stipulation and Order submitted on May 26, 2020. However, this Motion and Defendants' supplemental filing addressing Plaintiffs' RICO claim shall collectively constitute Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint.

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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, Plaintiffs' state law causes of action 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 Plaintiffs' state law claims.

Allowing Plaintiffs' 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. Plaintiffs are challenging the amount that they received on more than 10,000 separate health plan benefit claims they submitted to Defendants for payment, and are 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 controlling health plans by superimposing on them some different, uniformly higher amount of reimbursement 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 § 502(a)(1)(b), pursuant to which the Court can assess whether each challenged payment was consistent with the terms of the applicable plan.

Plaintiffs will attempt to argue that their claims are not preempted because this is a "rate

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of payment" case rather than a "right to payment" case. However, Plaintiffs' 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: Plaintiffs *admit* that they lack 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 Plaintiffs, and ERISA does not permit Plaintiffs 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 Plaintiffs fail 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 Plaintiffs' state law causes of action in their entirety and with prejudice.[2]

II. NEARLY ALL OF PLAINTIFFS' 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.[3] The purpose of this exception to the general rule is to prevent plaintiffs, like Plaintiffs here, from attempting to thwart congressional intent that ERISA provide the exclusive remedy for these types of claims through artful pleading.

Plaintiffs' 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

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[2] However, Plaintiffs should be given leave to replead their claims as statutory ERISA claims pursuant to 29 U.S.C. § 1132(a), subject to any defenses Defendants may have to such a claim.

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

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Complaint identifies is the general time frame during which Plaintiffs allegedly provided medical services to Defendants' members and submitted claims/requests for processing and adjudication to Defendants. *See* Compl. at ¶¶ 25-26. 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, Plaintiffs 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 Plaintiffs submitted to UHIC, UHS and UMR, based on the known information, all but one of the claims were made against ERISA-governed plans.[4] For the claims made against Oxford and SHO, all of the claims were made against ERISA governed plans.[5] For the claims made against SHL, approximately 72% of the claims were made against ERISA-governed plans.[6] For the claims made against HPN, approximately 84% of the claims were made against ERISA-governed plans.[7] In sum, over 90% of Plaintiffs' claims in the relevant period were for services provided to members of ERISA-governed plans.

Furthermore, for all of the claims that Plaintiffs are asserting in this litigation, Plaintiffs represented that they received assignments of benefits from their patients that, if valid, would allow Plaintiffs to sue under ERISA by standing in the shoes of each patient and asserting claims for benefits seeking additional reimbursement under the terms of the plans.[8] As discussed in

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

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

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

[7] *Id.* at ¶ 8.

[8] *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 Plaintiffs 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.

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more detail below, these assignments of benefits are critical because they render Plaintiffs 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 Plaintiffs' 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[9] insofar as they may now or hereafter **relate to** any employee benefit plan . . .". 29 U.S.C. § 1144(a) (pre-emption clause) (emphasis added).[10]

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,

[9] 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.

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

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> 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.

B. ERISA's "Relates to" Preemption Clause is Broad and Preempts any State Law Claim that Requires a Plan to Deviate from Plan Terms. Plaintiffs' 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.").[11] "[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 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 "<u>specify the basis on which payments are made to and from the plan</u>," 29 U.S.C. § 1102(b)(4), and that the fiduciary shall administer the plan "<u>in accordance with the documents and instruments governing the plan</u>," 29 U.S.C. § 1104(a)(1)(D)

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[11] Plaintiffs may argue in their response that the federal court has already rejected these preemption arguments when it granted Plaintiffs' 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 Plaintiffs' 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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(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 Plaintiffs' state law claims attempt to do. Plaintiffs are out-of-network medical providers that allege they provided treatment to thousands of patients who were members of health plans administered/issued by Defendants. Compl. at ¶ 64. Plaintiffs further allege that the Defendants failed to adequately reimburse Plaintiffs for these services and they seek a judgment requiring the Defendants to "reimburse the Health Care Providers at the usual and customary rate. . . or alternatively for the reasonable value of the services provided." *Id.* at ¶¶ 21, 62, 69, and subparagraphs E and F of Plaintiffs' Request for Relief. However, each health plan at issue already provides for particular coverage and reimbursement for types of services rendered to plan members for services received from out-of-network providers like Plaintiffs. Thus, the remedy Plaintiffs seek via their state law claims is nothing less than a complete rewriting of the health plans at issue. Plaintiffs are 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 at-issue claims, regardless of the plans' terms. 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. In sum, Plaintiffs' state law claims unquestionably "relate to" ERISA-governed health plans issued and/or administered by Defendants and are thus conflict preempted by ERISA.

C. Plaintiffs' 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 Plaintiffs' 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,

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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[12] 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).[13]

Here, none of Plaintiffs' state law claims fall within the ERISA saving clause. As to Plaintiffs' 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 preempted because "[a]ny breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages.").

With respect to Plaintiffs' 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

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[12] 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.

[13] 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)

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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 Plaintiffs' State Law Claims

Even if this Court were to find that some of Plaintiffs' 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

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> 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 Plaintiffs' 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 Plaintiffs' 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)[14] and permits a "participant or beneficiary" to bring a special statutory ERISA claim over which state and federal courts have concurrent jurisdiction.[15] The statute reads as follows:

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

[15] 29 U.S.C. § 1132(e)(1) (providing that a statutory ERISA claim may be brought in state or federal court).

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> 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, Plaintiffs' 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 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

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reimbursement for medical services. The Ninth Circuit has explicitly 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*, Plaintiffs are out-of-network medical providers that provided medical services to members of health plans administered by Defendants. Compl. at ¶¶ 17-20, 39. Plaintiffs then requested payments from Defendants, representing that they had received assignments of the patients' plan benefits. *Id.* at ¶¶ 40, 43. 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%."). Plaintiffs have now brought suit seeking additional reimbursements from the applicable health plans and, in doing so, stand in the shoes of Defendants' members.

Both prongs of the *Davila* test are therefore met. The first element is met because Plaintiffs obtained assignments that give them standing to bring ERISA claims. *In Re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1292 (S.D. Fla. 2003) (out-of-network providers' implied-in-fact contract claims were preempted because they received an assignment of benefits from the plan members). The fact that Plaintiffs now self-servingly disclaim that they are suing as the assignee of Defendants' plan members is not relevant to a *Davila* analysis. The only question is whether Plaintiffs "*could*" have brought an ERISA claim, and Plaintiffs clearly could have done so.

Prong 2 of the *Davila* test is met because Plaintiffs are out-of-network providers who lack a written contract with Defendants that sets forth negotiated payment terms. Compl. at ¶ 20. Thus, the only legal duties owed to Plaintiffs (if any) flow from the terms of the applicable ERISA plans. Regardless of the labels used and Plaintiffs' attempt at artful pleading, all of Plaintiffs' claims are completely preempted.

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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. PLAINTIFFS' 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 <u>breach of contract implied in fact</u>, 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. Plaintiffs are attempting to compel thousands of different ERISA-governed plans administered by the Defendants to pay Plaintiffs 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 what their terms afford. If, for example, a plan expressly provided that it would pay all medical claims at 150% of the benefit rate paid by Medicare,

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Plaintiffs would ask the Court to apply their 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). Plaintiffs' 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 Plaintiffs are 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) Plaintiffs have standing to bring a statutory § 502(a) ERISA claim due to the assignments of benefits they 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 Plaintiffs are out-of-network providers. 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).[16]

[16] Plaintiffs may argue in response that the Nevada Federal District Court found that complete preemption does not apply to Plaintiffs' 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 Plaintiffs' 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.").

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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, Plaintiffs fail to state a claim as they have not sufficiently alleged any of the above three elements. Nowhere in the Complaint is there an allegation that the Defendants "intended to contract" with Plaintiffs. 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 Plaintiffs, there is instead an allegation that (1) Plaintiffs provided medical services to members of Defendants' health plans, (2) Plaintiffs requested full reimbursement for these services from Defendants and (3) on some occasions Defendants obliged, and on other occasions Defendants did not. Compl. at ¶¶ 193-194, 196-199. In essence, Plaintiffs argue 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 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*, Plaintiffs are attempting to force the Defendants to compensate them for unsolicited[17] services that were provided without any contract in place.

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

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Further, Plaintiffs rely only on the past consideration of prior payments to create the alleged implied-in-fact contract—a theory that *Recrion Corp* expressly disapproved. Thus, Plaintiffs have failed to state a claim for implied-in-fact contract and this claim should be dismissed.

Alternatively, if Plaintiffs are 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 ¶¶ 18, 190. 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, Plaintiffs have failed to state a claim for implied-in-fact contract and this claim should be dismissed.

VII. PLAINTIFFS' 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 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.

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B. This Claim is Subject to Complete Preemption

Like Plaintiffs' 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 ¶¶ 22-25, 54-56. 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 ¶ 214 and p. 45:3-4. Such claims are completely preempted. *See 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 Plaintiffs 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 Plaintiffs have failed to allege an enforceable implied-in-fact contract, then it should end its analysis there and dismiss this claim, too.

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

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employment context).

Critically, the Nevada Supreme Court has refused to expand this tort to contracts between sophisticated parties in the commercial realm.[18] *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 Plaintiffs have alleged that there was "[a] special element of reliance or trust between the Health Care Providers and the Defendants," this is an entirely conclusory allegation, Compl. at ¶ 209, 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 (Plaintiffs and Defendants) who do not even have an express written contractual relationship. *See* Compl. at ¶ 20 (admitting no written agreement exists); *see also id.*. at ¶¶ 3-5, 17 (admitting that Plaintiffs are sophisticated "professional emergency medicine services group[s]" that run major emergency rooms in Las Vegas, Fallon and Elko).

Moreover, as explained above, even if Plaintiffs 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, Plaintiffs have failed to state a claim for tortious breach and this claim should be dismissed.

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[18] 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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VIII. PLAINTIFFS' CLAIM FOR UNJUST ENRICHMENT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Plaintiffs' 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 payment terms in the plans at issue. Notably, Plaintiffs' allegations supporting their unjust enrichment claim specifically reference health plans. Compl. at ¶ 220. 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 Plaintiffs seek to use this claim to recover a different amount than they 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, LL*C, 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'

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quantum meruit claim held to be completely preempted).[19]

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, Plaintiffs' 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 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

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

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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 Plaintiffs allege they conferred on the Defendants is the medical treatment of the Defendants' plan members, this claim fails as a matter of law and should be dismissed. *See* Compl. at ¶ 221.

IX. PLAINTIFFS' 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 Plaintiffs' "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, Plaintiffs' 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. Plaintiffs have standing to bring a statutory ERISA claim against Defendants due to the assignments of benefits they received, and Defendants do

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not owe any duty to Plaintiffs independent of the ERISA plans at issue.

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

Plaintiffs assert that the Defendants violated the Nevada Unfair Insurance Practices Act by not paying more on Plaintiffs' claims. Plaintiffs specifically cite 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. ¶ 229.

Plaintiffs' 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 Plaintiffs. NRS 686A.310(2) ("In addition to any rights or remedies available to the Commissioner, an insurer is liable to its <u>insured</u> for any damages sustained by the <u>insured</u> 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 Plaintiffs. *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. <u>This statute, however, does not provide a private right of action to third-party claimants</u>.

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

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created no private right of action in favor of third party claimants against the insurer.”).

Here, Plaintiffs are undisputedly third party medical providers who provided medical services to participants of plans administered by Defendants. Plaintiffs are not “insureds” but rather “third party claimants” with no contractual relationship with Defendants. Therefore, this claim should be dismissed, as Plaintiffs lack standing to bring it.

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

A. This Claim is Subject to Conflict Preemption

Plaintiffs allege 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 Plaintiffs within 30 days of Plaintiffs’ requests for payment. Compl. at ¶ 237. As a remedy for this alleged violation, Plaintiffs seek to recover Nevada statutory penalties. *Id.* at ¶¶ 237, 240.

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 the Health Care Providers the usual and customary rate within 30 days of receipt of the claim.” *Id.* at ¶ 236. 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.”).

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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 at 1294 (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

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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, Plaintiffs' claim is 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. PLAINTIFFS' 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, Plaintiffs seek 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 ¶¶ 244, 246. As part of this claim, Plaintiffs allege that Defendants are refusing to pay for "covered emergency services." *Id.* at ¶ 246. This claim is conflict preempted because (1) the Court would need to reference the ERISA plans at issue to determine whether the services Plaintiffs provided were in fact "covered," as well as whether any misrepresentations were made regarding the plan payment terms, and (2) the state law Plaintiffs rely 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);

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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. Plaintiffs could have brought their challenge to the payment amounts that they received through a statutory ERISA claim pursuant to the assignments of benefits they received from Defendants' plan members. Defendants do not owe any independent legal obligation to Plaintiffs beyond that set forth in the ERISA plan documents since Plaintiffs are out-of-network providers.

Moreover, this claim seeks punitive treble damages and a disgorgement of profits against Defendants. Compl. at ¶ 248. 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. <u>Plaintiffs Have Failed to Plead this Claim with Particularity</u>

When a claim sounds in fraud, it must be pled with particularity. *See* NRCP 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 NRCP 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

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practices claim with Rule 9(b) particularity.”).

To plead a fraud claim with particularity under NRCP 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).[20]

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, while Plaintiffs have alleged that *non-party* Data iSight made various false representations (Compl. at ¶¶ 128-188), the Complaint improperly lumps all the Defendants in with Data iSight by simply alleging they conspired together as part of a fraudulent “enterprise.” Further, Plaintiffs have failed to point to *any* false representations by the actual Defendants. While the Complaint does make reference to certain specific statements made by individuals associated with Defendants during contract negotiations, none of the statements are alleged to have been false. *Id.* at ¶¶ 93, 97-98, 104, 106. Rather, the Plaintiffs have alleged that the Defendants told them rates of reimbursement were going to be reduced and those rates were in fact subsequently reduced (i.e. a true statement was made, not a false one) *Id.* at ¶¶ 81, 88. Plaintiffs go on to compound these errors 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.* at ¶¶ 243-249 (referring only to the

[20] Federal case law on this issue is strong persuasive authority as FRCP 9(b) is identical to NRCP 9(b).

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"Defendants" generally in each allegation). For all these reasons, Plaintiffs have not pled this claim with particularity and it should be dismissed.

2. Plaintiffs are Not "Victims" Within the Meaning of NRS 41.600 and Thus Lack 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

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trade practice and did not "voluntarily" participate in the scheme that caused them harm.

Here, Plaintiffs' claim fails as they admit in the Complaint that they are not passive victims of Defendants' alleged scheme, but rather were active and knowing participants in the events in dispute. Plaintiffs admit that they entered into contract negotiations with Defendants beginning in 2017, that Defendants fully informed Plaintiffs during those negotiations of the rates they should expect to be paid for all future services rendered, and that Plaintiffs nonetheless thereafter willingly provided medical services to the Defendants' members. Compl. at ¶¶ 22, 25-26, 90-109, 246. As such, Plaintiffs do not qualify as passive "victims" under NRS 41.600 and lack standing to bring this claim.

XII. PLAINTIFFS' CLAIM FOR DECLARATORY JUDGMENT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Plaintiffs' declaratory judgment claim seeks a judicial declaration requiring Defendants to cause the plans they administer to pay Plaintiffs amounts of reimbursement set without regard to the terms of the plans. Compl. at ¶¶ 257-259. But it would be impossible for this Court to determine the correct amount of reimbursement, if any, for Plaintiffs' medical services without referring to and interpreting the terms and conditions of the members' ERISA plans. At bottom, the relief sought by Plaintiffs—a declaration that they are entitled to receive the "usual and customary rate" for their services—would require this Court to alter or rewrite the ERISA plans altogether. This Court simply cannot issue the declaratory relief sought by Plaintiffs without consulting the language in the ERISA plans. Therefore, Plaintiffs' 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"). Plaintiffs seek a declaratory judgment under state law regarding the correct amount of reimbursement for the medical services that they performed on Defendants' members. Compl. at ¶¶ 257-259. 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 Plaintiffs' state law claims with prejudice, but give Plaintiffs leave to attempt to plead a statutory claim under 29 U.S.C. § 1132(a)(1)(B) of ERISA.

Dated this 26th day of May, 2020.

/s/ Colby L. Balkenbush

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CERTIFICATE OF SERVICE

I hereby certify that on the 26th day of May, 2020, a true and correct copy of the foregoing **DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT** 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

UHIC, UHS and UMR Declaration

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EXHIBIT 1

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001060

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**

001060

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

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EXHIBIT 2

Oxford Declaration

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EXHIBIT 2

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001064

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**

001064

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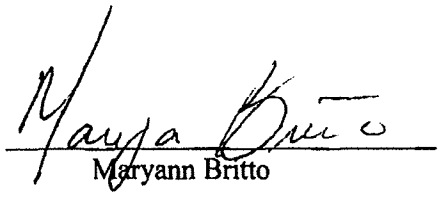
Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

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

SHO Declaration

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EXHIBIT 3

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001068

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**

001068

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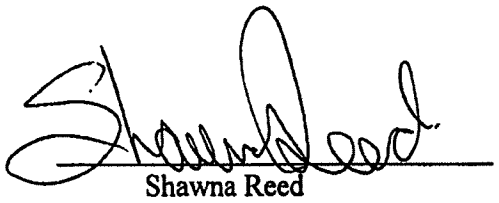
Further, for all of Fremont's claims against SHO, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

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

SHL and HPN Declaration

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EXHIBIT 4

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WEINBERG WHEELER HUDGINS GUNN & DIAL

001072

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**

001072

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

WEINBERG WHEELER HUDGINS GUNN & DIAL

001073

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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

WEINBERG WHEELER HUDGINS GUNN & DIAL

001074
001074
001074

EXHIBIT 5

Sample Claim Forms for UMR

001075

001075

EXHIBIT 5

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

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

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 [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? [X] 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 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. 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. I.D. 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 [X] 880262438

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT (For govt. claims, see back) [X] 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)

001076

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 [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)

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 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. 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. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	07 02 17	07 02 17	23		99285		A,B,C,D	1,295 00	1			1063462364
2												
3												
4												
5												
6												

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

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,295 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LOVINGER, AARON
1063462364
207P00000X

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FREMONT EMERGENCY SERVICES MAN
3186 S MARYLAND PKWY

LASVEGAS,NV 89109-2317

a. b.

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772

a. 1518120971 b.

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)

001077

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

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 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. 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
880262438 [ ] [X]

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)

001078

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

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 07/06/17

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 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. 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
880262438 X

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,787 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.)
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)

001079

001079

001079

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

PICA

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

[redacted]

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

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)

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 07/09/17

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 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. 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 880262438 SSN [ ] EIN [X]

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,295 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SLAUGHTER, KEVIN
1558317354
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
102 E LAKE MEAD PKWY

HENDERSON,NV 89015-5575
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

001080

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

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)

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)

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 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. 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	FIRST HOUR - 99291 A,B,C,D	1,681 00	1			1023391026
2												
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 $ 1,681 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.)
ALBEKORD, ARASH
1023391026
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 #
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)

001081

001081

001081

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

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)

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)

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 07/12/17

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 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. 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 880262438 SSN [ ] EIN [X]

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,295 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
MACEDO, MARK
1114286077
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
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)

001082

001082

001082

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 (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)

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)

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 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 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. 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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,295 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.)
MENES, KEVIN
1215138086
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
9300 W SUNSET RD
LASVEGAS,NV 89148-4844
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1679550149 b.

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)

001083

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)

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)

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 07/17/17

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 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. 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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,295 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.)
DUNAGAN, CLARENCE
1972505675
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS,NV 89128-0436
a. 1104870187 b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1366429821 b.

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)

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)

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 07/29/17

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: 07 29 17 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. S0502XA B. R030 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. I.D. 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: 880262438 X

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 463 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROOZENDAAL, SUZANNE
1104060169
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 : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

001085

001085

001085

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)

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)

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 08/14/17

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 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. 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 880262438 SSN [ ] EIN [X]

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 463 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ANDERSON, ERIC
1619979028
207P00000X

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FREMONT EMERGENCY SERVICES MAN
9300 W SUNSET RD

LASVEGAS,NV 89148-4844

a. b.

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772

a. 1679550149 b.

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)

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

1500

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

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 [redacted] 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)

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 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 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. R4182 B. I509 C. R7989 D. N289
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 26 17	08 26 17	23		93010		B	64 00	1			1629049945
2												
3												
4												
5												
6												

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

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 64 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.)

MCBRIDE, DANIEL
1629049945
207P00000X

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FREMONT EMERGENCY SERVICES MAN
3001 ST ROSE PKWY

HENDERSON,NV 89052-3839

a. b.

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772

a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

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

001087

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 [X] (ID#)

[redacted]

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)

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 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 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. O200 B. R030 C. Z3A01 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	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 880262438 SSN [ ] EIN [X]

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT (For govt. claims, see back) [X] 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.)

LI, TERRY
1336566579
207P00000X

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FREMONT EMERGENCY SERVICES MAN
102 E LAKE MEAD PKWY

HENDERSON,NV 89015-5575

a. b.

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772

a. 1689013161 b.

NUCC Instruction Manual at: www.nucc.org

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

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

001088

001088

001088

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 [redacted] 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)

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 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 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. 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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,295 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.)
CRAVEN, IAN
1285898049
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 : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

001089

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

1500

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

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 [X] (ID#)

[redacted]

ZIP CODE: 79119
TELEPHONE (Include Area Code):

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 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 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. O200 B. O2341 C. R102 D. 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 [X]: 880262438
26. PATIENT ACCOUNT NO.: [redacted]
27. ACCEPT ASSIGNMENT (For govt. claims, see back) [X] 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.)
KATZ, JASON
1720375322
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 : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

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

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)

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)

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 01/01/18

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. 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. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	01 01 18	01 01 18	23		99283		A,B	463 00	1			1578786877
2												
3												
4												
5												
6												

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

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 463 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ZAHAROFF, NATALIE
1578786877
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

ER AT THE LAKES
3325 SOUTH FORT APACHE

LAS VEGAS,NV 89117-6360

a. 9999999995 b.

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772

a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

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

001091

001091

001091

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 [X] (ID#)

[redacted]

ZIP CODE: 89108
TELEPHONE (Include Area Code):

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):

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

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 01/04/18

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 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. 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. I.D. 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 [X]: 880262438

26. PATIENT ACCOUNT NO.: [redacted]

27. ACCEPT ASSIGNMENT (For govt. claims, see back) [X] YES [ ] 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)

001092

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 (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)

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 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 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. 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
880262438 [ ] [X]

26. PATIENT ACCOUNT NO. [redacted]

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

TANG, MICHAEL
1073933057
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3186 S MARYLAND PKWY

LASVEGAS,NV 89109-2317

a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772

a. 1518120971 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 133068979 (MULTIPLAN 837 MEDICAL)

001093

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 [X] (ID#)

[redacted]

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 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 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. S91301A B. S91302A C. Y9389 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 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 880262438 SSN [ ] EIN [X]

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT [X] YES [ ] 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.)

INGLISH, DANIEL
1326294844
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 : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

001094

001094

001094

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

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)

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)

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 01/19/18

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 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. R531 B. R001 C. I452 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	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 880262438 SSN [ ] EIN [X]

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT [X] YES [ ] NO

28. TOTAL CHARGE $ 1,360 00

29. AMOUNT PAID $ 1,324 87

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

NUSSBAUM, CHRISTIN
1518387885

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

MOUNTAINVIEW HOSPITAL
3100 N TENAYA WAY

LAS VEGAS,NV 89128-0436

a. 1104870187 b.

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MA
PO BOX 638972

CINCINNATI,OH 45263-8972

a. 1366429821 b.

001095

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 [X] (ID#)

[redacted]

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)

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 01/24/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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

15. OTHER DATE MM DD YY QUAL.

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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT (For govt. claims, see back) [X] YES [ ] 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.)
CHAN, STEPHANIE
1548425259
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
9300 W SUNSET RD
LASVEGAS,NV 89148-4844
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10144 (UHC 837 MEDICAL)

001096

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 [X] (ID#) [redacted]

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: [redacted]

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)

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 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. 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. I.D. 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 [X] 880262438

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.

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

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 [redacted] PICA

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

[redacted]

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)

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 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 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. 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
880262438 X

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,360 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SLAUGHTER, KEVIN
1558317354
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
9300 W SUNSET RD
LASVEGAS,NV 89148-4844
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1679550149 b.

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)

001098

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

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 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

001099

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. R0789 B. I2510 C. E876 D. R000 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

001099

	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.

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

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)

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)

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 03/31/18

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 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. 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
880262438 [ ] [X]

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,404 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
LOVINGER, AARON
1063462364
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3186 S MARYLAND PKWY
LASVEGAS,NV 89109-2317
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1518120971 b.

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)

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

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)

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)

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 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 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. 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
880262438 [ ] [X]

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,956 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.)
TRANCHELL, NATHAN
1558599050
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3001 ST ROSE PKWY
HENDERSON,NV 89052-3839
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1689013161 b.

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

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

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

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)

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 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 05 16 18 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. 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
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.)
LIN, CHARLES
1194131854
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 : 201736437 (FIRST HEALTH/CCN ROUTED 837 MEDICAL)

001102

001102

001102

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	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 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		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. S80211A B. S80212A C. M542 D. R1011		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		
I. J. K. L.		

	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	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 (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 #
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.

001103

001103

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

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)

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)

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 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 07 15 18 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. S098XXA B. S0101XA C. R55 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 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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,803 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.)
CLARK, RUSSELL
1790787497
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)

001104

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 [X] (ID#)

[redacted]

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)

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 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 [X]
880262438

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.)
KUO, TIM
1013357102
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3001 ST ROSE PKWY
HENDERSON,NV 89052-3839
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1689013161 b.

Submitter : 752297429-10036 (UHC 837 MEDICAL)

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# : [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)

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 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 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. R002 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	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
880262438 X

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,353 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.)
SPENCE, ROBERT
1588653125
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ER AT ALIANTE
7207 N ALIANTE PKWY
LAS VEGAS,NV 89084-2502
a. 9999999995 b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1316488141 b.

NUCC Instruction Manual at: www.nucc.org

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

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

001106

001106

001106

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

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

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 [redacted] 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)

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)

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 01/02/19

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 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. 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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 530 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
WRIGHT, BROOKS
1336574250
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY

LAS VEGAS,NV 89128-0436
a. 1104870187 b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1366429821 b.

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)

001107

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 [X] (ID#)

[redacted]

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)

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 01/12/19

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 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. 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 [X]
880262438

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.)
RUSHTON, JOHN
1508055765
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3100 N TENAYA WAY
LAS VEGAS,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)

001108

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

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)

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 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 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. 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

	24A. 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 99285	A,B,C	1,360 00	1			1811395718
2												
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 $ 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.)
FORSMAN, ROBYN R
1811395718
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SUNRISE HOSPITAL AND MEDICAL C
3186 S MARYLAND PKWY
LAS VEGAS,NV 89109-2317
a. 1861439952 b.

33. BILLING PROVIDER INFO & PH #
FREMONT 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)

001109

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 [redacted] 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)

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)

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 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 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. 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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT (For Govt. Claims, See back) [X] YES [ ] 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.)
FLORES, PATRICK
1104087287
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3186 S MARYLAND PKWY

LAS VEGAS,NV 89109-2317

a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772

a. 1518120971 b.

001110

001110

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

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)

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]

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 03/04/19

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 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. 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
880262438 [ ] [X]

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT [X] YES [ ] 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.)
GOMEZ, ADRIAN
1235431388
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3100 N TENAYA WAY
LAS VEGAS,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)

001111

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

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)

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]

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 03/05/19

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. I.D. 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
880262438 [ ] [X]

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT (For govt. claims, see back) [X] YES [ ] 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.)
CHAN, STEPHANIE
1548425259
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
9300 W SUNSET RD
LAS VEGAS,NV 89148-4844
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1679550149 b.

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)

001112

001112

001112

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

PICA

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

[redacted]

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)

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 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 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. 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. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	03 06 19	03 06 19	23		99285		A,B	1,360 00	1			1972505675
2												
3												
4												
5												
6												

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

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT (For govt. claims, see back) X YES 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.)
DUNAGAN, CLARENCE
1972505675
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY

LAS VEGAS,NV 89128-0436
a. 1104870187 b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1366429821 b.

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

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 [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 03/09/19

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 880262438 ☐ [X]	26. PATIENT ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT (For govt. claims, see back) [X] YES ☐ NO	28. TOTAL CHARGE $ 1,337 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.) LUNDBERG, MICHAEL 1366865206 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.		

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 [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 03/11/19

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 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. M25562 B. M25462 C. 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 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.

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

PICA

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

[redacted]

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 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.

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. R0600 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	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
880262438 X

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,428 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
LIN, CHARLES
1194131854
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3186 S MARYLAND PKWY
LAS VEGAS,NV 89109-2317
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1518120971 b.

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

Submitter : 133068979 (PHCS ROUTED 837 MEDICAL)

001116

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

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)

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 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 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. J189 B. R0902 C. J45901 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 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
880262438 X

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1,474 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.)
WALKER, JAMES
1851592497
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3186 S MARYLAND PKWY
LAS VEGAS,NV 89109-2317
a. b.

33. BILLING PROVIDER INFO & PH #
FREMONT EMERGENCY SERVICES MAN
PO BOX 638972
CINCINNATI,OH 45263-8972
(888) 952-6772
a. 1518120971 b.

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

001117

001117

001117

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $964.00

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#) | OTHE [redacted] 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 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 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. 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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 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)

001118

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 [ ] 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)

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 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 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. 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. I.D. 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 [X] 880262438

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT (For Govt. Claims, See back) [X] YES [ ] NO

28. TOTAL CHARGE $ 1,853 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.)

CHANG, WILLIS
1609253103
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
3100 N TENAYA WAY

LAS VEGAS,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.

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 [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 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. 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 (For govt. claims, see back) [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)

EXHIBIT 6

Sample Claim Forms for SHO

001121

001121

EXHIBIT 6

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY N. UNIFORM CLAIM COMMITTEE 08/05

PICA [redacted] 8/1/13

MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | X | OTH (ID#) [redacted]

[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 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.
SIGNATURE ON FILE SIGNED

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 FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 08 26 17 TO MM DD YY 08 26 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. R03.0 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 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 ID 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 $ 1295 00
29. AMOUNT PAID $ 0 00
30. Rsvd for NUCC use

31. SIGNATURE OF PHYS.CLAIM OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
WRIGHT DO,BROOKS
SIGNATURE ON FILE
SIGNED 12/28/17

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)

SRS 5231 44 OUTSOURCED BILLEIN

VICMS 1500C S-12

SIERRA HEALTHCARE OPTIONS%\

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE DATE 01/02/18

SIGNATURE ON FILE

01 14 17 431

17a.

17b. NPI

16. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 01 14 17 TO 01 14 17

20. OUTSIDE LAB? YES X NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1,2,3 or 4 to item 24E by line below (24E) ICD Ind. 0

1. I21.3

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

	DATE(S) OF SERVICE From	To	PLACE OF SERVICE	EMG	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	218.00	1601	001		1104168293
2												
3												
4												
5												
6												

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1601 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.)

BAILEY MD,JAMES
SIGNATURE ON FILE
DATE 01/02/18

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS,NV 89128-0436
b. 1104870187

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1366429821 b. ZZ207P00000X

800-562-2945

MOA 5230 PLEASE PRINT OR TYPE SZR 60 COMM NPI 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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
05 14 17 QUAL. 431

15. OTHER DATE
QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM 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

PHYSICIAN OR SUPPLIER INFORMATION

24A. 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 05 14 17 05 14 17	23	X	99285	213.00	A	1233 00	1		NPI	1366766099
2 05 14 17 05 14 17	23	X	99053	Ø	A	40 00	1		NPI	1366766099
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
$ 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

SITE 52601 44-OUTSOURCED BILLING

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM 1500 (02-12)

VICIE 1500CS 12

001124

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 request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: 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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 08 15 17 QUAL. 431

15. OTHER DATE: MM DD YY QUAL.

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 08 15 17 TO 08 15 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. 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 Fam. 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	222.00	A	64 00	1		NPI	1629294004
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: $ 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 52600

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 HCFA-1500 (02-12)

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

[redacted]

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.
SIGNED: 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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 08 DD 19 YY 17 QUAL. 431
15. OTHER DATE: QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 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	223.00	ABC	1681 00	1		NPI	1740625946
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: $ 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.
SIGNED SIGNATURE ON FILE DATE 01/25/18

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 SIGNATURE ON FILE

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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 07 18 17 TO MM DD YY 07 18 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. 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	22,00	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 [ ] [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.)
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

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

[redacted]

HEALTH INSURANCE CLAIM FORM

[redacted]

CARRIER

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 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

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) 11 22 17 QUAL 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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. 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 ID. #
1	11 22 17	11 22 17	23	X	99291	25	ABCD	1681 00	1		NPI	1366555708
2	11 22 17	11 22 17	23	X	92960		A	925 00	1		NPI	1366555708
3	11 22 17	11 22 17	23	X	93010		A	256 00	4		NPI	1366555708
4	11 22 17	11 22 17	23	X	99152		A	93 00	1		NPI	1366555708
5											NPI	
6											NPI	

223.00

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 $ 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
SRD 52600

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
44-OUTSOURCED-BILLING

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

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
PATIENT AND INSURED INFORMATION. SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or to the party who accepts assignment services described below.

SIGNATURE ON FILE DATE 02/01/18

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

SIGNATURE ON FILE SIGNED

08 06 17 Qual. 431

15. OTHER DATE MM DD YY Qual.

17a. 17b. NPI

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 08 06 17 TO 08 06 17

20. OUTSIDE LAB? YES X NO

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. 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.

24A. 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 06 17	08 06 17	23	X	99285	22-00	AB	1295 00	1			1063462364
08 06 17	08 06 17	23	X	99053	Ø	AB	~~42 00~~				1063462364

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

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
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 Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OUTSOURCED BILLING

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]

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: 02/22/18

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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 09 29 17 QUAL 431
15. OTHER DATE: QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a 17b NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM 09 29 17 TO 09 29 17
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? 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 Fam. 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: 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: $ 1681.00
29. AMOUNT PAID: $ 0.00
30. BALANCE DUE: $ 1681.00
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.
CRAVEN MD, IAN ANDREW
SIGNATURE ON FILE
SIGNED 02/22/18 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

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

SRC 5231 44-OUTSOURCED BILLING

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

1	12 28 17	12 28 17	23	X	99284		ABC	927 00	1		NPI	1649569583
2	12 28 17	12 28 17	23	X	99053		ABC	44 00	1		NPI	1649569583
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

(800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
1518120971 ZZ207P00000X

PLEASE PRINT OR TYPE

PHYSICIAN OR SUPPLIER INFORMATION

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

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 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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 12 16 17 TO MM DD YY 12 16 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. 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	001		NPI	1003869504
12 16 17	12 16 17	23	X	93010		A	67	001		NPI	1003869504
										NPI	
										NPI	
										NPI	
										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 $ 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
SIGNATURE ON FILE
SIGNED 03/06/18 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

NOTICE: Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 (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

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED SIGNATURE ON FILE DATE 04/19/18

SIGNED SIGNATURE ON FILE

DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 08 17 17 QUAL. 431

OTHER DATE QUAL.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 08 17 17 08 17 17

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

A. I21.3 B. G51.0 C. I16.0 D. E. F. G. H. I. J. K. L.

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 ID.
08 17 17	08 17 17	23	X	99291		ABC	1681 00	1			1972505675

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 $ 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.)

DUNAGAN MD, CLARENCE
SIGNATURE ON FILE
SIGNED 04/19/18

32. SERVICE FACILITY LOCATION INFORMATION

MOUNTAIN VIEW HOSPITAL
3100 N TENAYA WAY
LAS VEGAS, NV 89128-0436
a. 1104870187

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

FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
b. 1366429821 77207P000000X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

MOA 5290 CKK 60 COMM NPI FORM

PHYSICIAN OR SUPPLIER INFORMATION

[redacted]

KAISER PPO
PO BOX 14392
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. 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 04 DD 13 YY 18 QUAL. 431

15. OTHER DATE QUAL. 439 MM 04 DD 13 YY 18

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM 04 DD 13 YY 18 TO MM 04 DD 13 YY 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. 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 00	1		NPI	~~1073933057~~
2	04 13 18	04 13 18	23	X	99053		ABCD	44 00	1		NPI	~~1073933057~~
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 $ 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/MICHAEL
SIGNATURE ON FILE 04/30/18
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS,NV 89109-2317
a. ~~1861439952~~ b.

33. BILLING PROVIDER INFO & PH. # ( ) ~~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

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

001134

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.
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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 06 17 17 TO MM DD YY 06 17 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. 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	

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 $ 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 b

33. BILLING PROVIDER INFO & PH. # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a 1689013161 b ZZ207E00000X

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WCMS-1500CS-12

SEC 52501 41 OUTSOURCED BILLIN

[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

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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 11 19 17 TO MM DD YY 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 [X]
88-0262438

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

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SRS 5231 44 OUTSOURCED BILLIN

WCMS-1500CS-12

001136

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[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.
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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY: 06 05 18 TO MM DD YY: 06 05 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. 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 ☐ ☒

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.)
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 NATIONAL UNIFORM CLAIM COMMITTEE (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

[redacted]

PATIENT AND INSURED INFORMATION — CARRIER

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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY: 02 09 18 TO MM DD YY: 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

24A. 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 Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02 09 18	02 09 18	23	X	99285		AB	1360 00	1		NPI	1114212743
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX ID. 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.)
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 NUCC 02/12

WCMS-1500CS-12

[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]

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: 08/16/18

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: 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 FROM MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 11 17 17 TO 11 17 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X]

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. DATES(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		NP	1285898049
										NP	
										NP	
										NP	
										NP	
										NP	

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 $ 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.)
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 BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SRS 5231

44 OUTSOURCED BILLIN

WCMS-1500CS-12

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

HEALTH INSURANCE CLAIM FORM

[redacted]

SIGNATURE ON FILE DATE 09/25/18 SIGNATURE ON FILE

001140

DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) 02 17 18 QUAL. 431 15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 02 17 18 TO 02 17 18

X

R06.00 J18.1 E87.2 0

24A. DATE(S) OF SERVICE FROM	TO	PLACE OF SERVICE	EMG	24B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	24E. DIAGNOSIS POINTER	24F. CHARGES	24G. DAYS OR UNITS	24J. RENDERING PROVIDER ID. #
02 17 18	02 17 18	23	X	99285		ABC	1360 00	1	1437398476

25. FEDERAL TAX I.D. NUMBER 88-0262438 SSN EIN X [redacted] 27. ACCEPT ASSIGNMENT? X YES NO 28. TOTAL CHARGE 1360 00 29. AMOUNT PAID 0 00

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
8280 W WARM SPRINGS RD
LAS VEGAS, NV 89113-3612
1528101284

33. PHYSICIAN OR SUPPLIER BILLING NAME, ADDRESS, ZIP CODE & PHONE #
FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
800-562-2945
1689013161 ZZ207P00000X

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
LO DO, JOSEPH
SIGNATURE ON FILE
09/25/18

SRD 526600 PLEASE PRINT OR TYPE DAA 60-6 APPROVED FOR USE

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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 08 11 18 TO 08 11 18

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

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. 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 00	1		NPI	1437398476
2	08 11 18	08 11 18	23	X	93010		B	67 00	1		NPI	1437398476
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 $ 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. 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 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]

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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 04 22 18 TO MM DD YY 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

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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]

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: 10/26/18

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: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 07 DD 13 YY 18 QUAL. 431

15. OTHER DATE: QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM 07 DD 13 YY 18 TO MM 07 DD 13 YY 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. 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

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 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	

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.)
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. 1518120971 b. 2220 7P000000X

NUCC 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-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

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

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 FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 10 16 TO 11 10 16
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. 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

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 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	

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 $ 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
SIGNED SIGNATURE ON FILE DATE 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

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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]

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.
SIGNED SIGNATURE ON FILE DATE 12/27/18

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 07 DD 29 YY 18 QUAL. 431

15. OTHER DATE QUAL. 439 MM 07 DD 29 YY 18

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM 07 DD 29 YY 18 TO MM 07 DD 29 YY 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. 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 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.)
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. ZZ207P00000X

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

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 01/16/19

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 03 DD 29 YY 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM 03 DD 29 YY 18 TO MM 03 DD 29 YY 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 DATE 01/16/19

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

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

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WCMS-1500CS-12

SIERRA HEALTHCARE - OPTIONS-A

[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.
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 10 03 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 10 03 18 TO 10 03 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. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	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 [ ] [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.)
CHAN MD, STEPHANIE
SIGNATURE ON FILE
SIGNED DATE 01/30/19

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

790-0116 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SIERRA HE [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 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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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	

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 $ 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

790-0116 (02-12) (OCR) 1PT

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE GMS APPROVED OMB-0938-1197 FORM 1500 (02-12)

[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 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 26 18 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY 08 26 18

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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. 672.012A B. W07.XXXA C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 26 18	08 26 18	23	X	99285		AB	1360 001			NPI	1588653125
2	08 26 18	08 26 18	23	X	99053		AB	44 001			NPI	1588653125
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 $ 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 LOCATION 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

790-0119 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE GMS APPROVED OMB-0938-1197 FORM 1500 (02-12)

[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 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 11 24 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	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.)
GRONSETH MD, AARON
SIGNED SIGNATURE ON FILE DATE 01/30/19

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
b 1518120971 b ZZ207P00000X

790-0116 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE GMS APPROVED OMB-0938-1197 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 MMS 60 COMM NPI FORM

SIERRA HEALTH
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 10 26 18 TO MM DD YY 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-0938-0997 FORM 1500 (02-12)

WCMS-1500CS-12

14 OUTSOURCED BILLING

[redacted]

KAISER-CA
PO BOX 15392
LAS VEGAS NV 89114

CARRIER

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.
SIGNED 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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 13 18 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY 10 13 18

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 10 13 18 TO MM DD YY 10 13 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] 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 DATE 02/25/19

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

FIRST FOLD WMCF-10-ENV / WMCF-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

[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.
SIGNED SIGNATURE ON FILE DATE 03/29/19

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 10 DD 17 YY 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

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

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 $ 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

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

WCMS-1500CS-12

[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]

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 09 DD 11 YY 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM 09 DD 11 YY 18 TO MM 09 DD 11 YY 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.)
INGLISH DO,DANIEL JO
SIGNATURE ON FILE
SIGNED 04/02/19 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

[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 04/02/19
SIGNED ____ DATE ____

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 12 06 18 QUAL. 431
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 12 06 18 TO 12 06 18
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? [ ] 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 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.)
ANDERSON MD,ERIC YOH
SIGNATURE ON FILE
SIGNED 04/02/19 DATE
MOA 5230

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

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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

SIERRA HEALTHCARE OPTIONS-N

[redacted]

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]

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 04/04/19
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 08 04 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 08 04 18 TO MM DD YY 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. 0
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 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.)
SANDESH I. MD, NICK
SIGNATURE ON FILE
SIGNED 04/04/19 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

790-0116 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

SIERRA HEALTHCARE OPTIONS%\

[redacted]

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

HEALTH INSURANCE CLAIM FORM

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

CARRIER

[redacted]

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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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: 06 02 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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: 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.)
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 b.

33. BILLING PROVIDER INFO & PH # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1518120971 b. ZZ207P00000X

790-0116 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

SIERRA HEALTHCARE OPTIONS-N

[redacted]

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

HEALTH INSURANCE CLAIM FORM

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

CARRIER

[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 04/04/19
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 10 DD 17 YY 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

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

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 88-0262438 SSN [ ] EIN [X]

[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
SIGNATURE ON FILE
SIGNED 04/04/19 DATE

[redacted]

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

790-0116 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SIERRA HEALTHCARE OPTIONS-N [redacted]

SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
ATTN: KAISER CLAIMS
LAS VEGAS, NV 89114-5392

HEALTH INSURANCE CLAIM FORM

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

CARRIER

[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 04/16/19

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 02 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	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	

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.)
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) 562-2945
FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1366429821 b. ZZ207P00000X

790-0116 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE SC6 APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT 7

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EXHIBIT 7

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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.	§	

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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

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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

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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.*

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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.*

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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

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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).

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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.")).

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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

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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.*

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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

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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

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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.

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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

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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

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[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).

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Attorneys for Defendants

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., 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 **DEFENDANTS' SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT ADDRESSING PLAINTIFFS' EIGHTH CLAIM FOR RELIEF** Hearing Date: June 5, 2020 Hearing Time: 1:00 PM

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I. INTRODUCTION[1]

This supplemental brief seeks dismissal of Plaintiffs' eighth cause of action, a Nevada RICO claim. Plaintiffs' RICO claim should be dismissed because it fails for multiple, independent reasons. First, as with Plaintiffs' other state law claims, Plaintiffs' racketeering claim is preempted by ERISA because it is ultimately about Plaintiffs challenging the reimbursements received for medical services that were provided to Defendants' plan members. To resolve that issue, the Court will have to closely examine the terms of the employee benefit plans at issue and, as a result, this claim "relates to" plans governed by ERISA and is preempted.

Second, Plaintiffs have failed to plead the critical element of proximate cause to support a cognizable RICO claim. In fact, the Complaint admits that both Nevada and federal law require the Plaintiffs to provide emergency medical treatment to Defendants' plan members regardless of insurance coverage or the members' ability to pay. Thus, even if the Defendants made misrepresentations about future payment rates, it is impossible for those alleged misrepresentations to have *caused* Plaintiffs' damages. For this reason alone, Plaintiffs' RICO claim fails.

Third, Plaintiffs have failed plead their RICO claim, which sounds in fraud, with the particularity required by NRCP 9(b). Plaintiffs improperly lump all eight Defendants together with Data iSight and fail to identify the role each Defendant played in the alleged fraudulent scheme. Ultimately, when Plaintiffs' conclusory allegations are set aside, Plaintiffs have alleged nothing more than an ordinary commercial contractual relationship between Defendants and MultiPlan, Inc., pursuant to which Defendants received pricing information through MultiPlan's Data iSight tool. For this reason alone, Plaintiffs' RICO claim fails.

For all these reasons and those set forth below, Plaintiffs' RICO claim should be dismissed.

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[1] This supplemental brief is being submitted pursuant to a stipulation and order submitted by the Parties on May 26, 2020. Defendants' May 26, 2020 Motion to Dismiss addresses Plaintiffs' first seven causes of action.

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II. PLAINTIFFS' NEVADA RICO CLAIM SHOULD BE DISMISSED

A. This Claim is Subject to Complete Preemption and Conflict Preemption

Plaintiffs' RICO claim is both completely preempted and conflict preempted under ERISA. *See Moorman v. UnumProvident Corp.*, 2007 WL 4984162, at *3 (N.D. Ga. Oct. 30, 2007) (even where a plaintiff successfully pleads a RICO claim with particularity, the current state of law is such that a state RICO claim is preempted by ERISA); *see also Bridges v. Blue Cross and Blue Shield Ass'n*, 935 F. Supp. 37, 43 (D. D.C. 1996)) ("plaintiffs' [civil] RICO claims must be dismissed, because the detailed enforcement scheme of the FEHBA,[2] leaves no room for a RICO action here."); *Norman v. Niagara Mohawk Power Corp.*, 873 F.2d 634, 637 (2d Cir. 1989) ("Artful invocation of controversial civil RICO, particularly when inadequately pleaded, cannot conceal the reality that the gravamen of the complaint" is subject to some other exclusive remedy); *Danielsen v. Burnside-Ott Aviation Training Ctr., Inc.*, 746 F. Supp. 170, 176 (D.D.C. 1990), *aff'd*, 941 F.2d 1220 (D.C. Cir. 1991) ("RICO is preempted by . . . statutes that establish comprehensive administrative schemes."). This lawsuit is ultimately about whether Plaintiffs are entitled to additional plan benefit payments for medical services that they rendered to Defendants' plan members. Compl. ¶¶ 65-69, Request for Relief ¶ G. But if Defendants establish (as they will) that the claim payments were properly calculated under the terms of the various plans, Defendants will be entitled to judgment. Plaintiffs cannot use a RICO claim to get around the fact that coverage and the applicable rate of reimbursement are governed by the terms of the members' ERISA plans, and the Court should find that this claim is both completely preempted and conflict preempted.

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

To state a claim for relief under Nevada's civil racketeering statute, a plaintiff must allege facts demonstrating that it was injured in its business or property by reason of a violation of NRS 207.400. *See* NRS 207.470. NRS 207.400 renders unlawful "racketeering activity,"

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[2] FEHBA is analogous to ERISA in that it is a federal law that governs claims related to federal employee health benefit plans and courts regularly find state causes of action preempted by it.

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which means "engaging in at least two crimes related to racketeering" that are similar in nature. NRS 207.390.[3] *See Allum v. Valley Bank of Nevada*, 109 Nev. 280, 282, 849 P.2d 297, 299 (1993) ("[F]or a plaintiff to recover under Nevada RICO . . . the plaintiff's injury must flow from the defendant's violation of a predicate Nevada RICO act . . . ."). [4] NRS 207.360 lists thirty-seven different racketeering crimes, which are commonly referred to as predicate RICO acts. Thus, to state a RICO claim, Plaintiffs must adequately plead, among other things, that Defendants engaged in at least two of the thirty-seven predicate RICO crimes listed in NRS 207.360, and that the identified racketeering crimes caused their alleged injuries. Because the Complaint fails to adequately plead any crime of racketeering, and further fails to identify any injury to Plaintiffs that was proximately caused by the alleged racketeering crimes, the Court should dismiss Plaintiffs' Nevada RICO claim, with prejudice.

1. Plaintiffs have failed to plead proximate cause as required by RICO.

"To recover under RICO . . . the plaintiff must show that the defendant's RICO violation proximately caused the plaintiff's injury." *See Allum*, 849 P.2d at 300; *Hemi Grp., LLC v. City of N.Y., N.Y.*, 559 U.S. 1, 17–18 (2010) ("This Court has interpreted RICO broadly, consistent with its terms, but we have also held that its reach is limited by the 'requirement of a direct causal connection' between the predicate wrong and the harm."); *Holmes v. Sec. Inv'r Prot. Corp.*, 503 U.S. 258, 266–68 (1992) (proximate cause demands a "direct relation between the injury asserted and the injurious conduct alleged."). [5] In the Complaint, Plaintiffs contend that

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[3] The Ninth Circuit has held that a district court may "correctly dismiss[] [a] state law RICO claim" based on its "analysis of [a] federal RICO claim," because "Nevada courts have interpreted the state RICO statute consistently with the provisions of federal RICO." *Steele v. Hosp. Corp. of Am.*, 36 F.3d 69, 71 (9th Cir. 1994) (citing *Allum*, 849 P.2d at 298 n.2 ("Nevada's racketeering statutes ... are patterned after the federal [RICO] statutes")).

[4] Plaintiffs grasp at numerous undeveloped racketeering theories in the Complaint, broadly citing entire swaths of Nevada's statute without providing supporting, connective details. Compl. at ¶ 116 (alleging that Defendants have violated NRS 207.400(1)(a)-(d), (1)(f), (1)(i)-(j)). All of the broadly cited subsections, however, require a plaintiff to plead an injury caused by racketeering activity. Plaintiffs' racketeering claim is foreclosed in its entirety because, for the reasons discussed in the main text, Plaintiffs have not pleaded any crimes of racketeering, nor have they pleaded that any crimes of racketeering caused an injury to Plaintiffs. Plaintiffs' argument that certain of these subsections do not require the existence of an enterprise, even if it were correct, is thus irrelevant. *See* ECF No. 36 at 9.

[5] *See also Wodka v. Causeway Capital Mgmt. LLC*, 433 F. App'x 563, 564 (9th Cir. 2011) (concluding that "the cause of [plaintiff's] asserted harm was 'a set of actions ... entirely distinct from the alleged

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the Defendants violated RICO by using websites and other communications to make false representations to providers concerning the transparency and objectivity of the Data iSight claim pricing service that Defendants used to assist them in determining plan payment rates. Compl. at ¶¶ 177–78. The Complaint specifically identifies Plaintiffs' asserted injury as the alleged underpayment of various health claims that they submitted to Defendants for payment. *Id.* at ¶¶ 268–269. Plaintiffs' inescapable problem, however, is that the Complaint makes clear that the alleged misrepresentations played no role in causing Plaintiffs' asserted underpayment injuries; Plaintiffs would have rendered the same services, and received the same alleged underpayments, if the asserted misrepresentations on Data iSight's website had never been made. This is a textbook case of lack of causation.

The Complaint states that "federal and state law requires that emergency services be provided to individuals by the Health Care Providers." *Id.* at ¶ 21. It further acknowledges that Plaintiffs accordingly are legally obligated to—and do—provide services to patients "without regard to insurance status or ability to pay." *Id.* These admissions make plain that no representation that Defendants or Data iSight may have made concerning their payment rates or methodologies could have had any effect on Plaintiffs' provision of services, because Plaintiffs were legally obligated to provide those services without regard to any understandings they may have had about what the associated payment rates would be. Even if the health claims at issue were underpaid under the terms of the relevant plans—and they were not—that alleged underpayment injury would bear no causal connection to any of the alleged misrepresentations identified in the Complaint.

Plaintiffs also cannot establish the required causation for the separate reason that the Complaint admits Defendants provided advance notice to Plaintiffs that their out-of-network payment rates were expected to drop. *Id.* at ¶¶ 93, 96–97. This frank disclosure—assertedly made by Defendants on at least three separate occasions—breaks any conceivable causal chain

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RICO violation' and thus too attenuated for RICO purposes."); *Greenstein v. Peters*, 2009 WL 722067, at *3 (C.D. Cal. Mar. 16, 2009) (finding plaintiff lacked standing under RICO where he failed to "allege that [defendant's] conduct affected his decision" and "caus[ed] him to incur" the alleged injury).

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connecting Plaintiffs' purported underpayment injuries to the asserted misrepresentations on Data iSight's website. Plaintiffs have offered no coherent legal argument supporting RICO causation.

In short, it is clear from the Complaint that Plaintiffs would have suffered the exact same alleged injury had the alleged misrepresentations never been made at all. Because Plaintiffs have not plausibly alleged the "direct relation between the injury asserted and the injurious conduct alleged" that RICO requires, *Holmes*, 503 U.S. at 268, Plaintiffs' RICO claim fails as a matter of law and must be dismissed.

2. Plaintiffs have failed to properly plead predicate RICO crimes.

To plead a cognizable RICO claim, Plaintiffs are required to plead facts sufficient to show that their alleged injury "flow[s] from the defendant's violation of a predicate Nevada RICO act . . . ."). *Allum*, 849 P.2d at 299. The Complaint purports to identify three predicate RICO crimes:

- "[O]btaining possession of money or property valued at $650 or more," NRS 207.390, 207.360(28);
- "[M]ultiple transactions involving fraud or deceit in [the] course of [an] enterprise or occupation," NRS 205.377, NRS 207.360(35); and
- "[I]nvoluntary servitude," NRS 207.360(36).

Compl. at ¶¶ 110, 117, 264, 269. The first two crimes are fraud-based,[6] and therefore must meet the heightened pleading standard of NRCP 9(b). *See Hale v. Burkhardt*, 104 Nev. 632, 637, 764 P.2d 866, 869 (1988) (finding "the requirement of pleading with particularity" applies "in state [RICO] actions just as it does in the federal context."). Plaintiffs have not properly pleaded either of these fraud-based crimes, both because the Complaint does not come close to meeting the Rule 9(b) pleading standard, and because the Complaint fails to establish the required elements of reliance and intent to deceive for both crimes. The third asserted crime—involuntary servitude—is facially absurd, and also is not remotely established by the Complaint.

[6] Nevada false pretenses law requires, among other things, an "intent to defraud," and that "the victim be defrauded." *Barron v. State*, 783 P.2d 444, 449 (Nev. 1989) (citing *Bright v. Sheriff*, 90 Nev. 168, 170, 521 P.2d 371, 372 (1974)).

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i. *Plaintiffs do not properly plead fraud-based predicate RICO crimes under NRS §§ 207.360(28) or (35).*

NRS 207.360(35), which prohibits "[a]ny violation of NRS 205.377," requires Plaintiffs, through its statutory definition, to allege both reliance and intent to deceive:

> A person shall not, in the course of an enterprise or occupation, knowingly and *with the intent to defraud*, engage in an act, practice or course of business or employ a device, scheme or artifice which operates or would operate as a fraud or deceit upon a person by means of a false representation or omission of a material fact that: (a) The person knows to be false or omitted; (b) *The person intends another to rely on*; and (c) Results in a loss to any person *who relied on* the false representation or omission.

NRS 205.377 (emphasis added); *see also Mendoza v. Amalgamated Transit Union Int'l*, 2019 WL 4221078, at *6 (D. Nev. Sept. 5, 2019) (stating that NRS 205.377 "requires not only that the fraud or deceit result in a loss, but also that the loss be attributable to a person who *relied* on the false representation or omission" and dismissing a Nevada racketeering claim where "plaintiffs have provided no factual support plausibly evincing that any plaintiff relied on [defendant's] allegedly false representations to their detriment"). NRS 207.360(28) (obtaining possession of money or property by false pretenses) also requires Plaintiffs to allege both reliance and intent to deceive through its incorporation by reference of Nevada's false pretenses law: "[The] elements of the crime of obtaining money under false pretenses . . . are: (1) *intent to defraud*; (2) a false representation; (3) *reliance on* that representation; and, (4) that the victim be defrauded." *Barron*, 783 P.2d at 449 (citing *Bright*, 90 Nev. at 170, 521 P.2d at 372 (emphasis added).

Plaintiffs admit that they were required by state and federal law to provide the medical services in question without regard to the rates Defendants would pay. Compl. at ¶ 21 ("[F]ederal and state law requires that emergency services be provided to individuals by the Health Care Providers without regard to insurance status or ability to pay . . . ."). Plaintiffs further expressly admit that they do in fact provide medical services "to all patients, regardless of insurance coverage or ability to pay, including to Patients with insurance coverage issued, administered and/or underwritten by Defendants." *Id.* at ¶ 18. These admissions definitively establish that Plaintiffs never relied on any representations concerning Defendants' payment rates in deciding whether to render services to patients. Nor can Plaintiffs establish intent to deceive: Plaintiffs admit that Defendants expressly notified them well in advance of the very

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reimbursement reductions about which they now complain, *id.* at ¶¶ 93–97, 104–106, defeating any suggestion of deception.[7] *See Card v. Ralph Lauren Corp.*, 2020 WL 353464, at *5 (N.D. Cal. Jan. 21, 2020) (dismissing RICO claim, with prejudice, where plaintiff failed to allege how the communications she identified as predicate acts satisfied the elements of mail and wire fraud, including intent to deceive or defraud, and concluding, "[plaintiff's] allegations regarding Defendants' conduct may give rise to a claim that Defendants breached the parties' implied contract or a claim that Defendants breached the duty of good faith, but they do not give rise to a civil RICO claim without specific allegations of fraud made in accordance with Rule 9(b).").

In addition to failing to plead these required elements of the two fraud-based RICO predicate crimes alleged in the Complaint, Plaintiffs also fail to satisfy NRCP 9(b)'s heightened pleading standard. To plead a fraud claim with particularity under NRCP 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*, 97 Nev. at 583–84, 636 P.2d at 874. 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).[8] "This means the [RICO] complaint should provide information as to 'when, where [and] how' the underlying criminal acts occurred." *Cummings v. Charter Hosp. of Las Vegas, Inc.*, 111 Nev. 639, 646, 896 P.2d 1137, 1141 (1995). "Any averments which do not meet that standard should be 'disregarded,' or 'stripped' from the claim for failure to satisfy Rule 9(b)." *Wegner v. Wells Fargo Bank Nat'l Ass'n*, 2018 WL 3114528, at *8 (D. Nev. June 25, 2018) (quoting *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1124 (9th Cir. 2009)).

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[7] While a plaintiff may aver intent generally, *Brown v. Kellar*, 97 Nev. 582, 584, 636 P.2d 874, 874 (1981), this does not save Plaintiffs' RICO claim because they fail to plead *any* intent to deceive, general or specific, and thus their fraud-based racketeering crimes fall short of either standard.

[8] Federal case law on this issue is strong persuasive authority as FRCP 9(b) is identical to NRCP 9(b).

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Plaintiffs' allegations fail to meet this standard. To be sure, the Complaint recounts various representations that Data iSight—which is *not* a named defendant—allegedly made on its website, provider portal, and in certain notes that allegedly accompanied processed claims. Compl. at ¶¶ 128–174. But Data iSight is a service that Plaintiffs acknowledge is used by many different payers and health plans, not just Defendants, *see id.* at ¶ 101, and Plaintiffs fail to attribute the identified Data iSight representations to any particular United Defendant, or provide any facts establishing that any United Defendant can plausibly be viewed as responsible for the content on Data iSight's website. *See Swartz*, 476 F.3d at 764–75 ("Rule 9(b) does not allow a complaint to merely lump multiple defendants together . . . . In the context of a fraud suit involving multiple defendants, a plaintiff must, at a minimum, 'identif[y] the role of [each] defendant[ ] in the alleged fraudulent scheme.'"); *In re Volkswagen "Clean Diesel" Mktg., Sales Practices, & Prod. Liab. Litig.*, 2019 WL 4581340, at *7–8, 10 (N.D. Cal. Sept. 20, 2019) (dismissing RICO claim for failure to satisfy Rule 9(b) where plaintiffs alleged without supporting details that "'Volkswagen' . . . which is the umbrella term used to refer to all Defendants" made certain representations "on their websites, YouTube, and through advertisements made . . . on the internet . . . all of which were intended to mislead regulators and the public," but "this type of group pleading is not permitted").

Plaintiffs instead impermissibly lump the United Defendants together in vague and conclusory allegations that assert the "Defendants" are "engag[ing] in a scheme" or "conspir[ing]" with Data iSight to "impose arbitrary and unreasonable payment rates" and "manipulate payment rates and payment data to their benefit," *see, e.g.*, Compl. at ¶¶ 102, 113–116, 120, but are devoid of the required "who, when, where, and how" concerning the various United Defendants' supposed role in the alleged conspiracy.[9] In the absence of the required particularity, any aspect of Plaintiffs' Nevada RICO claim that is dependent on a fraud-based crime fails on the pleadings. *See Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1107 (9th Cir.

[9] Indeed, the only representations the Complaint attributes to specific United personnel or entities are frank disclosures of the impact that Defendants' "new benchmark pricing program" was expected to have on payment rates. Compl. at ¶¶ 90–106.

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2003) (affirming dismissal of fraud-based claims because "[w]hen an entire complaint, or an entire claim within a complaint, is grounded in fraud and its allegations fail to satisfy the heightened pleading requirements of Rule 9(b), a district court may dismiss the complaint or claim"); *Am. Dental Ass'n v. Cigna Corp.*, 605 F.3d 1283, 1290–93 (11th Cir. 2010) (affirming dismissal of similar RICO claims brought by providers against an insurer alleging a fraudulent scheme to reduce plan payment rates through various methodologies).

At the federal court hearing on their motion to amend, Plaintiffs proffered the erroneous theory that "RICO is drafted" such that "[i]t's the enterprise that does the predicate acts," Tr. 42:11–12, 24–25, and therefore Plaintiffs have "no obligation" to "have named every single party that's involved" so long as they have "asserted that the enterprise is each one of the individual United defendants." Tr. 43:2–11, 22–25, 44:1-3; *id.* at 43:22–44:1.[10] This attempt to use an "enterprise" allegation to get around NRCP 9(b)'s prohibition on lumping defendants together has been consistently rejected by the courts. In *Doane v. First Franklin Fin.*, for example, the court stated as follows:

> Doane's conclusory allegations are insufficient to state a RICO claim under Rule 9(b). For the majority of the RICO claim elements, Doane simply lists each element and then alleges that all of the Defendants violated it without specifying what, exactly, Defendants did, which Defendants were involved, when the alleged actions occurred or anything else that might satisfy Rule 9(b)'s particularity requirement.

Doane v. First Franklin Fin., 2012 WL 2129369, at *7 (E.D. Cal. June 12, 2012); *see also Walker-Cook v. Integrated Health Res., LLC*, 2012 WL 12893272, at *10 (D. Haw. Oct. 3, 2012) ("Civil RICO allegations subject to the standards of Rule 9(b) may not merely lump multiple defendants together; rather, this rule 'require[s] 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.' A plaintiff must, at a minimum, 'identif[y] the

[10] At the same hearing, Plaintiffs attempted to circumvent 9(b)'s differentiation requirement by insisting that they had "identified United as the parent company, and it controls all of its subsidiaries." Tr. 43:4-5. The Complaint contains no such allegation of control; rather, it alleges that each United Defendant is a distinct corporate entity with its own unique responsibilities and state licensing. Compl. at ¶¶ 6-13.

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role of [each] defendant[ ] in the alleged fraudulent scheme.'") (citing to *Swartz v. KPMG LLP*, 476 F.3d 756, 764–65 (9th Cir. 2007); *Mai Ngoc Bui v. Lan Bich Nguyen*, 2014 WL 12775081, at *9 (C.D. Cal. Oct. 14, 2014) ("The FAC impermissibly lumps together allegations of the various defendants under the label 'Defendants[,]'. . . . [and f]or this independent reason, Plaintiff fails to state a RICO claim."). Plaintiffs' lumping together of all eight Defendants in undifferentiated allegations fails to satisfy NRCP 9(b), and requires dismissal of the claim.

ii. *Plaintiffs do not properly plead a predicate crime of involuntary servitude.*

Plaintiffs' attempt to invoke involuntary servitude under NRS 207.360(36) is entirely specious. The Nevada statutes describe involuntary servitude as "knowingly subject[ing], or attempt[ing] to subject, another person to *forced labor or services*" by certain enumerated means, NRS 200.463 (emphasis added), "[r]ecruiting, enticing, harboring, transporting, providing or obtaining another person to be held in involuntary servitude; benefiting from another person being held in involuntary servitude," NRS 200.464, or "[a]ssuming rights of ownership over another person; purchase or sale of person," NRS 200.465. Unsurprisingly, the few cases that have addressed NRS 207.360(36) have understood it to deal with crimes involving physical harm, forced labor, or abuse. *See Crawford v. State of Nev.*, 2019 WL 3854796, at *3 (Nev. Ct. App. Aug. 14, 2019) ("physically abusing" victims); *see also Bonanza Beverage Co. v. MillerCoors, LLC*, 2018 WL 6729776, at *8 n.87 (D. Nev. Dec. 21, 2018) (dismissing as "hyperbolic" a claim that plaintiff would "suffer irreparable harm akin to involuntary servitude" if it was "forced to sell and work for" defendant); *Zavala v. Wal Mart Stores Inc.*, 691 F.3d 527, 540–41 (3d Cir. 2012) (affirming dismissal of RICO claim predicated on involuntary servitude and stating, "[T]he phrase 'involuntary servitude' was intended . . . 'to cover those forms of compulsory labor akin to African slavery'" and noting that "[m]odern day examples of involuntary servitude have been limited to labor camps, isolated religious sects, or forced confinement.") (citations omitted).[11] Plaintiffs do not allege any such conduct here. Indeed, to

[11] *See also DeSilva v. N. Shore-Long Island Jewish Health Sys., Inc.*, 2012 WL 748760, at *7 (E.D.N.Y. Mar. 7, 2012) (dismissing with prejudice RICO claim based on predicate act of forced labor).

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the extent anything was responsible for "forcing" Plaintiffs to provide the services at issue, the Complaint makes clear that federal and state law did so, not Defendants. *See* Compl. at ¶ 21. What is more, Plaintiffs acknowledge that the relevant plans paid each and every one of the claims at issue; they simply contend that the plans should have paid more. *See, e.g., id.* at ¶¶ 26, 40.

Plaintiffs' involuntary servitude claim further fails because they do not have standing to bring it. Plaintiffs acknowledge that the victims who were allegedly pressed into service against their will are not Plaintiffs themselves, but instead the doctors they employ. Plaintiffs make no allegation that those doctors have assigned them their claims or authorized them to bring suit on their behalf. Tr. 19:9–20:25. Absent such an assignment or authorization, Plaintiffs have no standing to assert this claim.

3. Plaintiffs have not properly pleaded the existence of an "Enterprise."

Plaintiffs have not adequately pleaded (and cannot plausibly plead) the existence of an "enterprise" among the Defendants or with any third parties regarding the payment of Plaintiffs' claims, as NRS 205.377 requires.[12] Plaintiffs allege that the "Enterprise" consists of "Defendants, non-parties Data iSight and other entities that develop software used in reimbursement determinations used by the Defendants." Compl. at ¶ 111. Stripping away Plaintiffs' legal conclusions, pejorative adjectives, and conclusory assertions, Plaintiffs establish nothing more than an ordinary commercial contractual relationship between Defendants and MultiPlan, Inc., pursuant to which Defendants received pricing information through MultiPlan's Data iSight tool. Compl. at ¶¶ 100, 175–76. An ordinary commercial contract of this nature does not establish an actionable RICO "enterprise." *See Gardner v. Starkist Co.*, --- F. Supp. 3d ----, 2019 WL 6698109, at *10–11 (N.D. Cal. Dec. 2, 2019) (dismissing RICO claim where Plaintiffs' RICO enterprise allegations were "conclusory" and reasoning, "[Plaintiffs] allege that the 'common purpose' between StarKist and co-conspirators"—"a number of entities StarKist

[12] For purposes of NRS 205.377, an "enterprise" is defined as "Any natural person, sole proprietorship, partnership, corporation, business trust or other legal entity" and "Any union, association or other group of persons associated in fact although not a legal entity." NRS 207.380.

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allegedly engages in business with"—"was to fraudulently market, advertise and label StarKist tuna as dolphin-safe, [] but have failed to plausibly allege facts that show StarKist and RICO Co-Conspirators committed acts towards this alleged common purpose. *Simply characterizing routine commercial dealing as a RICO enterprise is not enough*.") (internal citations omitted) (emphasis added); *Gomez v. Guthy-Renker, LLC*, 2015 WL 4270042, at *11 (C.D. Cal. July 13, 2015) ("[T]here has been a remarkable uniformity in [the] conclusion that RICO liability must be predicated on a relationship more substantial than a routine contract between a service provider and its client."); *Hilton v. Apple Inc.*, 2014 WL 12597143, at *8 (C.D. Cal. Jan. 9, 2014) (dismissing a federal RICO claim for failure to allege enterprise because "[w]hat Plaintiff has alleged is a garden variety, run-of-the-mill business relationship");[13] *Greenstein v. Peters*, 2009 WL 722067, at *2 (C.D. Cal. Mar. 16, 2009) (dismissing a federal RICO claim because plaintiff failed to plead that defendants were "(1) associated for a 'common purpose'; (2) formed an 'ongoing organization' . . .; and (3) functioned as a 'continuing unit'" (quoting *Odom v. Microsoft Corp.*, 486 F.3d 541, 552 (9th Cir. 2007)). Plaintiffs' failure to properly plead an enterprise is an additional deficiency that requires dismissal of the RICO claim.

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[13] Plaintiffs have previously attempted to distinguish *Gomez* and *Hilton Apple* by pointing out that those RICO claims were deficient because the fraud allegations were limited to the defendant; "[i]n other words, there were no allegations of fraud of other enterprise participants." ECF No. 36 at 10, n.11. Plaintiffs maintain that their allegations are sufficient because they "adequately alleged involvement by third-parties including Data iSight." *Id.* But Plaintiffs' allegations pertaining to non-party Data iSight cannot overcome the NRCP 9(b) deficiencies described in the main text; namely, that Plaintiffs lump all the Defendants together and make only conclusory and unsupported assertions that they "agreed" or "conspired" with Data iSight to "manipulate reimbursement rates" and to "conceal their scheme." Compl. at ¶¶ 102, 122-123.

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III. CONCLUSION

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

Dated this 26th day of May, 2020.

/s/ Colby L. Balkenbush

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CERTIFICATE OF SERVICE

I hereby certify that on the 26th day of May, 2020, a true and correct copy of the foregoing **DEFENDANTS' SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT ADDRESSING PLAINTIFFS' EIGHTH CLAIM FOR RELIEF** 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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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.: XXVII **PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS FIRST AMENDED COMPLAINT** Hearing Date: June 5, 2020 Hearing Time: 1:00 p.m.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest

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Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") oppose the Motion to Dismiss the First Amended Complaint (the "Motion") filed by UnitedHealth Group, Inc., UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc. (the foregoing United entities are referred to as the "UH Parties"); Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc. (Sierra Health, Sierra Health-Care and Health Plan of Nevada are referred to as the "Sierra Affiliates") (UH Parties and Sierra Affiliates are collectively referred to as "United"). This Opposition is based upon the record in this matter, the points and authorities that follow, the Health Care Providers' Opposition to United's Supplemental Briefing on the Eighth Claim for Relief filed concurrently herewith, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

POINTS AND AUTHORITIES

I. INTRODUCTION AND PROCEDURAL POSTURE

The Health Care Providers are professional emergency medicine service groups that staff the emergency departments at ten hospitals and other facilities throughout Nevada. First Amended Complaint (hereinafter "FAC") ¶¶ 3-5. Defendants ("United") are large health insurance companies and claims administrators. FAC ¶¶ 6-13. United provides healthcare benefits to its members ("United's Members"), including coverage for emergency care. FAC ¶¶ 19, 33.

The Health Care Providers and the hospitals whose emergency departments they staff are obligated by both federal and Nevada law and medical ethics to render emergency services and care to all patients who present in the emergency department, regardless of an individual's insurance coverage or ability to pay. FAC ¶ 18; *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. At all relevant times, United and the Health Care Providers have not had a written "network" agreement governing rates of reimbursement for emergency services rendered by the Health Care Providers to United's Members. FAC ¶ 20. Nevertheless, in accordance with their legal and ethical obligations, the Health Care Providers have provided emergency care to United's Members. FAC ¶¶ 18, 22.

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The Health Care Providers have submitted claims to United seeking reimbursement for this emergency care. FAC ¶¶ 25-26, 40. United, in turn, has paid the Health Care Providers. *Id*. This longstanding and historical practice establishes the basis for an implied-in-fact contract, as well as the usual and customary (or reasonable) rates of reimbursement for the emergency services. FAC ¶¶ 54, 189-206, 216-226. Thereafter, however, circumstances changed. United continued to pay the Health Care Providers' claims for emergency services, but arbitrarily and drastically reduced the rates of reimbursement to levels below the billed charges and usual and customary rates. FAC ¶ 55.

Due to the unilateral and self-serving reduction in United's rates of reimbursement, on April 15, 2019, Fremont brought suit in this Court. Complaint, filed April 15, 2019 (hereinafter "Compl.") ¶¶ 2-9. The original Complaint made clear that the lawsuit involved only claims for reimbursement which United already had determined were payable and had paid, although at artificially reduced rates. Compl. ¶ 27. The original Complaint asserted seven state-law causes of action, including breach of implied-in-fact contract, tortious breach of the implied covenant of good faith and fair dealing, unjust enrichment, violation of NRS 686A.020 and 686A.310, violations of Nevada Prompt Pay statutes and regulations, violations of Nevada Consumer Fraud & Deceptive Trade Practices Acts, and declaratory judgment. *See* Compl. *generally*. All of these legal claims are based on United's underpayment of claims which it had determined were payable and paid, *i.e.*, a dispute over the proper rates of payment rather than the right to payment. Compl. ¶ 27.

Having opted to violate Nevada law by reimbursing the Health Care Providers at unreasonably low rates, United now seeks impunity for its wrongdoing. It argues that the Health Care Providers cannot pursue their state law claims, because those claims are preempted by the federal ERISA statute which limits recovery of benefits to amounts allowed by the terms of the relevant ERISA plans (here, conveniently, such allowed amounts fall well below the reasonable value of the medical services rendered). In other words, United wields ERISA—a statute enacted to protect employee benefits—as a sword to ensure that such benefits remain insufficient to cover the reasonable costs of plan members' medical care and that emergency medical providers—

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who are required by law to render care—enjoy no legal recourse to challenge the unreasonable, arbitrarily determined rates. That position is not only shockingly inequitable, but contrary to the law. As explained in detail below, under controlling Supreme Court precedent, ERISA preempts only those state laws "with a reference to" or "impermissible connection with" ERISA plans. The Health Care Providers' common law and statutory claims fall into neither category. At bottom, the Health Care Providers simply assert that legal obligations entirely separate from and independent of ERISA require United to reimburse the Health Care Providers for medical services rendered to United's members at reasonable market rates. Plaintiffs' legal claims do not seek recovery of ERISA benefits, do not rely upon any of ERISA's provisions, do not require analysis of or reference to ERISA plan terms, do not obstruct ERISA plan administration, and do not implicate any of ERISA's goals. That some of the claims for reimbursement happen to fall under health plans regulated by ERISA is utterly immaterial to the issues at stake in this action. Plaintiffs' claims are not preempted.

II. STATEMENT OF RELEVANT FACTS

The Health Care Providers are professional practice groups of emergency medicine physicians and healthcare providers that provides emergency medicine services to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by the Health Care Providers. FAC ¶ 14. The Health Care Providers are obligated by both federal and Nevada law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. FAC ¶ 18; NRS 439B.410. These patients therefore include those with insurance issued, administered and/or underwritten by United's Members. FAC ¶ 18.

United is responsible for administering and/or paying for certain emergency medical services provided by Fremont which are at issue in the litigation. FAC ¶¶ 6-13. United provides, either directly or through arrangements with providers such as hospitals and Fremont, healthcare benefits to its members. FAC ¶ 19. There is no written agreement between United and the Health

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Care Providers for the healthcare claims at issue in this litigation; Fremont is therefore designated as "non-participating" or "out-of-network" for all of the claims at issue. FAC ¶ 20.

Despite not participating in United's "provider network" for the period in dispute, the Health Care Providers have continued to provide emergency medicine treatment, as required by law, to the Members who seek emergency medical services. FAC ¶ 59. United is obligated, as a matter of Nevada law, to reimburse the Health Care Providers at the usual and customary rate for emergency services they provided to United's Members, or alternatively for the reasonable value of the services provided. FAC ¶ 62. United arbitrarily began manipulating the rate of payment for claims submitted by the Health Care Providers. United drastically reduced the rates at which they paid the Health Care Providers for emergency services for some claims, but not others. FAC ¶ 57. United paid some of the claims for emergency services rendered by the Health Care Providers at far below the usual and customary rates. Yet, United paid other substantially identical claims (e.g. claims billed with the same Current Procedural Terminology (CPT) Code, as maintained by American Medical Association) submitted by the Health Care Providers at higher rates and in some instances at 100% of the billed charge. FAC ¶ 57.

For each of the healthcare claims at issue in this litigation, United has already determined that each claim is payable; however, it paid the claim at an artificially reduced rate. *Id.* at ¶ 27. Thus, there is no open question of whether the claim should be covered under a health plan or whether it is payable – United already answered those questions affirmatively when it paid the claims. Rather, the questions to be answered in this case are whether United paid the claim at rates that complied with applicable state law – namely the usual and customary rate (i.e. the billed rate) or, alternatively, at the reasonable value of services rendered. The answer to these questions does not require the jury to ever read or refer to an ERISA plan. Instead, these are straightforward questions of Nevada law.

On April 15, 2019, Fremont filed the Complaint against the Removing Defendants. *See generally* Compl. On May 14, 2019, the Removing Defendants filed its Notice of Removal with this Court, contending that the state law claims asserted are completely preempted by ERISA. *See* Notice of Removal. On May 21, 2019, United filed a Motion to Dismiss arguing, *inter alia*,

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that each of Fremont's claims are preempted by complete preemption and conflict preemption and that even if such claims are not preempted, they fail as a matter of law.[1]

On May 24, 2019, Fremont filed a Motion to Remand (ECF No. 5) because this case, which only involves questions of the proper rate of payment, and not the right to payment, is not completely preempted by ERISA.[2] With the Federal District Court's permission, the Health Care Providers filed their First Amended Complaint (the "Am. Comp.") on January 7, 2020.[3] Given the procedural posture of the action, the Court directed the Health Care Providers to file a renewed motion to remand, which they did on January 18, 2020 (ECF No. 49). After completed briefing, the Federal District Court granted the Renewed Motion to Remand, expressly *rejecting* United's argument that the Health Care Providers' claims were completely preempted by ERISA, the very arguments that United reasserts here. *See* Notice of Entry of Remand Order. Thereafter, pursuant to a May 15, 2020 Order, the Health Care Providers filed the FAC.

III. APPLICABLE LEGAL STANDARDS ON A MOTION TO DISMISS

Rule 8(a)(2) of the Nevada Rules of Civil Procedure states that a complaint shall contain "a short and plain statement of the claim showing that the pleader is entitled to relief." NRCP 8(a)(2). Thus, Nevada is a notice-pleading state and a pleading is liberally construed to "place into issue matter which is fairly noticed to the adverse party." *Chavez v. Robberson Steel Co.*, 94 Nev. 597, 598, 584 P.2d 159, 160 (Nev. 1978); *Hay v. Hay*, 100 Nev. 196, 198, 678 P.2d 672, 674 (1984). In other words, so long as the "adverse party has adequate notice of the nature of the claim and relief sought," trial courts should allow a pleading to survive any challenge asking for

[1] As mentioned in the Introduction herein, the instant Motion is largely repurposed from the earlier filing, especially with respect to the inapplicable complete preemption analysis therein.

[2] As the Health Care Providers set forth in the Amended Motion to Remand, binding Ninth Circuit precedent makes clear that disputes concerning **rates of payment** -- which is the exact dispute at issue here -- do not fall within ERISA's scope and are not subject to complete preemption. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.,* 581 F.3d 941 (9th Cir. 2009); *see also California Spine & Neurosurgery Inst.*, 2019 WL 1974901, at *3 ("Under Ninth Circuit law, ERISA does not preempt claims by a third party [medical provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages.").

[3] The Health Care Providers served UnitedHealth Group, Inc. on January 15, 2020. *See* Summons Returned Executed (ECF No. 67).

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dismissal. *Hay*, 100 Nev. at 198, 678 P.2d at 674; *see also Liston v. Las Vegas Metro. Police Dept.*, 111 Nev. 1575, 1579, 908 P.2d 720, 723 (1995).

When examining whether a defendant received notice of the claims against it, Nevada courts have recognized that notice is "knowledge of facts which would naturally lead a…person to make inquiry of everything which such injury pursued in good faith would disclose." *Liston*, 111 Nev. at 1579, 908 P.2d at 723. Furthermore, a plaintiff is not required to give itemized descriptions of evidence but rather "need only broadly recite the 'ultimate facts' necessary to set forth the elements of a cognizable claim that a party believes can be proven at trial." *Nutton v. Sunset Station, Inc.*, 131 Nev. 279, 290, 357 P.3d 966, 974 (Nev. App. 2015). Accordingly, in considering the dismissal of a complaint pursuant to NRCP 12(b)(5), a court must "determine whether or not the challenged pleading sets forth allegations sufficient to make out the elements of a right to relief." *Bemis v. Estate of Bemis*, 114 Nev. 1021, 1021, 967 P.2d 437, 439 (1998) (citing *Edgar v. Wagner*, 101 Nev. 226, 227, 699 P.2d 110, 111 (1985)).

Importantly, a district court is required to accept all factual allegations as true and to draw all inferences in favor of the non-moving party; dismissal is only proper where there is a complete lack of a cognizable legal theory. *See Buzz Stew, LLC v. City of North Las Vegas*, 124 Nev. 224, 228-229, 181 P.3d 670, 672 (2008); *Garcia v. Prudential Ins. Co. of Am.*, 129 Nev. 15, 19, 293 P.3d 869, 871-72 (2013). A complaint should only be dismissed "if it appears beyond a doubt that [the plaintiff] could prove no set of facts, which, if true, would entitle [the plaintiff] to relief." *Buzz Stew, LLC*, 124 Nev. at 228, 181 P.3d at 672 (emphasis added). A review of the FAC demonstrates that dismissal is not warranted, and the Court should, respectfully, deny Defendant's Motion.

IV. THE HEALTH CARE PROVIDERS' CLAIMS ARE NOT SUBJECT TO EITHER COMPLETE ERISA PREEMPTION OR CONFLICT PREEMPTION

A. Overview of ERISA

ERISA was passed by Congress in 1974 primarily to address "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016); *Skillin v. Rady*

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Children's Hosp.-San Diego, 226 Cal. Rptr. 3d 505, 509 (Ct. App. 2017). "The comprehensive and reticulated statute, contains elaborate provisions for the regulation of employee benefit plans." *Skillin*, 226 Cal. Rptr. 3d 505, 509. It sets forth reporting and disclosure obligations for plans, imposes a fiduciary standard of care for plan administrators, and establishes schedules for the vesting and accrual of pension benefits." *Massachusetts v. Morash*, 490 U.S. 107, 112–113, 109 S. Ct. 1668 (1989). "ERISA does not guarantee substantive benefits. The statute, instead, seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Gobeille*, 136 S.Ct. at 943 (2016).

B. ERISA Complete Preemption and Conflict Preemption Explained

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). These two forms of preemption are doctrinally distinct. *Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225 (9th Cir. 2005) (these "two strands to ERISA's powerful preemptive force, differ in their purpose and function.") (internal quotations omitted).

1. Conflict Preemption

Section 514 (codified at 29 U.S.C. § 1144) contains ERISA's conflict preemption provision. It expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[.]" 29 U.S.C. § 1144(a). However, § 514 saves from preemption "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The saving clause functions to preserve a state's traditional regulatory power over insurance, banking, and securities. *Rudel v. Hawai'i Mgmt. All. Ass'n*, 937 F.3d 1262, 1269–70 (9th Cir. 2019), cert. denied sub nom. *HI Mgmt. All. Assoc. v. Rudel*, 19-752, 2020 WL 871750 (U.S. Feb. 24, 2020); *Gobeille*, 136 S. Ct. at 943. Section 514, however, does not confer federal jurisdiction. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 945 (9th Cir. 2009). In addressing conflict preemption under ERISA, the "starting presumption" is that "Congress does not intend to supplant state law," and "'that the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of

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Congress.'" *Viad Corp v. MoneyGram Int'l, Inc.*, No. 1 CA-CV 15-0053, 2016 WL 6436827, at *2 (Ariz. Ct. App. Nov. 1, 2016), as amended (May 3, 2017) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 654-55 (1995)).

2. Complete Preemption

Separately, ERISA completely preempts state law only to the extent that the state law "duplicates, supplements, or supplants the ERISA civil enforcement remedy." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Section 502 (codified at 29 U.S.C. § 1132) sets forth "a comprehensive scheme of civil remedies to enforce ERISA's provisions." *Rudel*, 937 F.3d at 1269–70. Section 502's purpose is to ensure that federal courts remain the only forum and vehicle for adjudicating claims for benefits under ERISA. *Marin Gen. Hosp.*, 581 F.3d at 945.

C. This Action Is Not Subject to Conflict Preemption

1. The Proper Section 514(a) Analysis

The proper analysis starts with a presumption that ERISA does not supplant state law claims. Generally speaking, a common law claim "relates to" an employee benefit plan governed by ERISA "if it has a connection with or reference to such a plan." *Providence Health Plan v. McDowell*, 385 F.3d 1168, 1172 (9th Cir. 2004); *see also Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045, 1052 (9th Cir. 1999). The Supreme Court has limited the parameters of § 514(a) preemption to two categories of state laws. *Gobeille*, 136 S.Ct. at 943. Those categories are: (1) laws "with a reference to ERISA plans," which include laws which "act[ ] immediately and exclusively upon ERISA plans . . .or where the existence of ERISA plans is essential to the law's operation," and (2) laws with "an impermissible connection with ERISA plans, meaning a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration." *Id.*

The Health Care Providers' state-law claims do not fall within either of the *Gobeille* categories. Here, the Health Care Providers allege that they and United have an implied-in-fact contract, which obligates United, under Nevada law, to pay the Health Care Providers reasonable compensation (FAC ¶¶ 189-206), and that, alternatively, Nevada law of unjust enrichment obligates United to pay the Health Care Providers the reasonable value for their services. *Id.* ¶¶

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216-226. The Health Care Providers have not pled claims for ERISA benefits. "[The Health Care Providers are] the master[s] of [their] complaint and ha[ve] chosen to plead [their] claims based on the existence of an implied contract." *N. Jersey Brain & Spine Ctr. v. Aetna Life Ins. Co.*, 2017 WL 659012, at *5 (D.N.J. Feb. 17, 2017), R&R adopted by 2017 WL 1055957 (D.N.J. Mar. 20, 2017). As the court aptly concluded in *Emergency Case Physicians of St. Clare's v. United Health Care*, "the fact that there is no contract between the parties in this case, if true, would not convert Plaintiff's claims for additional reimbursements into claims for coverage or the denial of benefits." 2014 WL 7404563, at *6 (D.N.J. Dec. 29, 2014).

In *Glastein v. Aetna, Inc.*, a district court determined that an out-of-network healthcare provider's analogous state law claims against an ERISA plan administrator were not conflict preempted. 2018 WL 4562467, at *2-3 (D.N.J. Sept. 24, 2018). The *Glastein* court's analysis is well-reasoned and instructive:

> The state laws at issue here…neither 'refer to' nor have an 'impermissible connection with' an ERISA plan….[T]he Complaint does not claim that Plaintiff was a contracting party to an ERISA plan. It does not allege that payment is due to him according to the terms of an ERISA plan, or even that any relevant ERISA plan provides reimbursement rates for the out-of-network services provided. To the contrary, the Complaint states that Plaintiff is entitled to recover $209,000 because that amount 'represents reasonable and normal charges' under an implied-in-fact contract. The Complaint's factual assertions . . . do nothing to suggest that the claims brought in this case will require examination of an ERISA plan. The state laws here therefore do not 'refer to' an ERISA plan.
>
> Second, these laws do not have an 'impermissible connection with' an ERISA plan. The central purpose of ERISA is to protect plan participants and beneficiaries….As several Circuit Courts have held, claims brought by a provider against an insurance company do not implicate ERISA's goals of protecting participants and beneficiaries. Such claims therefore do not have an 'impermissible connection with' an ERISA plan, and are not preempted.

Id. (citations omitted).

The Ninth Circuit has also made it clear that § 514(a) does not apply to claims brought by third-party healthcare providers, like the Health Care Providers here. *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc.*, 2 Cal. App. 5th 793, 799, 206 Cal. Rptr. 3d 461, 466

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(Ct. App. 2016); *Providence Health Plan*, 385 F.3d at 1172;[4] *Abraham v. Norcal Waste Sys., Inc.*, 265 F.3d 811, 820–21 (9th Cir.2001); *Blue Cross of Cal.*, 187 F.3d at 1052–53; *see also The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995) (stating that § 1144(a) does not preempt "claims by a third-party who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages").

The *Morris B. Silver M.D., Inc.*, case is instructive. In that case, the California court utilized a two-part test to determine whether a third-party provider's state-law quasi-contract claims (like those asserted by the Health Care Provider's here) were subject to ERISA's conflict preemption. The two-part test considers: (1) whether the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationship among the traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries. *Id.,* 2 Cal. App. 5th at 804, 206 Cal. Rptr. 3d at 470; *see also The Meadows*, 47 F.3d at 1009. Employing this test, the *Morris B. Silver, M.D.* court held that third-party provider state-law claims are not conflict preempted. As the court explained, third-party providers are not parties to the bargain "struck in ERISA" between plaintiffs and employers; accordingly, the court could not "believe that Congress intended the preemptive scope of ERISA to shield welfare plan fiduciaries from the consequences of their acts toward non-ERISA health care providers when a cause of action based on such conduct would not relate to the terms or conditions of a welfare plan, nor affect—or

[4] In *Providence*, the Ninth Circuit found a contract claim did not have the requisite "connection with" or "reference to" an ERISA plan. The court determined that the plaintiff "is simply attempting, through contract law, to enforce the reimbursement provision. Adjudication of its claim does not require interpreting the plan or dictate any sort of distribution of benefits." *Id.* Similarly, in *Summit Estate, Inc.*, 2017 WL 4517111 at *15, the court held that claims for breach of express contract, breach of implied contract, and negligent failure to disclose did not fall under either of the two categories; therefore they were not preempted by Section 514(a). Under the "reference to" prong, the court recognized that state law contract and tort laws do not "act exclusively upon ERISA plans." *Id.* Nor is "the existence of ERISA plans...essential to [the laws'] operation." *Id.* Instead, the court ruled that contract and tort law "are laws of general application, and do not focus exclusively (or, for that matter, even primarily) upon ERISA plan administration." *Id.* (quoting *In re Anthem, Inc. Data Breach Litig.*, 2016 WL 3029783, at *49 (N.D. Cal. May 27, 2016)); *see also Viad Corp.*, 2016 WL 6436827, at *3. In *Viad*, the plaintiff did not sue as an assignee of an ERISA plan participant or beneficiary, instead suing in its own right pursuant to an independent contract. As a result, the Court concluded plaintiffs' claims were not preempted.

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affect only tangentially—the ongoing administration of the plan." *Morris B. Silver M.D., Inc.*, 206 Cal. Rptr. 3d at 471.

And, the *Morris B. Silver M.D., Inc.* decision is just one of many similar cases, finding that claims by third-party providers arising out of analogous circumstances to those asserted by Health Care Providers here, are not preempted. *See, e.g., Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243–246 (5th Cir. 1990) (holding hospital's claim for deceptive and unfair practices arising from representations regarding coverage not preempted and articulating two-factor test); *see also Access Mediquip LLC v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 385 (5th Cir. 2011) ("The state law underlying Access's misrepresentation claims does not purport to regulate what benefits United provides to the beneficiaries of its ERISA plans, but rather what representations it makes to third parties about the extent to which it will pay for their services."); *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 667 (9th Cir. 2019), *cert. denied*, 140 S. Ct. 223 (2019) ("State-law claims are based on other independent legal duties when they are in no way based on an obligation under an ERISA plan and would exist whether or not an ERISA plan existed.") (citing *Marin Gen. Hosp.*, 581 F.3d at 950) (internal alteration omitted).[5]

At its core, the Health Care Providers' state law claims are not subject to conflict preemption because they neither seek recovery under an ERISA plan, require examination of an

[5] United cites to *Pilot Life Ins. v. Dedeaux,* 481 U.S. 41, 57, 107 S. Ct. 1549, 1558 (1987) for the proposition that claims of tortious breach of contract and fraud in the inducement are expressly preempted, without actually even considering the facts of that case. Indeed, many of the above cases rejected reliance on *Pilot Life* because it "does not address the circumstances unique to third-party provider claims." In *Pilot Life*, the plaintiff was an insured who sought to recover against the insurer for claims arising directly from his plan – specifically, the insurer's failure to provide coverage. Of course, because such claims arose directly from his rights under the subject plan, the court held that such claims were expressly preempted. The Health Care Providers' position is entirely consistent with this decision. They, though, are not seeking to recover against United for any claims arising under their plans with their insured. Rather, the claims asserted in the Operative Pleading have no connection to the plans. The plans could say that emergency services will not be covered or they could say that emergency services will be covered 100%. Under either case, such terms would not form the basis for the Health care Providers' claims because the Health care Providers bring their claims as separate, independent claims relating to the relationship between United and the Health Care Providers. The claims all rely on independent statutory and common law to address whether a certain rate of payment is appropriate – not any one benefit plan. Thus, because nothing about the benefit plans needs to be considered in order to fully adjudicate each of the claims at issue, the claims asserted do not "relate to" any ERISA benefit plans and cannot be expressly preempted.

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ERISA plan, nor implicate any discernible goal of ERISA.[6] Accordingly, the Health Care Providers' state-law claims are not conflict preempted. *See Blue Cross of California Inc. v. Insys Therapeutics Inc.*, 390 F. Supp. 3d 996, 1004 (D. Ariz. 2019) (holding that state-law claims for common law fraud, misrepresentation, negligent misrepresentation, unjust enrichment, civil conspiracy, tortious interference with contract, and statutory claims for unfair and deceptive competition and practices were not subject to conflict preemption) (collecting cases);[7] *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, 2015 WL 1954287, at *10 (E.D. Pa. Apr. 30, 2015) (holding that the out-of-network provider claims for unjust enrichment and breach of contract were not preempted by ERISA because the plaintiff's state law claims were independent of the ERISA beneficiaries' rights under any ERISA plan); *Jewish Lifeline Network, Inc. v. Oxford Health Plans (NJ), Inc.*, 2015 WL 2371635, at *3 (D.N.J. May 18, 2015) (ERISA preemption "does not foreclose a plaintiff from pleading a state law claim based on a legal duty that is independent from ERISA or an ERISA-governed plan"). As a result, the Motion should be denied in its entirety.

2. United's Motion Overstates the Scope of ERISA Conflict Preemption

In the face of this controlling law, United relies on outdated and now-rejected overbroad interpretations of Section 514(a). *See Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990). United argues that the "relates to" language in the preemption provision of Section

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[6] United argues that the state law claims threaten to disrupt nationally uniform plan administration by "seeking to use state law claims to force the plans to pay more." Motion at 3: 22-23. The Court need not address this contradiction, as other courts have rejected United's argument out of hand, finding that "state law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted." *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994); *Glastein*, 2018 WL 4562467, at *3 n.4 (collecting cases); *Rocky Mountain Holdings LLC v. Blue Cross and Blue Shield of Fla., Inc.*, 2008 WL 3833236, at *5 (M.D. Fla. Aug. 13, 2008) (collecting cases); *Med. & Chirurgical Facility of the State of Md. v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618, 619-20 (D. Md. 2002) (collecting cases).

[7] The cases are: *Spinedex v. Physical Therapy, U.S.A., Inc. v. Arizona*, No. 04-CV-1576-PHX-JAT, 2005 WL 3821387, at *8 (D. Ariz. Nov. 9, 2005); *Almont Ambulatory Surgery Center, LLC v. UnitedHealth Grp., Inc.*, 121 F. Supp. 3d 950, 962-71 (C.D. Cal. 2015); *Scripps Health v. Schaller Anderson, LLC*, No. 12-CV-252-AJB(DHB), 2012 WL 2390760, at *2-*6 (S.D. Cal. Jun. 22, 2012); *Ass'n of N.J. Chiropractors v. Aetna, Inc.*, No. CIV.A. 09-3761 JAP, 2012 WL 1638166, at *5-7 (D.N.J. May 8, 2012); *United Healthcare Servs., Inc. v. Sanctuary Surgical Ctr., Inc.*, 5 F. Supp. 3d 1350, 1363 (S.D. Fla. 2014)).

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514 (a) is one of the "broadest preemption clauses ever enacted by Congress." Motion at 7:17-20. United is mistaken.

The Supreme Court and more recent Ninth Circuit cases have declined to adopt a literal interpretation of the "relates to" language. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 115 S. Ct. 1671 (1995), the court clarified that ***the "starting presumption" is that Congress does not intend to supplant state law***. *Id.* at 654, 115 S.Ct. 1671; *Bertoni v. Stock Bldg. Supply*, 989 So. 2d 670, 674–75 (Fla. Dist. Ct. App. 2008). It went on to describe the "relates to" language of the preemption statute as "unhelpful," and instructed that one is instead to look "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S.Ct. 1671. The *Travelers* court noted that in light of the objectives of ERISA and its preemption clause, Congress intended to preempt "state laws providing alternative enforcement mechanisms" for employees to obtain ERISA plan benefits. Id. at 658, 115 S.Ct. 1671.

United's Motion overlooks this more circumspect interpretation. Indeed, even the cases upon which United relies recognize that the Supreme Court has "cautioned against an 'uncritical literalism' that would make pre-emption turn on "infinite connections." *Egelhoff v. Egelhoff ex rel. Breiner*, 121 S. Ct. 1322, 1327 (2001). As the *Egelhoff* Court noted:

> But at the same time, we have recognized that ***the term "relate to" cannot be taken "to extend to the furthest stretch of its indeterminacy***," or else "for all practical purposes pre-emption would never run its course."

Id. at 1327 (emphasis added). The Court should decline to entertain United's outdated analysis.

United also relies on legal authority that is inapplicable because it addresses complete preemption under § 502(a) of ERISA; involve claims expressly seeking ERISA benefits and/or brought directly by plan members rather than third-party medical providers.[8] Because the Health

[8] *See e.g. Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000), as amended on denial of reh'g and reh'g en banc (Nov. 3, 2000) (employee plan member's counterclaims directly against plan administrator conflict preempted); *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984) (nonunion salaried employees brought suit against employer for benefits under employee welfare plan); *Parlanti v. MGM Mirage*, No. 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *1 (D. Nev. Feb. 15, 2006) (plaintiff directly sued former employer over supplemental executive retirement plan).

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Care Providers are pursuing the instant lawsuit in their own capacity, the Health Care Providers' claims are not preempted. The Court or jury will never need to reference any ERISA plan to resolve the question of at what rate Nevada law requires United to reimburse the Health Care Providers for the services in question.

United essentially argues that the Health Care Providers' claims expressly depend on the existence of the employee welfare benefit plans and the administration of claims for benefits submitted under those plans, as if the mere existence of an ERISA plan renders any state law claims the Health Care Providers wish to pursue against United preempted. As the case law above makes clear, that is wholly irrelevant. Otherwise, every state law claim arising out of a medical provider's rendition of services to persons covered by an ERISA Plan would *always* "relate to" ERISA. But that is not the test, and indeed, courts have rejected this very argument. *See In re Managed Care Litig.*, 2011 WL 1595153, at *5 (S.D. Fla. Mar. 31, 2011).

In *In re Managed Care*, a defendant health insurer sought the dismissal of a plaintiff's claims on the grounds that they were defensively preempted by ERISA Section 514(a). *Id.* at *5. The health insurer contended (as United does here) that the provider's rate of payment claims "related to" ERISA because the provider had to "first establish the appropriate level of coverage which necessitates reference to the ERISA plans." *Id.* at *5. The court rejected that argument, stating that "while . . . Plaintiffs' claims exist only because Defendant has ERISA plans, the claims themselves do not implicate the plans." *Id.* (citing *Pascack Valley Hosp. Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 402-04 (3d Cir. 2004)). Similarly, here, even assuming that the Health Care Providers' claims exist only because United's Members have ERISA plans, that has no bearing on whether the Health Care Providers' claims "relate to" ERISA. As the *In re Managed Care* court held, the Health Care Providers' claims themselves would have to "implicate the plans." *Id.*

Further, United's attempt to distinguish self-funded plans from other employee-sponsored plans is misleading and unavailing. With regard to self-funded plans, the analysis of whether a state law affecting the ERISA plan is defensively preempted simply begins and ends with a determination of whether a law "relates to" ERISA. Self-funded ERISA plans are only

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shielded from state laws (insurance or otherwise) that "*relate to*" ERISA.[9] *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) ("[S]elf-funded ERISA plans are exempt from state regulation ***insofar as that regulation 'relate[s] to' the plans.*** State laws directed toward the [self-funded] plans are ***pre-empted because they relate to an employee benefit plan*** but are not 'saved' because they do not regulate insurance.") (emphasis added).

Finally, no less critical in terms of the Court's adjudication of a Rule 12(b)(5) motion, the existence of an ERISA plan is a question of fact. *Ellington v. Metropolitan Life Ins. Co.*, 696 F. Supp. 1237, 1240 (S.D. Ind. 1988); *see also Credit Managers Ass'n v. Kennesaw Life & Acc. Ins.*, 809 F.2d 617, 625 (9th Cir. 1987). Therefore, to the extent such a determination on a Rule 12(b)(5) motion to dismiss is not proper in light of recognized pleading standards because whether an oral agreement exists is one of fact.

D. Plaintiffs' State Law Claims Are Not Completely Preempted

1. Complete Preemption Does Not Provide a Basis for Dismissal of State Court Claims

As a threshold issue, United's discussion of complete preemption is misplaced because complete preemption is a jurisdictional doctrine and cannot be used to obtain dismissal of a state law claim on a Rule 12(b)(5) motion to dismiss. *Owayawa v. Am. United Life Ins. Co.*, CV 17-5018-JLV, 2018 WL 1175106, at *3 (D.S.D. Mar. 5, 2018) ("[A]lthough complete

[9] The only relevance of whether an ERISA plan is "self-funded" is that, with regard to plans that are ***not*** self-funded, state laws that "regulate[] insurance, banking, or securities" are ***still not preempted*** even if they "relate to" ERISA. *See FMC Corp.*, 498 U.S. at 58, 61 ("[ERISA's preemption clause] establishes as an area of exclusive federal concern the subject of every state law that 'relates to' an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that 'regulate insurance,' except as provided in the deemer clause. . . . We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause.") (internal bracketing omitted); *see also* 29 U.S.C. § 1144(b)(2)(A) ("Except as provided in [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."). Thus, under the ERISA "savings clause," ***even if***, the Health Care Providers' claims did "relate to" ERISA, which they clearly do not, the Health Care Providers' statutory claims still ***would not be preempted*** with respect to any claims relating to any non-self-funded ERISA plans, because such statutes are ones that "regulate[] insurance, banking, or securities" and are exempted from ERISA preemption by the "savings clause."

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preemption...can be used to invoke federal question jurisdiction, Defendants cannot use [the doctrine] as a ground for dismissing Plaintiffs' claims under Federal Rule of Civil Procedure 12(b)(6).");[10] *Summit Estate, Inc. v. Cigna Healthcare of Cal., Inc.*, Case No. 17-CV-03871, 2017 WL 4517111, at *13 (N.D. Cal. Oct. 10, 2017);[11] *Marin Gen. Hosp.*, 581 F.3d at 945 (complete preemption under ERISA is not a ***defense*** to a state law claim); *Mid-Town Surgical Ctr., L.L.P. v. Humana Health Plan of Tex., Inc.*, 16 F. Supp. 3d 767, 779 (S.D. Tex. 2014) ("complete preemption ***is not grounds for dismissal***, but instead a mechanism to confer federal jurisdiction on a state-law claim that is in fact an ERISA claim."). Because complete preemption is not a defense to a state law claim, it cannot serve as the foundation of an argument in a Rule 12(b)(5).

In any event, the Federal District Court addressed this precise issue in the motion to remand, aptly concluding—in accord with the overwhelming weight of authority—that a third-party medical provider's challenge to the rate of payment afforded by an ERISA plan on indisputably covered claims for reimbursement is not completely preempted. The Court should follow this highly persuasive opinion. [12]

2. The FAC is Not Completely Preempted

Even if the Court is inclined to engage in a complete preemption analysis, it will undoubtedly determine, like the Federal District Court, that the Health Care Providers' claims are not completely preempted. *See* Ex. 2 and 3.

In *Davila*, the Supreme Court established a two-part framework governing complete ERISA preemption. Under *Davila*, complete preemption obtains only where: (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(B)," and (2) "no other independent legal

[10] Complete preemption is a jurisdictional doctrine which converts state law claims into federal claims for purposes of removal, but does not dismiss claims. *Autonation, Inc. v. United Healthcare Ins. Co.*, 423 F.Supp.2d 1265, 1268 (S.D. Fla. 2006).

[11] As the Ninth Circuit has explained, complete preemption under § 1132(a) is "really a jurisdictional rather than a preemption doctrine….[and was] created...as a basis for federal question removal jurisdiction under 28 U.S.C. § 1441(a)." *Id.*

[12] The Health Care Providers attach their full briefing submitted to the Federal District Court on this issue and incorporate those arguments in full herein. **Exhibit 1**, Amended Motion for Remand; and **Exhibit 2**, Reply in Support of Amended Motion For Remand.

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duty . . . 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. *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 146 (2d Cir. 2017).

a. Davila Prong 1

Davila Prong 1 looks to whether the plaintiff "could have brought [the] claim under ERISA § 502(a)(1)(B)." *Marin*, 581 F.3d at 947. To satisfy this element, two requirements must be met: the asserted claims must fall within the scope of ERISA and the plaintiff must have standing to sue under ERISA. *Conn. Dental*, 591 F.3d at 1350. Regarding the first requirement, multiple appellate courts have held that claims which challenge the ***rates*** of reimbursement paid for covered healthcare services, rather than the right to reimbursement for such services, do not fall within the scope of § 502(a)(1)(B). *Id.* at 1349-50; *Lone Star*, 579 F.3d at 531; *Montefiore*, 642 F.3d at 325; *CardioNet Inc. v. Cigna Health Corp.*, 751 F.3d 165, 177-78 (3d Cir. 2014); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (affirming remand of health care providers' state law claim for breach of contract because the dispute was "not over the right to payment, which might be said to depend on the patients' assignments to the Providers, but the amount, or level, of payment, which depends on the terms of the provider agreements.").[13]

Here, the Health Care Providers explicitly plead that they challenge only rates of reimbursement on claims which Defendants have adjudicated as payable and actually paid, not the right to reimbursement for those claims. FAC ¶¶ 1, 26; 1 n.1 ("The Health Care Providers also do not assert any claims…with respect to the right to payment under any ERISA plan."); s*ee also Garber v. United Healthcare Corp.*, 2016 WL 1734089, at *3-5 (E.D.N.Y. May 2, 2016); *Long Island Thoracic Surgery, P.C. v. Building Serv. 32BJ Health Fund*, 2019 WL 5060495, at *2 (E.D.N.Y. Oct. 9, 2019); *Premier Inpatient Partners LLC v. Aetna Health & Life Ins. Co.*, 371 F. Supp. 3d 1056, 1068-74 (M.D. Fla. 2019); *Gulf-to-Bay Anesthesiology Assocs. v.*

[13] 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.

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UnitedHealthCare of Fla., Inc., 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc.*, 258 F. Supp. 3d 1323, 1327-30 (S.D. Fla. 2017); *N. Jersey Brain & Spine Ctr. v. MultiPlan, Inc.*, 2018 WL 6592956, at *7 (D.N.J. Dec. 14, 2018); *E. Coast Advanced Plastic Surgery v. AmeriHealth*, 2018 WL 1226104, at *3 (D.N.J. Mar. 9, 2018). Here, as in *Blue Cross, Marin*, and their progeny, the Health Care Providers assert claims based upon contractual and quasi-contractual legal obligations independent of any ERISA plans. For this reason, the Court should deny the Motion.

b. Davila Prong 2

Davila Prong 2 looks to whether an independent legal duty is implicated by the defendant's actions. 542 U.S. at 210. "If there is some other independent legal duty beyond that imposed by an ERISA plan, a claim based on that duty is not completely preempted . . . ." *Marin*, 581 F.3d at 949. "A legal duty is independent if it is not based on an obligation under an ERISA plan, or it would exist whether or not an ERISA plan existed." *N.J. Carpenters and the Trs. Thereof v. Tishman Constr. Corp. of N.J.*, 760 F.3d 297, 303 (3d Cir. 2014). Courts routinely hold that claims predicated upon duties imposed by state common and statutory law do not satisfy *Davila* Prong 2. *See, e.g., McCulloch*, 857 F.3d at 150 (second *Davila* prong unsatisfied because "[plaintiff's] promissory-estoppel claim against Aetna arises not from an alleged violation of some right contained in the plan, but rather from a freestanding state-law duty grounded in conceptions of equity and fairness."); *Wurtz v. Rawlings Co., LLC*, 761 F.3d 232, 243 (2d Cir. 2014) ("[W]hile defendants' reimbursement claims relate to plaintiffs' plans, this is not the test for complete preemption. Plaintiffs' claims do not derive from their plans or require investigation into the terms of their plans; rather, they derive from [a state statute]."); *Bay Area Surgical*, 2012 WL 3235999, at *4 (second *Davila* prong unsatisfied because plaintiff alleging claim under an oral agreement "is suing on its own right pursuant to an independent obligation, and its claims would exist regardless of an ERISA plan."); *Christ Hosp. v. Local 1102 Health and Benefit Fund*, 2011 WL 5042062, at *4 (D.N.J. Oct. 24, 2011) (second *Davila* prong unsatisfied where claims "depend[ed] on the operation of a third-party contract" between plaintiff medical provider and defendant

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ERISA plan, rather than on the terms of the ERISA plan). As such, Davila Prong 2 is unsatisfied, providing yet another basis to deny the Motion.

V. The Amended Complaint States Viable Claims for Relief

A. The Health Care Providers Stated a Claim for Breach of Implied In Fact Contract Claim

The Health Care Providers have pled detailed factual allegations about the parties' conduct, understanding, and course of dealing from which a jury could conclude an implied contract arose.[14] In an implied contract, such intent is inferred from the conduct of the parties and other relevant facts and circumstances. *Warrington v. Empey*, 95 Nev. 136, 138–139 (1979). The terms of an implied contract can also be manifested by conduct or by other customs. *Smith*, 541 P.2d at 668; *Nevada Ass'n Servs., Inc. v. First Am. Title Ins. Co.*, No. 2:11-cv-02015-KD-VCF, 2012 WL 3096706, at *3 (D. Nev. July 30, 2012) (denying motion to dismiss on breach of contract claim because the plaintiff stated "a plausible claim that, through a course of dealing involving hundreds of transactions over several years, Defendants and Plaintiff manifested an intent to be bound and agreed to material terms of an implied contract."). In *Nevada Ass'n Servs., Inc.*, the district court also noted that a motion to dismiss is not the proper place for such a factual evaluation of whether parties entered into an implied contract because "it necessarily requires examination of the facts and circumstance." *Id.*

The Health Care Providers have alleged a claim for breach of implied in fact contract against United based on the parties' course of dealing over thousands of claims. United contends that this claim fails because there is no allegation that United intended to contract with Fremont, that promises were exchanged or what the terms of the promises were; however, this argument ignores the explicit allegations from the Amended Complaint. Fremont alleges that:

> 197. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by the Health Care Providers to Defendants' Patients, ***the parties implicitly***

[14] A plaintiff states a claim for breach of contract, whether express or implied, by alleging: (1) the existence of a valid contract, (2) a breach by the defendant, and (3) damage as a result of the breach. *Saini v. Int'l Game Tech.*, 434 F. Supp. 2d 913, 919-20 (D. Nev. 2006) (*citing Richardson v. Jones*, 1 Nev. 405, 405 (1865)); *Smith v. Recrion Corp.*, 541 P.2d 663, 664 (Nev. 1975) (recognizing the elements of breach of express and implied contract claims are the same).

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> ***agreed, and the Health Care Providers had a reasonable expectation and understanding, that Defendants would reimburse the Health Care Providers for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates Defendants pay for other substantially identical claims also submitted by the Health Care Providers.***

FAC ¶ 197; *see also* Compl. ¶ 38 (emphasis added). This course of conduct clearly supports the existence of an implied contract, based on an exchange of consideration, and a breach by United that has caused damage to the Health Care Providers. Moreover, the Health Care Providers' allegations that both parties, throughout the course of conduct, understood United's legal obligation to pay, only further supports the assertion that an implied contract was formed.

United also argues that payments for past services cannot constitute a promise by United to pay for future services and cites to *Recrion Corp*. to support this proposition. United misunderstands the allegations presented by Fremont. Under Nevada law, the Health Care Providers are required to provide emergency medical services and, in exchange, United is required to pay for such services. *See Williams v. EDCare Mgmt., Inc.*, No. CIV. A. 1:08-CV-278, 2008 WL 4755744, at *5 (E.D. Tex. Oct. 28, 2008) (remanding state law claims that alleged violation of federal regulations as an element of those claims); *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. *Recrion Corp*. is distinguishable for this reason. As United highlighted, the services provided in *Recrion Corp*. were *unsolicited*. Here, Nevada law mandates that the Health Care Providers provide these services to United's insureds, a key distinction from *Recrion Corp*. Of course, if the Health Care Providers provided these services to United's Members without any obligation to do so, this may not form the basis for an implied in fact agreement. However, United has always understood that if its Members encounter an emergency situation, the Health Care Providers will provide the necessary medical services and, in exchange United will be required to pay for such services. An implied in fact contract exists here, and United has breached this contract, as expressly alleged in the Complaint. Because the Health Care Providers have stated a cognizable claim for breach of implied contract, United's Motion to Dismiss must be denied.

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B. The Health Care Providers Have Stated a Claim for Tortious Breach of Implied Covenant of Good Faith and Fair Dealing

In Nevada, a plaintiff need only allege three elements to assert a claim for tortious breach of the implied covenant of good faith and fair dealing: (1) an enforceable contract (2) "a special relationship between the tortfeasor and the tort victim…a relationship of trust and special reliance" and (3) the conduct of the tortfeasor must go beyond the bounds of ordinary liability for breach of contract. *Martin v. Sears, Roebuck and Co.*, 111 Nev. 923, 929, 899 P.2d 551, 555 (1995). The special relationship required in *Martin* is characterized by elements of public interest, adhesion, and fiduciary responsibility." *Ins. Co. of the W. v. Gibson Tile Co.,* 122 Nev. 455, 461, 134 P.3d 698, 702 (2006). Moreover, a tortious breach of the covenant requires that "the party in the superior or entrusted position has engaged in grievous and perfidious misconduct." *Great Am. Ins. Co. v. Gen. Builders, Inc.,* 113 Nev. 346, 355, 934 P.2d 257, 263 (1997) (internal quotes and citations omitted).

Contrary to United's conclusory statements, Nevada has never limited the application of a claim for tortious breach of implied covenant of good faith and fair dealing to two instances; rather, Nevada has recognized that this claim is viable in *at least* two scenarios. Simply because a Nevada court has not faced the facts alleged herein does not mean that Nevada has foreclosed the possibility of asserting this claim under the facts alleged. Under the applicable pleading standard and with the facts alleged, this claim is viable.

Moreover, *Aluevich v. Harrah's* does not stand for the proposition that "the Nevada Supreme Court has refused to expand this tort to contracts between sophisticated parties in the commercial realm" as argued by United. Motion at 19:11-12. Rather, in *Aluevich v. Harrah's*, the Nevada Supreme Court held that "[t]he relationship between appellant and respondent was that of lessee and lessor. We do not find, in the present case, the special element of reliance which prompted this court in *Peterson* to recognize a cause of action in tort for the breach of an implied covenant of good faith and fair dealing." 99 Nev. 215, 218, 660 P.2d 986, 987 (1983). The *Aluevich* did not make a blanket statement, as United implies, that this claim for relief could not apply to sophisticated parties in the commercial realm. In fact, the *Aluevich* court cited to

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U.S. Fidelity v. Peterson, 91 Nev. 617, 540 P.2d 1070 (1975), a case involving insurance agreements, and noted that "an implied covenant of good faith and fair dealing has mainly been implied in contractual relations which involve a special element of reliance such as that found in partnership, **insurance** and franchise **agreements**." *Id.* at 217. While *Peterson* involved a dispute between an insurer and an insured, neither *Peterson* nor *Aluevich* forecloses the possibility that a special element of reliance can exist between the Health Care Providers and United. The type of relationship at issue here is one that undoubtedly gives rise to a relationship in which Fremont relies on United. The Health Care Providers performed millions of dollars in services to United's Members with the expectation that United would pay for these services. Because the Health Care Providers are obligated to provide these services under Nevada law, United sits in a superior position over Fremont, wielding a disparate level of power over whether the Health Care Providers get paid for its services and therefore, the facts alleged in the Operative Pleading fall squarely within the scope of a claim of tortious breach of implied covenant of good faith and fair dealing.

Finally, United appears to contend, without any support, that a higher pleading standard is required for a claim of tortious breach of implied covenant of good faith and fair dealing. No such obligation exists. The Health Care Providers have satisfied its pleading requirements under *Iqbal* and *Twombly* and, at this stage in litigation, the Health Care Providers have articulated a special relationship exists between United and the Health Care Providers. Because the Health Care Providers have adequately pled this claim, the Court should reject United's effort to litigate the facts at this juncture.

C. The Health Care Providers Stated an Alternative Claim for Unjust Enrichment

Nevada law permits recovery for unjust enrichment where a plaintiff provides an indirect benefit to the defendant that defendant accepts without adequate compensation, as United has done here. *Topaz Mut. Co. v. Marsh*, 108 Nev. 845, 856, 839 P.2d 606, 613 (1992) (recognizing that benefit in unjust enrichment claim can be indirect). The Health Care Providers' provision of services to United's Members allows United to discharge its duties under its contracts with its

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Members to cover medically necessary emergency healthcare services, thereby creating an indirect benefit to United, giving rise to an actionable claim for unjust enrichment under Nevada law. *See Emergency Physicians LLC v. Arkansas Health & Wellness Health Plan, Inc.*, No. 4:17-CV-00492-KGB, 2018 WL 3039517, at *5 (E.D. Ark. Jan. 31, 2018) (finding that because Texas law allows for an indirect benefit to sustain a claim for unjust enrichment, a claim for unjust enrichment based on indirect benefits received by insurer for services provided to insureds was actionable); *Bell v. Blue Cross of California*, 131 Cal. App. 4th 211, 221, 31 Cal. Rptr. 3d 688, 695–96 (2005) (emergency provider had standing to assert quantum meruit claim against payor because "he who has 'performed the duty of another by supplying a third person with necessaries…is entitled to restitution…").[15]

To support its position, United cites to a handful of cases from Florida, Texas, New York, Georgia and California which are readily distinguishable. *See e.g. 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) (noting that Florida law requires that the benefit conferred be "direct, not indirect or attenuated" thus any indirect benefit would not be actionable under Florida law); *Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc.*, No. 14-81271-CV, 2015 WL 2198470, at *5 (S.D. Fla. May 11, 2015) (same); *Encompass Office Sols., Inc. v. Ingenix, Inc.*, 775 F. Supp. 2d 938, 966 (E.D. Tex. 2011) (addressing payment for equipment and nursing staff not in the context of

[15] *See also El Paso Healthcare System, Ltd. v. Molina Healthcare of New Mexico*, 683 F.Supp.2d 454, 461–462 (W.D. Tex. 2010) (insurer "receive[d] the benefit of having its obligations to its plan members, and to the state in the interests of plan members, discharged."); *Appalachian Reg'l Healthcare vs. Coventry Health & Life Ins*. Co., 2013 WL 1314154 at *4 (E.D. Ky. Mar. 28, 2013) (granting summary judgment to provider on unjust enrichment claim where plaintiff's services allowed managed care organization to discharge its duty to provide coverage to Medicaid patients); *Fisher v. Blue Cross Blue Shield of Texas, Inc.*, 2011 WL 11703781, at *8 (N.D. Tex. June 27, 2011) (defendant insurer received the benefit of having its obligations to its plan members discharged.); *Forest Ambulatory Surgical Associates, L.P. v. United Healthcare Ins. Co.*, 2013 WL 11323600, at *10 (C.D. Cal. March 12, 2013) ("Plaintiff sufficiently stated a claim upon which relief can be granted because the allegations ... establish that Defendants received the benefit of having their obligations to the [policyholders] discharged."); *River Park Hosp., Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W.3d 43, 58-59 (Tenn. Ct. App. 2002) (MCO was unjustly enriched by hospital's emergency services provided to the insurer's enrollees); *New York City Health & Hosps. Corp. v. Wellcare of New York*, Inc., 35 Misc. 3d 250, 251, 937 N.Y.S.2d 540, 541, 546 (2011) (non-contracted hospital's unjust enrichment claim for systematic underpayment for emergency services by MCO should not be dismissed under New York law).

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emergency medical services); *Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.*, 962 F. Supp. 2d 887, 898 (S.D. Tex. 2013), *aff'd in part, rev'd in part*, 614 F. App'x 731 (5th Cir. 2015) (concerning payments relating to the sale of a medical device, not in the context of emergency medical services); *Travelers Indem. Co. of Connecticut v. Losco Grp., Inc.*, 150 F. Supp. 2d 556, 562–63 (S.D.N.Y. 2001) (under New York law, claim of quantum meruit requires more than a benefit received, plaintiff must show services were performed at the behest of the defendant); *Joseph M. Still Burn Centers, Inc. v. AmFed Nat. Ins. Co.*, 702 F. Supp. 2d 1371, 1377 (S.D. Ga. 2010) (plaintiff was already paid reimbursement rates set forth in Mississippi's and Georgia's workers' compensation fee schedules); *Cedars Sinai Med. Ctr. v. Mid-W. Nat. Life Ins. Co.*, 118 F. Supp. 2d 1002, 1013 (C.D. Cal. 2000) (since this decision, the same court has concluded in *Forest Ambulatory Surgical Associates v. United Healthcare Ins. Co.,* that a claim for quantum meruit can survive dismissal upon "establish[ing] that Defendants received the benefit of having their obligations to the [policyholders] discharged.").

Thus, the overwhelming majority of cases considering this issue conclude that where a state allows for an indirect benefit to provide the basis for an unjust enrichment claim, a claim of unjust enrichment against an insurer is actionable. United's grounds for dismissal therefore fail because Nevada law permits an unjust enrichment claim to lie on assertions of United's receipt of a material, indirect benefit from the Health Care Providers' services.

D. The Health Care Providers Stated a Claim for Violation of NRS 686A.020 and 686A.310

United cites to *Gunny v. Allstate Ins. C*o. for the proposition that Nevada's Unfair Insurance Practices Act "does not create a private right of action against insurers in favor of third party claimants like Fremont." Motion at 23:16-17. *Gunny* does not reach this blanket conclusion, rather the *Gunny* court emphasized that Gunny did not have a contractual relationship with the insurer. *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992). Thus, while the *Gunny* court did find that Gunny could not assert a private action against the insurer under NRS 686A.310, the absence of a contract between Gunny and the insurer makes this case distinguishable. Here, the Health Care Providers do have an implied in fact contract

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with United and, consequently, a claim asserted by a medical services provider under NRS 686A.020 and 686A.310 should be deemed actionable. Notably, the plain language of NRS 686A.310 does not *prohibit* a third party, such as the Health Care Providers, from raising claims under NRS 686A.310, but, instead, provides that claims may be asserted by the Commissioner and an insured. 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."). Under NRS 686A.020, "[a] person shall not engage in this state in any practice which is defined in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." Thus, based on the plain language of NRS 686A.310 and 686A.020 and the specific holding in *Gunny*, there is no express prohibition barring the Health Care Providers from asserting this claim. Accordingly, dismissal on this basis would be improper.

E. The Health Care Providers Stated a Claim for Violation of Nevada's Prompt Pay Statutes

United did not challenge the Health Care Providers' claim for violation of Nevada's prompt pay statutes under Rule 12(b)(5); consequently, this claim is not subject to dismissal on this basis.

F. The Health Care Providers Stated a Claim for Violation of Nevada's Deceptive Trade Practices Act

1. The Health Care Providers Have Pled This Claim with Particularity Even Though Such Is Not Required Under Nevada Law

In its Motion to Dismiss, United relies entirely on an unpublished and federal district court decision in asserting that a claim for violation of Nevada's Deceptive Trade Practices Act ("DTPA") must be pled with particularity. *See* Motion at 27:17-28:1. However, the Nevada Supreme Court has held, in a published decision, that violations of DTPA do not need to be proven with the same level of particularity as fraud claims. *Betsinger v. D.R. Horton, Inc.*, 232 P.3d 433, 436 (2010) (holding that a violation of the DTPA need not be proven under the clear and convincing standard as is required for a fraud claim). Thus, by analogy, such claims should

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not need to be pled with the particularity required for fraud claims and, based on the statements made in *Betsinger,* when faced with this question, the Nevada Supreme Court would not likely require a heightened pleading standard for a violation of the DTPA.

Even if this Court were to require that this claim be subject to heightened pleading standards, the Health Care Providers pled its claim for violation of DTPA with particularity. To support its claim, the Health Care Providers allege:

> 246. Defendants have violated the DTPA and the Consumer Fraud Statute through their acts, practices, and omissions described above, including but not limited to (a) wrongfully refusing to pay the Health Care Providers for the medically necessary, covered emergency services the Health Care Providers provided to Members in order to gain unfair leverage against the Health Care Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Health Care Providers to accept lower amounts than it is entitled for its services; and (b) engaging in systematic efforts to delay adjudication and payment of the Health Care Providers' claims for its services provided to UH Parties' members in violation of their legal obligations

FAC ¶ 246; *see also* ¶¶ 25, 57, 65. The Health Care Providers adequately allege that the UH Parties knowingly made a false representation by paying the Health Care Providers for emergency medical services at artificially reduced rates, thereby representing that, through their actions, these payments represent usual and customary rates and a reasonable value for services rendered when such rates are not usual and customary or reasonable. These representations commenced in July 2017 and have continued to present date. Accordingly, the Health Care Providers have adequately alleged this part of the DTPA claim.

Next, the Health Care Providers allege that the UH Parties violated "a state or federal statute or regulation relating to the sale or lease of goods or services." The Health Care Providers sufficiently allege this claim as United has violated NRS 679B.152, NRS 686A.020, 686A.310, NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), NRS 695C.185 (HMO) and NAC 686A.675 by failing to timely pay claims submitted at a usual and customary rate within 30 days of receipt of the claim. FAC ¶¶ 243-249. The Health Care Providers expressly states that the UH Parties began to violate these provisions in July 2017 (FAC ¶ 254) and the Sierra Affiliates in March 2019 (*id.* ¶ 255)and continue to

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violate such provisions through the present date. Nothing further is required to establish that this claim is actionable. As such, the Health Care Providers have sufficiently alleged this portion of the DTPA claim.

The Health Care Providers also properly alleges that the DPTA has been violated by United's use of "coercion, duress or intimidation in a transaction." FAC ¶ 244. Specifically, the Health Care Providers allege that United is "wrongfully refusing to pay the Health Care Providers for the medically necessary, covered emergency services the Health Care Providers provided to Members in order to gain unfair leverage against the Health Care Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Health Care Providers to accept lower amounts than it is entitled for its services." FAC ¶ 246. Further, as is detailed above, the Health Care Providers allege:

> Defendants paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount Defendants pay to the Health Care Providers. Defendants implemented this program to coerce, influence and leverage business discussions with the Health Care Providers to become a participating provider at significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates.

FAC ¶ 65. Based on the foregoing, the Health Care Providers have alleged who engaged in these bad acts (the United entities) when such parties engaged in these acts (from 2017 to present, FAC ¶ 90) and the scope of the bad acts alleged (improperly lowering amounts paid to leverage negotiations) (FAC ¶ 65).

Finally, the Health Care Providers properly allege that United has knowingly misrepresented the "legal rights, obligations or remedies of a party to a transaction." FAC ¶ 244. Specifically, the Health Care Providers assert that by paying claims at artificially reduced rates, United is representing that these claims are being paid at usual and customary and reasonable rates when such a representation is clearly inaccurate. With respect to the UH Parties, this conduct commenced in July 2017 (FAC ¶ 254); and with respect to the Sierra Affiliates this conduct commenced in September 2019 (*id.* ¶ 255) and continues to present date and each

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Defendant has engaged in these bad acts. Accordingly, the Health Care Providers have sufficiently alleged this aspect of its claim for violation of DTPA.

While United argues that it is improper to lump all the parties together in the Health Care Providers' allegations, this is not a situation in which only one party engaged in the improper acts. Motion at 28:9-14, 28:24-29:2. Rather, United has improperly engaged in artificially reducing the rates paid to the Health Care Providers for an ulterior purpose. Thus, it is certainly permissible for the Health Care Providers to make an allegation which encompasses all of these parties. To force the Health Care Providers to reallege this same claim using each of the Defendants' names would be inefficient and unnecessary under these circumstances. As is detailed herein, the Health Care Providers have satisfied the heightened pleading standard required for claims based on violation of DTPA.

Although United agreed to only file a renewed motion to dismiss that only addresses the FAC's allegations, United added a new substantive argument to its section on the Health Care Providers' sixth claim for violations of Consumer Fraud & Deceptive Trade Practices Acts. Motion at 28:15-23. But, the argument is misplaced and of no consequence to the sixth claim because, with references to Data iSight, an "enterprise" and false representations in connection with contract negotiations, it obviously is an argument related to the Health Care Providers' Nevada civil racketeering claim.[16] *Id.* As a result, the Court should disregard the argument as outside the permissible agreed filing parameters, and substantively because it does not address the right allegations relative to the sixth claim for relief.

2. The Health Care Providers are "Victims" Under NRS 41.600 and Have Standing

NRS 41.600(1) provides that "[a]n action may be brought by any person who is a victim of consumer fraud." The statute does not define the scope of "victim," but upon review of the deceptive trade practice statutes as a whole, it is clear that the legislature did not intend to limit the scope of this term. However, even under *Igbinovia's* definition of "victim" limiting it to

[16] United filed a Supplemental Brief in support of this Motion to address the Health Care Providers' eighth claim for violation of NRS 207.350 *et seq.*

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passive victims who suffered a loss that was "unexpected and occurs without voluntary participation of the person suffering the harm or loss," the Health Care Providers qualify as victims. *See Igbinovia v. State*, 111 Nev. 699, 706, 895 P.2d 1304, 1308 (1995). As is detailed in the FAC, the Health Care Providers do not voluntarily provide services to out of network patients. Rather, state law mandates that the Health Care Providers provide emergency medical services to any person presenting to an emergency room in need of emergency medical services. NRS 439B.410(1) ("each hospital … has an obligation to provide emergency services and care, including care provided by physicians…regardless of the financial status of the patient."). The provision of services to United's Members was not voluntary and the loss the Health Care Providers have suffered was unexpected given that United is refusing to pay usual and customary rates and the reasonable value of the services provided despite previously doing so. Thus, the Health Care Providers are not an active participant in United's fraudulent conduct and should be deemed "victims" under NRS 41.600(1) even if the definition of "victim" is limited in the way United proposes.

Furthermore, contrary to United's arguments, while one court has found that business competitors cannot be victims under Nevada law, the Ninth Circuit has reached a contrary conclusion, finding that the term "victim of consumer fraud" is broad and includes "any person" who is a victim of consumer fraud, including business competitors, consumers and even businesses which do not have competing interests. *Del Webb Community, Inc. v. Partington*, 652 F.3d 1145, 1153 (9th Cir. 2011). Thus, United's passing reference to *Rebel Oil Co*. for the proposition that business competitors are not "victims" should be disregarded.

Based on the foregoing, the Health Care Providers would undoubtedly be treated as victims of consumer fraud, even if this Court accepts the narrow definition of "victim" forwarded by United because the Health Care Providers have never been an active participant in United fraud.

G. The Health Care Providers Have Stated a Claim for Declaratory Relief

United did not challenge the Health Care Provider's declaratory relief claim under a NRCP 12(b)(5) standard. As a result, this claim is not subject to dismissal for failure to state a

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claim for relief.

VI. CONCLUSION

Based on the foregoing, the Health Care Providers respectfully request that United's Motion to Dismiss First Amended Complaint and Supplement thereto be denied in their entirety.

DATED this 29th day of May, 2020.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 29th day of May, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS FIRST AMENDED COMPLAINT** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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EXHIBIT 1

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EXHIBIT 1

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UNITED STATES DISTRICT COURT

DISTRICT OF 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.: 2:19-cv-00832-JAD-VCF **AMENDED MOTION TO REMAND**

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") (collectively, the "Health Care Providers") move the Court to

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remand this action to the Eighth Judicial District Court for Clark County, Nevada. In addition, pursuant to 28 U.S.C. § 1447(c), the Health Care Providers also ask that the Court award them their reasonable attorneys' fees and costs attributable to the improper removal.

This Amended Motion to Remand is submitted at the request of the Court, and based upon the record in this matter, the points and authorities that follow, the exhibits attached hereto, and any argument of counsel entertained by the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

PRELIMINARY STATEMENT

The Health Care Providers initiated this action in Nevada state court, and Nevada state court is where it belongs. The Health Care Providers assert claims arising exclusively under Nevada state law. As such, given the absence of complete diversity between the Parties, there is no basis for federal subject-matter jurisdiction. But rather than defend against the Health Care Providers' claims in the proper forum, Defendants have improperly removed. They argue that the doctrine of "complete preemption" under ERISA § 502(a)[1] transforms the Health Care Providers' state law claims into federal claims, thus creating federal question jurisdiction pursuant to 28 U.S.C. § 1331.

Defendants' position is meritless for multiple reasons. First, federal courts across the country, at both the district and appellate levels, are virtually unanimous in distinguishing between claims challenging the rates of reimbursement paid for healthcare services rendered to ERISA plan beneficiaries and claims challenging the right-to-payment for such services. Only right-to-payment claims are completely preempted. Rate-of-payment claims, like those asserted here, are not preempted and are routinely remanded to state court. Additionally, a healthcare provider's lack of standing to pursue ERISA benefits and assertion of claims predicated upon legal duties independent of an ERISA plan (such as contractual, quasi-contractual, tort, or statutory duties), factors which are present in this case, are both independently fatal to complete preemption.

[1] "ERISA" is the Employee Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829. Section 502(a) is codified at 29 U.S.C. § 1132(a).

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United has conceded that the overwhelming weight of authority prohibits complete preemption under ERISA where there exists a written, oral or quasi contract between the provider and the insurer which gives rise to the claims at issue. *See* Ex. 1, January 6, 2020 Hearing Tr. at 37:2-4 ("If it's a rate of payment case based on a -- a contract or a quasi contract, then it's outside of ERISA."). Notwithstanding that concession, United argues that the claims asserted here are preempted because an implied in fact agreement is different than a written, oral or quasi contract. Nevada law compels a different conclusion. Nevada courts uniformly agree that implied in fact agreements and express agreements stand on equal footing. *See Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379, 283 P.3d 250, 256 (2012) (an implied-in-fact contract "is a true contract that arises from the tacit agreement of the parties."); *Smith v. Recrion Corp.*, 91 Nev. 666, 668, 541 P.2d 663, 665 (1975) ("Both express and implied contracts are founded on an ascertained agreement."); *Magnum Opes Const. v. Sanpete Steel Corp.*, 2013 WL 7158997 (Nev. Nov. 1, 2013) (quoting 1 Williston on Contracts § 1:5 (4th ed. 2007) (noting that the legal effects of express and implied-in-fact contracts are identical); *Cashill v. Second Judicial Dist. Court of State ex rel. Cty. of Washoe*, 128 Nev. 887, 381 P.3d 600 (2012) (unpublished) ("The distinction between express and implied in fact contracts relates only to the manifestation of assent; both types are based upon the expressed or apparent intention of the parties."). There is no question that implied in fact agreements are treated the same as written, oral and quasi contracts in Nevada and, consequently, the caselaw rejecting ERISA preemption for claims arising out of such contracts equally applies to implied in fact agreements.

As shown below, in cases such as this—where a healthcare provider asserts state law causes of action challenging the rates of reimbursement allowed by an ERISA plan for claims which the plan has determined to be covered and payable, and the defendant removes on the basis of complete preemption—remand is essentially automatic. The Court should follow this well-established authority and grant the Amended Motion.

SUMMARY OF ALLEGATIONS & PROCEDURAL HISTORY

The Health Care Providers are professional emergency medicine service groups that staff the emergency departments at ten hospitals and other facilities throughout Nevada. *See* First Amended

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Complaint (ECF No. 40) (hereinafter "Am. Compl.") ¶¶ 3-5. Defendants ("United") are large health insurance companies and claims administrators. Am. Compl. ¶¶ 6-13. United provides healthcare benefits to its members ("United's Members"), including coverage for emergency care. Am. Compl. ¶¶ 19, 33.

The Health Care Providers and the hospitals whose emergency departments they staff are obligated by both federal and Nevada law and medical ethics to render emergency services and care to all patients who present in the emergency department, regardless of an individual's insurance coverage or ability to pay. Am. Compl. ¶ 18; *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. At all relevant times, United and the Health Care Providers have not had a written "network" agreement governing rates of reimbursement for emergency services rendered by the Health Care Providers to United's Members. Am. Compl. ¶ 20. Nevertheless, in accordance with their legal and ethical obligations, the Health Care Providers have provided emergency care to United's Members. Am. Compl. ¶¶ 18, 22.

The Health Care Providers have submitted claims to United seeking reimbursement for this emergency care. Am. Compl. ¶¶ 25-26, 40. United, in turn, has paid the Health Care Providers. *Id.* Over the period of 2008 through 2017, United paid the Health Care Providers at a range of 75-90% of the Health Care Providers' billed charges. Am. Compl. ¶ 53. This longstanding and historical practice establishes the basis for an implied-in-fact contract, as well as the usual and customary (or reasonable) rates of reimbursement for the emergency services. Am. Compl. ¶¶ 54, 189-206, 216-226. Thereafter, however, circumstances changed. United continued to pay the Health Care Providers' claims for emergency services, but arbitrarily and drastically reduced the rates of reimbursement to levels below the usual and customary rates. Am. Compl. ¶ 55.

Not satisfied with the reduced rates of reimbursement, on April 15, 2019, Fremont brought suit in the Eighth Judicial District Court for Clark County, Nevada. *See* Original Complaint (ECF No. 1-1) (hereinafter "Compl.") ¶¶ 2-9. The Original Complaint made clear that the lawsuit involved only claims for reimbursement which United already had determined were payable and had paid, albeit at artificially reduced rates. Compl. ¶ 27. The Original Complaint asserted seven state-law causes of action, including breach of implied-in-fact contract, tortious breach of the implied

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covenant of good faith and fair dealing, unjust enrichment, violation of NRS 686A.020 and 686A.310, violations of Nevada Prompt Pay statutes and regulations, violations of Nevada Consumer Fraud & Deceptive Trade Practices Acts, and declaratory judgment. *See* Compl. *generally*. All of these legal claims are based on United's underpayment of claims which it had determined were payable and paid, *i.e.*, a dispute over the proper rates of payment rather than the right to payment. Compl. ¶ 27.

Although the basis for federal subject-matter jurisdiction was facially lacking, on May 14, 2019, Defendants filed a Notice of Removal with this Court, contending that the asserted state-law claims are completely preempted by ERISA because they "relate to" an employee benefit plan. *See* Notice of Removal (ECF No. 1) at ¶¶ 2-12. Fremont timely moved to remand. *See* Motion to Remand (ECF No. 5). The Motion to Remand was denied without prejudice on January 6, 2020, in light of the anticipated filing of the First Amended Complaint.

On January 7, 2020, with the Court's permission, the Health Care Providers filed the First Amended Complaint. *See* Am. Compl. In this amended pleading, the Health Care Providers added additional parties (two plaintiffs and one defendant), as well as an additional state statutory cause of action (violation of NRS 207.350 *et seq.* (Nevada RICO)). Am. Compl. ¶¶ 3-13, 261-73. The Original Complaint featured claims arising exclusively under Nevada state statutory and common law, and the First Amended Complaint has not changed this.

Because there is no basis for federal subject-matter jurisdiction, the Health Care Providers seek remand to Nevada state court.

LEGAL STANDARD

"Under 28 U.S.C. § 1441, a defendant may remove an action filed in state court to federal court if the federal court would have original subject matter jurisdiction over the action." *Moore-Thomas v. Alaska Airlines, Inc.*, 553 F.3d 1241, 1243 (9th Cir. 2009). And "[f]ederal courts have original jurisdiction over 'all civil actions arising under the Constitution, laws, or treaties of the United States.'" *Id.* (citing 28 U.S.C. § 1331). In general, "[a]n action arises under federal law only if federal law 'creates the cause of action' or 'a substantial question of federal law is a necessary element'" of the plaintiff's state law claim. *Coeur d'Alene Tribe v. Hawks*, 933 F.3d

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1052, 1055 (9th Cir. 2019) (citing *Morongo Band of Mission Indians v. Cal. State Bd. of Equalization*, 858 F.2d 1376, 1383 (9th Cir. 1988)). The Ninth Circuit "has long and consistently held that [such] federal-law element must appear on the face of plaintiff's well-pleaded complaint." *Morongo*, 858 F.2d at 1383 (citing *Franchise Tax Bd. v. Construction Laborers Vacation Tr.*, 463 U.S. 1, 9-10 (1983)). "This means that a plaintiff may not establish federal jurisdiction by asserting in its complaint that the defendant will raise a federal-law defense to the plaintiff's claim, or by including in its complaint allegations of federal-law questions that are not essential to its claim[.]" *Id.* (citing *Franchise Tax Bd.*, 463 U.S. at 13-14).

Further, "[t]he removal statute is strictly construed, and any doubt about the right of removal requires resolution in favor of remand." *Moore-Thomas v. Alaska Airlines, Inc.*, 553 F.3d 1241, 1244 (9th Cir. 2009) (citing *Gaus v. Miles, Inc.*, 980 F.2d 564, 566 (9th Cir.1992)). "The presumption against removal means that the defendant always has the burden of establishing that removal is proper." *Id.* (internal quotations omitted). *See also Hansen v. Group Health Coop.*, 902 F.3d 1051, 1057 (9th Cir. 2018) ("The removing defendant bears the burden of overcoming the strong presumption against removal jurisdiction.") (citation omitted). And so, "[i]f a district court determines at any time that less than a preponderance of the evidence supports the right of removal, it must remand the action to the state court." *Id.* (citing *Geographic Expeditions, Inc. v. Estate of Lhotka ex rel. Lhotka*, 599 F.3d 1102, 1107 (9th Cir. 2010)).

Finally, Plaintiffs are the "master[s]" of their complaints and may choose to litigate in state court by pleading only state law causes of action, even where a federal cause of action would otherwise be available. *See Hansen*, 902 F.3d at 1056; *ARCO Envtl. Remediation, L.L.C. v. Dep't of Health & Envtl. Quality of Montana*, 213 F.3d 1108, 1114 (9th Cir. 2000) ("As the master of the complaint, a plaintiff may defeat removal by choosing not to plead independent federal claims"). Removal based on federal-question jurisdiction is reviewed under the longstanding well-pleaded complaint rule, which "provides that an action 'aris[es] under' federal law 'only when a federal question is presented on the face of the plaintiff's properly pleaded complaint.'" *Hansen*, 902 F.3d at 1057 (citing *Caterpillar Inc. v. Williams*, 482 U.S. 386, 398–99 (1987)). Thus, "a defendant cannot remove on the basis of a federal defense." *Id.* (citation omitted).

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ARGUMENT

I. ONLY COMPLETE ERISA PREEMPTION YIELDS FEDERAL SUBJECT-MATTER JURISDICTION

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). These two forms of preemption are doctrinally distinct. Complete preemption occurs where "Congress intended the scope of a federal law to be so broad as to entirely replace any state-law claim." *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 945 (9th Cir. 2009) (internal citation and quotation marks omitted). Complete preemption is a "rare" doctrine, by which a "state-created cause of action can be deemed to arise under federal law[,]" regardless of whether a plaintiff, as "the master of [its] complaint," intentionally "cho[se] not to plead independent federal claims." *ARCO*, 213 F.3d at 1114. As such, complete preemption operates as an exception to the well-pleaded complaint rule. *Marin*, 581 F.3d at 945. "Even if the only claim in a complaint is a state law claim, if that claim is one that is 'completely preempted' by federal law, federal subject matter jurisdiction exists and removal is appropriate." *Toumajian v. Frailey*, 135 F.3d 648, 653 (9th Cir. 1998).

"Unlike complete preemption, preemption that stems from a conflict between federal and state law is a defense to a state law cause of action and, therefore, does not confer federal jurisdiction over the case." *ARCO*, 213 F.3d at 1114. Accordingly, conflict preemption is not a basis for removal to federal court. *Toumajian*, 135 F.3d at 654. If a claim is conflict preempted, "[t]he district court lacks power to do anything but remand the case to the state court where the preemption issue can be addressed and resolved." *Id.* 655.

ERISA contains an express preemption provision—§ 514(a)—which directs that "this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a). ERISA conflict preemption arises from this language. *See Conn. Dental*, 591 F.3d at 1344. Separately, complete preemption is derived from ERISA's civil enforcement provision—§ 502(a)—in which Congress enacted a "comprehensive scheme of civil remedies to enforce ERISA's provisions." *Cleghorn v. Blue*

Shield of Cal., 408 F.3d 1222, 1225 (9th Cir. 2005). These doctrines are not coextensive in reach. "Complete preemption is narrower than [conflict] ERISA preemption . . . . Therefore, a state-law claim may be defensively preempted under § 514(a) but not completely preempted under § 502(a)." *Conn. Dental*, 591 F.3d at 1344 (internal brackets omitted).

Defendants contend that "state law claims that ***relate to*** an employee welfare benefit plan are properly removed to federal court even where the complaint does not facially state an ERISA cause of action." Notice of Removal ¶ 11 (emphasis added). That is a blatant misstatement of the law. The Ninth Circuit has expressly held that "the question whether a law or claim 'relates to' an ERISA plan is not the test for complete preemption under § 502(a)(1)(B). Rather it is the test for conflict preemption under § 514(a)." *Marin*, 581 F.3d at 949. And "conflict preemption under § 514(a) does not provide a basis for federal question jurisdiction . . . ." *Id.* Because only complete preemption—not conflict preemption—yields federal subject-matter jurisdiction, Defendants must establish that that the Health Care Providers' claims are completely preempted in order to avoid remand. Conflict preemption is irrelevant in this context.

II. PLAINTIFFS' CLAIMS ARE NOT COMPLETELY PREEMPTED

In *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), the Supreme Court established a two-part framework governing complete ERISA preemption. Under *Davila*, complete preemption obtains only where: (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(B)," and (2) "no other independent legal duty . . . 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.[2] *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 146 (2d Cir. 2017). Multiple federal circuits, including the Ninth Circuit, have analyzed and applied this framework. *See Marin*, 581 F.3d at 946; *Pascack Valley Hosp., Inc. v. Local 464A Welfare Reimbursement*

[2] A number of courts have further disaggregated the first *Davila* prong into two subparts. *See, e.g., Montefiore Med. Ctr. v. Teamsters Local 272*, 642 F.3d 321, 328 (2d Cir.2011); *Conn Dental*, 591 F.3d at 1350 (citing *Marin*, 581 F.3d at 947-49); *Comprehensive Spine Care P.A. v. Oxford Health Ins. Inc.*, 2018 WL 6445593, at *2 (D.N.J. Dec. 10, 2018). These courts find that *Davila* Prong 1 is satisfied only where: (1) the plaintiff is the type of party who could bring a claim pursuant to ERISA § 502(a)(1)(B), *i.e.*, the plaintiff must have ERISA standing; and (2) the actual claim asserted by the plaintiff can be construed as a colorable claim for ERISA benefits, *i.e.* the claim falls within the scope of § 502(a)(1)(B). *Id.*

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Plan, 388 F.3d 393, 399 (3d Cir. 2004); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 529 (5th Cir. 2009); *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health and Welfare Tr. Fund*, 538 F.3d 594, 598 (7th Cir. 2008); *Conn. Dental*, 591 F.3d at 1345; *Montefiore*, 642 F.3d at 328. As shown below, neither *Davila* prong is satisfied here.

A. *Davila* Prong 1

Davila Prong 1 looks to whether the plaintiff "could have brought [the] claim under ERISA § 502(a)(1)(B)." *Marin*, 581 F.3d at 947. To satisfy this element, two requirements must be met: the asserted claims must fall within the scope of ERISA and the plaintiff must have standing to sue under ERISA. *Conn. Dental*, 591 F.3d at 1350. Regarding the first requirement, multiple appellate courts have held that claims which challenge the rates of reimbursement paid for covered healthcare services, rather than the right to reimbursement for such services, do not fall within the scope of § 502(a)(1)(B). *Id.* at 1349-50; *Lone Star*, 579 F.3d at 531; *Montefiore*, 642 F.3d at 325; *CardioNet Inc. v. Cigna Health Corp.*, 751 F.3d 165, 177-78 (3d Cir. 2014). This crucial distinction between rate-of-payment and right-to-payment claims finds its genesis in a Ninth Circuit decision called *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (affirming remand of health care providers' state law claim for breach of contract because the dispute was "not over the *right* to payment, which might be said to depend on the patients' assignments to the Providers, but the *amount*, or level, of payment, which depends on the terms of the provider agreements."). 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, the Health Care Providers explicitly plead that they challenge only rates of reimbursement on claims which Defendants have adjudicated as payable and actually paid, not the right to reimbursement for those claims. Am. Compl. ¶¶ 1, 26; 1 n.1 ("The Health Care Providers also do not assert any claims . . . with respect to the right to payment under any ERISA plan."). As such, the claims asserted in this action do not fall within the scope of ERISA, and the Court should grant the Amended Motion for this reason alone. Indeed, federal district courts routinely remand cases removed based upon complete ERISA preemption where the plaintiff

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challenges only rates of reimbursement. *See, e.g., Garber v. United Healthcare Corp.*, 2016 WL 1734089, at *3-5 (E.D.N.Y. May 2, 2016); *Long Island Thoracic Surgery, P.C. v. Building Serv. 32BJ Health Fund*, 2019 WL 5060495, at *2 (E.D.N.Y. Oct. 9, 2019); *Premier Inpatient Partners LLC v. Aetna Health & Life Ins. Co.*, 371 F. Supp. 3d 1056, 1068-74 (M.D. Fla. 2019); *Gulf-to-Bay Anesthesiology Assocs. v. UnitedHealthCare of Fla., Inc.*, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc.*, 258 F. Supp. 3d 1323, 1327-30 (S.D. Fla. 2017); *N. Jersey Brain & Spine Ctr. v. MultiPlan, Inc.*, 2018 WL 6592956, at *7 (D.N.J. Dec. 14, 2018); *E. Coast Advanced Plastic Surgery v. AmeriHealth*, 2018 WL 1226104, at *3 (D.N.J. Mar. 9, 2018).

The cases cited by Defendants in the Notice of Removal (ECF No. 1) are inapposite because they all concern disputes over the right to payment/coverage under a health plan, rather than the rate of payment, as is the case here. In *Tingey v. Pixley-Richards W., Inc.*, the plaintiff was an *employee* bringing suit for claims concerning the employer's and insurer's termination of health insurance coverage, squarely within the scope of ERISA because the claims arose out of an employee welfare benefit plan. *Tingey v. Pixley-Richards W., Inc.*, 953 F.2d 1124, 1133 (9th Cir. 1992). Similarly, in *Misic v. Bldg. Serb. Employees Health & Welfare Tr.*, the insurer was being sued for failure to cover a claim based on the amount that was expressly required to be paid under the health plan when the beneficiary's rights were assigned to the medical provider. *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374, 1376 (9th Cir. 1986). In *Gables*, the claims concerned an alleged wrongful denial of *coverage* under the health care plan. *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc.*, 813 F.3d 1333, 1338 (11th Cir. 2015). Finally, in *Cleghorn*, an employee bringing claims against the insurer asserted claims based on his health plan's denial of coverage. *Cleghorn v. Blue Shield of California*, 408 F.3d 1222, 1223–24 (9th Cir. 2005). This case is distinct from all the cases cited by Defendants because this is a rate of payment case, not a right to payment case, as in *Cleghorn*, *Gables*, *Misic* and *Tingey*.

Defendants have also indicated (ECF Doc. No. 38) that they will rely upon a recent decision called *Hill Country Emergency Med. Assocs., P.A. et al. v. UnitedHealthCare Ins. Co. et al.*, No. 1:19-CV-00548-RP (W.D. Tex. Dec. 10, 2019), in which a district court in the Western

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District of Texas held that an out-of-network healthcare provider's rate-of-payment claims were completely preempted. The *Hill Country* Court premised this conclusion upon its reading of the Fifth Circuit's decision in *Lone Star* to hold that the right-to-payment / rate-of-payment distinction applies only to claims brought by in-network providers. *See* Petition in *Hill Country Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.* (Ex. 2) at 6-7. But that reflects a misreading of *Lone Star*, which, while addressing claims by an in-network provider, in no way so limits its recognition of the distinction in out of network cases. *Lone Star*, 579 F.3d at 530-32. *Hill Country* is an extreme outlier, standing in stark contrast to the multitude of cases in which district courts have remanded rate-of-payment disputes brought by out-of-network providers. *See, e.g., Garber*, 2016 WL 1734089, at *3-5; *Long Island Thoracic Surgery*, 2019 WL 5060495, at *2; *Premier Inpatient*, 371 F. Supp. 3d at 1068-74; *Gulf-to-Bay*, 2018 WL 3640405, at *3; *Hialeah*, 258 F. Supp. 3d at 1327-30; *Comprehensive Spine*, 2018 WL 6445593, at *2; *N. Jersey Brain & Spine Ctr. v. United Healthcare Ins. Co.*, 2019 WL 6317390, at *5 (D.N.J. Nov. 25, 2019), R&R adopted, 2019 WL 6721652.

In addition, *Hill Country* is distinguishable because the factual allegations and legal theories in that case were different: the *Hill Country* plaintiffs asserted claims based upon assignments of benefits and did not allege the existence of any contract. Ex. 2 at 2, 5. Here, the Health Care Providers have alleged the existence of an implied-in-fact agreement and have expressly stated that they are not pursuing any claims under an assignment of benefit theory. As the Ninth Circuit explained in *Marin,* such a claim "does not stem from the ERISA plan, and the [provider] is therefore not suing as an assignee of an ERISA plan participant or beneficiary . . . it is suing in its own right pursuant to an independent obligation." 581 F.3d at 948.

Davila Prong 1 is unsatisfied for the additional reason that the Health Care Providers lack ERISA standing. Section 502(a)(1)(B) confers standing to bring a benefits-due action upon plan "participant[s]" and "beneficiar[ies]." 29 U.S.C. § 1132(a)(1)(B). The Health Care Providers are neither. Defendants assert that the Health Care Providers enjoy derivative standing because they received assignments of benefits from their patients. Notice of Removal ¶ 13. Putting aside that Defendants have not even attempted to demonstrate the existence, scope, or legal effectiveness of

such assignments, the Health Care Providers have explicitly pled that they pursue claims based upon duties owed directly to them, not derivative claims based upon duties owed to their patients. Am. Compl. at 1 n.1. The law is clear that the existence of an assignment does not convert a healthcare provider's claims based upon legal obligations independent of an ERISA plan into claims for ERISA benefits. *See Blue Cross*, 187 F.3d at 1052 ("[W]e find no basis to conclude that the mere fact of assignment converts the Providers' claims into claims to recover benefits under the terms of an ERISA plan.").

Marin is highly instructive. In that case, the healthcare provider plaintiff asserted state law claims for breach of an implied-in-fact contract, breach of oral contract, negligent misrepresentation, quantum meruit, and estoppel. 581 F.3d at 944. The defendant removed based upon complete ERISA preemption, arguing that the first *Davila* prong was satisfied because the provider allegedly had standing to pursue claims under an assignment of benefits. *Id.* at 949. The Ninth Circuit disagreed, concluding that because the provider had asserted claims based upon a purported oral contract with the defendant, the relevant legal obligation "does not stem from the ERISA plan, and the [provider] is therefore not suing as an assignee of an ERISA plan participant or beneficiary . . . it is suing in its own right pursuant to an independent obligation." *Id.* at 948. The Ninth Circuit considered and squarely rejected the argument that United makes here: that because the provider plaintiff allegedly obtained an assignment of benefits, it was prevented from seeking relief under state law:

> Second, defendants argue that because the Hospital was assigned the patient's rights to payment under his ERISA plan, it was prevented from seeking additional payment under state law. That is, they argue that because the Hospital could have brought a suit under § 502(a)(1)(B) for payments owed to the patient by virtue of the terms of the ERISA plan, this is the *only* suit the Hospital could bring. This argument is inconsistent with our analysis in *Blue Cross*. There we concluded that, even though the Providers had received an assignment of the patient's medical rights and hence could have brought a suit under ERISA, there was "no basis to conclude that the mere fact of assignment converts the Providers' claims [in this case] into claims to recover benefits under the terms of an ERISA plan." 187 F.3d at 1052.
>
> We conclude that the Hospital's state-law claims based on its alleged oral contract with [defendant] were not brought, and could not have been brought, under § 502(a)(1)(B). Therefore, the Hospital's state-law claims do not satisfy the first prong of *Davila*.

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Id. at 949. In other words, that the plaintiff could have but chose not to assert a derivative claim for ERISA benefits did not foreclose it from instead asserting non-ERISA claims based on separate legal obligations owed to it directly. *See also Bay Area Surgical Mgmt., LLC v. United Healthcare Ins. Co.*, 2012 WL 3235999, at *4 (N.D. Cal. Aug. 6, 2012) (no ERISA standing where causes of action "arise from the alleged oral contract between [plaintiff] and United"); *N. Jersey Brain & Spine Ctr. v. Aetna Life Ins. Co.*, 2017 WL 659012, at *4-5 (D.N.J. Feb. 17, 2017) (no ERISA standing where "[plaintiff] is not seeking relief as an assignee of an ERISA plan's benefits, but pursuing recovery under the terms of an implied contract between it and Aetna.").

Here, as in *Blue Cross*, *Marin*, and their progeny, the Health Care Providers assert claims based upon contractual and quasi-contractual legal obligations independent of any ERISA plans. Assignments of benefits, to the extent they exist and are effective, would not convert the claims pled into claims for ERISA benefits. For this reason, the Court should grant the Amended Motion.

B. *Davila* Prong 2

Davila Prong 2 looks to whether an independent legal duty is implicated by the defendant's actions. 542 U.S. at 210. "If there is some other independent legal duty beyond that imposed by an ERISA plan, a claim based on that duty is not completely preempted . . . ." *Marin*, 581 F.3d at 949. "A legal duty is independent if it is not based on an obligation under an ERISA plan, or it would exist whether or not an ERISA plan existed." *N.J. Carpenters and the Trs. Thereof v. Tishman Constr. Corp. of N.J.*, 760 F.3d 297, 303 (3d Cir. 2014). Courts routinely hold that claims predicated upon duties imposed by state common and statutory law do not satisfy *Davila* Prong 2. *See, e.g., McCulloch*, 857 F.3d at 150 (second *Davila* prong unsatisfied because "[plaintiff's] promissory-estoppel claim against Aetna arises not from an alleged violation of some right contained in the plan, but rather from a freestanding state-law duty grounded in conceptions of equity and fairness."); *Wurtz v. Rawlings Co., LLC*, 761 F.3d 232, 243 (2d Cir. 2014) ("[W]hile defendants' reimbursement claims relate to plaintiffs' plans, this is not the test for complete preemption. Plaintiffs' claims do not derive from their plans or require investigation into the terms of their plans; rather, they derive from [a state statute]."); *Bay Area Surgical*, 2012 WL 3235999, at *4 (second *Davila* prong unsatisfied because plaintiff alleging claim under an oral agreement

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"is suing on its own right pursuant to an independent obligation, and its claims would exist regardless of an ERISA plan."); *Christ Hosp. v. Local 1102 Health and Benefit Fund*, 2011 WL 5042062, at *4 (D.N.J. Oct. 24, 2011) (second *Davila* prong unsatisfied where claims "depend[ed] on the operation of a third-party contract" between plaintiff medical provider and defendant ERISA plan, rather than on the terms of the ERISA plan).

Once again, *Marin* is analogous. The *Marin* Court held that legal and equitable claims asserted by a healthcare provider plaintiff based upon a purported contract that was never reduced to writing—similar to the claims alleged in this action—were supported by an independent legal duty because they were "in no way based on an obligation under an ERISA plan" and "would exist whether or not an ERISA plan existed." 581 F.3d at 950. Here too, the Health Care Providers' claims are based upon obligations imposed by Nevada state law and in no way depend upon the existence of an ERISA plan. And importantly, United has already conceded the point, acknowledging that contractual or quasi-contractual claims for reimbursement do not give rise to complete ERISA preemption. *See* January 6, 2020 Hearing Tr. at 37:2-4.

As such, *Davila* Prong 2 is unsatisfied, providing yet another fatal flaw in Defendants' complete preemption argument.

III. COSTS AND FEES

Should the Court grant this Motion, it should award the Health Care Providers their reasonable fees and costs incurred as a result of the improper removal, pursuant to 28 U.S.C. § 1447(c). In applying § 1447(c), this Court has explained that fees are appropriate if the removal was not objectively reasonable based on the relevant case law. *See J.M. Woodworth Risk Retention Grp., Inc. v. Uni-Ter Underwriting Mgmt. Corp*, 2014 WL 6065820, at *1 (D. Nev. Nov. 12, 2014). Here, United did not have an objectively reasonable basis for removal. Voluminous case law, in the Ninth Circuit and beyond, demonstrated that removal was improper because rate-of-payment disputes are not completely preempted by ERISA. But United chose to disregard this precedent and remove nonetheless. Accordingly, the Health Care Providers are entitled to recover its attorneys' fees and costs incurred in filing the original Motion and this Amended Motion.

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CONCLUSION

For all the foregoing reasons, the Court should grant the Amended Motion, remand this action to the Eighth Judicial District Court for Clark County, Nevada, and award the Health Care Providers their reasonable costs and attorney's fees pursuant to 28 U.S.C. § 1447(c).

DATED this 15th day of January, 2020.

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 15th day of January, 2020, I caused a true and correct copy of the foregoing **AMENDED MOTION TO REMAND** to be served via the U.S. District Court's Notice of Electronic Filing system ("NEF") in the above-captioned case, upon the following:

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INDEX OF EXHIBITS

Description	Exhibit No.
Transcript of Hearing on January 6, 2020 (relevant portions)	1
Petition in *Hill Country Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.*	2

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EXHIBIT 1

Transcript of Hearing on January 6, 2020

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EXHIBIT 1

TRANSCRIBED FROM DIGITAL RECORDING

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF 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,	Case No. 2:19-cv-00832-JAD-VCF
vs.	Las Vegas, Nevada January 6, 2020 Courtroom 3D
UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation, et al.,	
Defendants.	Recording method: Liberty/CRD 2:50 p.m. - 3:58 p.m. MOTION HEARING

ORIGINAL

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE CAM FERENBACH
UNITED STATES DISTRICT COURT MAGISTRATE JUDGE

(Appearances contained on page 2.)

Recorded by: Jerry Ries

Transcribed by: Amber M. McClane, RPR, CRR, CCR #914
United States District Court
333 Las Vegas Boulevard South, Room 1334
Las Vegas, Nevada 89101
AM@nvd.uscourts.gov

Proceedings recorded by electronic sound recording.
Transcript produced by mechanical stenography and computer.

something to do with whether the dispute is coverage or rate of payment? Does that make a difference?

MR. ROBERTS: Yes.

THE COURT: Okay.

MR. ROBERTS: Yes. And that may be more detail than we need to go in now --

THE COURT: Okay.

MR. ROBERTS: -- but I -- I --

THE COURT: That's probably what I told Ms. Lundvall I didn't want to hear about.

MR. ROBERTS: Yes, you did. And I don't know that the Court needs to address it, but they -- they do make clear in -- in their reply brief --

THE COURT: Right.

MR. ROBERTS: -- that they acknowledge this is only about the rate of payment.

THE COURT: Rate of payment. Right. Yeah.

MR. ROBERTS: And we paid them something, but it's just not satisfactory to them.

THE COURT: And that way -- that -- you know, if that's accepted, then it's outside of ERISA. If it's truly and only a rate of payment case, then it's -- it's not ERISA. No?

MR. ROBERTS: I don't -- I think that's a little bit too broad.

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THE COURT: Too broad? Okay.

MR. ROBERTS: If it's a rate of payment case based on a -- a contract or a quasi contract, then it's outside of ERISA.

THE COURT: Okay.

MR. ROBERTS: But if there is no contract except the ERISA contract, I don't believe it is outside of ERISA.

THE COURT: Okay. So -- so the -- then the question is, is there a contract or a quasi contract.

MR. ROBERTS: Correct.

THE COURT: Aah. Okay. Okay. Thank you.

MR. ROBERTS: And -- and for that very issue, this Court in the order on the motion to stay, Document 25 --

THE COURT: Right. And I was looking at that just before I came in here.

MR. ROBERTS: Yes.

THE COURT: I said, gosh, I entered an order in this case. I better read what I had to say. Okay.

MR. ROBERTS: And I think --

THE COURT: That's Number 25; right?

MR. ROBERTS: Yes.

THE COURT: Yeah.

MR. ROBERTS: And -- and the Court took a preliminary peek at these issues and determined that it was unlikely that the case would be remanded --

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Thank you very much.

MS. LUNDVALL: Thank you, Your Honor.

MR. ROBERTS: Thank you, Your Honor.

MS. GALLAGHER: Thank you.

(Proceedings adjourned at 3:58 p.m.)

* * *

I, AMBER M. McCLANE, court-appointed transcriber, certify that the foregoing is a correct transcript transcribed from the official electronic sound recording of the proceedings in the above-entitled matter.

/s/ Amber M. McClane 1/15/2020
AMBER MCCLANE, RPR, CRR, CCR #914 Date

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EXHIBIT 2

Petition in *Hill Country Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.*

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EXHIBIT 2

4/15/2019 4:15 PM
Velva L. Price
District Clerk
Travis County
D-1-GN-19-002050
Jessica A. Limon

CAUSE NO. D-1-GN-19-002050

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, P.A.,	§	IN THE DISTRICT COURT
Plaintiffs,	§	
v.	§	201ST JUDICIAL DISTRICT
UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc.,	§	
Defendants.	§	TRAVIS COUNTY, TEXAS

PLAINTIFFS' ORIGINAL PETITION

TO THE HONORABLE COURT:

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COME NOW Plaintiffs 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, P.A., by and through undersigned counsel, file this Original Petition against Defendants UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc. (collectively, "The Insurance Companies"), and would show the Court as follows:

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INTRODUCTION

1. Plaintiffs 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, P.A. (collectively, the "Plaintiff Doctors") are four groups of physicians who provide emergency care to thousands of citizens of central Texas. Unlike most other physicians,

who generally have the ability to choose the patients that they treat, these doctors do not. By necessity and under compulsion of federal and state law, Plaintiff Doctors are obligated to treat all patients who require emergency services. In recognition of the nature and critical importance of these services, Texas law requires health insurers to compensate emergency medicine physicians at usual and customary rates, whether or not the doctors are part of the insurers' preferred provider networks. Reasonable compensation is essential to permit Plaintiff Doctors to continue to provide high-quality emergency services and to attract and retain physicians who are willing to work long hours under great stress in order to perform life-saving medical services in otherwise underserved areas of Texas.

2. The Insurance Companies historically have compensated Plaintiff Doctors at more reasonable rates, as required under Texas statutes. In recent years, however, the Insurance Companies began slashing the rates at which they paid Plaintiff Doctors for their emergency services. The Insurance Companies began paying some of the claims for emergency services rendered by Plaintiff Doctors at far below the usual and customary rates—substantially below the historic levels for the same services and significantly below the rates at which the Insurance Companies continued to pay other substantially identical claims.

3. One explanation for this disparity is that the Insurance Companies are reimbursing Plaintiff Doctors for services provided to members of the plans they fully underwrite at significantly lower rates than they are reimbursing Plaintiff Doctors for services provided to members of the employer-funded plans for which the Insurance Companies only provide administrative services.

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4. This action seeks damages for the Insurance Companies' violations of Texas law and to compel the Insurance Companies to abide by Texas law with respect to payment of future claims.

PARTIES

5. Plaintiff Hill Country Emergency Medical Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas.

6. Plaintiff Longhorn Emergency Medicine Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas.

7. Plaintiff Central Texas Emergency Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas.

8. Plaintiff Emergency Associates of Central Texas, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas

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9. Defendant UnitedHealthCare Insurance Company is a corporation organized under the laws of the State of Connecticut doing business in Texas. UnitedHealthCare Insurance Company is licensed by the Texas Department of Insurance as a life, health or accident insurance company, and underwrites or administers preferred provider benefit plans and other health insurance products in the State of Texas. It may be served through its agent for service of process, C T Corporation System, 350 North Paul Street, Dallas, TX 75201.

10. Defendant UnitedHealthCare of Texas, Inc. is a corporation organized under the laws of the State of Texas with a principal office in Plano, Texas. UnitedHealthCare of Texas, Inc. is licensed by the Texas Department of Insurance as a basic health maintenance organization ("HMO"). It may be served through its agent for service of process C T Corporation System, 1999 Bryan St., Suite 900, Dallas, TX 75201-3136.

DISCOVERY CONTROL PLAN AND CLAIM FOR RELIEF

11. This case will be governed by Level 3 discovery pursuant to Rule 190.4 of the Texas Rules of Civil Procedure. Plaintiff doctors seek monetary relief in excess of $1,000,000.00.

JURISDICTION & VENUE

12. This Court has subject-matter jurisdiction because this dispute involves an amount in controversy in excess of this Court's minimum jurisdictional requirements.

13. Venue is proper in Travis County, Texas pursuant to Section 15.002(a)(1) of the Texas Civil Practice & Remedies Code because a substantial part of the events or omissions giving rise to Plaintiff Doctors' claims occurred in Travis County, Texas.

14. The Insurance Companies are subject to personal jurisdiction in this state pursuant to Tex. Civ. Prac. & Rem. Code § 17.042(1) because they have entered into contracts to provide insurance to Texas residents and conduct business in this State.

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FACTS

The Plaintiffs Provide Necessary Emergency Care

15. This is an action for damages stemming from the Insurance Companies' failure to properly reimburse Plaintiff Doctors for emergency services provided to members of the Insurance Companies' health plans.[1]

[1] Plaintiff Doctors do not assert any causes of action with respect to any patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA). Thus, there is no basis to remove this lawsuit to federal court under federal question jurisdiction. Plaintiff Doctors also do not assert any claims relating to the Insurance Companies' Managed Medicare business. As explained below, upon entry of an appearance by counsel for the Insurance Companies, Plaintiff Doctors will serve, via encrypted transmission, a list of the individual healthcare claims at issue in this litigation. To the extent that list contains any healthcare claims relating to Managed Medicare, FEHBA, or Managed Medicaid business, Plaintiff Doctors will remove them upon notice by the Insurance Companies.

16. Plaintiff Doctors are emergency medicine physicians who staff emergency departments 24 hours a day, 7 days a week. Plaintiff Doctors provide emergency department coverage at 25 Texas emergency departments.

17. As providers of emergency medical care, Plaintiff Doctors have made a commitment to providing emergency medical services to all patients, regardless of insurance coverage or ability to pay, including to patients with insurance coverage issued or underwritten by the Insurance Companies.

18. This philosophy is echoed in the federal Emergency Medical Treatment and Labor Act ("EMTALA") and Texas law, which require emergency room physicians to evaluate, stabilize, and treat all patients, regardless of their insurance status or ability to pay. *See* EMTALA, 42 U.S.C. § 1395dd; Tex. Health & Safety Code Ann. §§ 311.022–.024; Tex. Health & Safety Code Ann. §§ 241.027–.028, 241.055–.056.

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19. EMTALA is one of the central sources of patient protection in the United States healthcare system.

20. However, EMTALA also places a financial burden on emergency medicine physicians, many of whom also adhere to grueling schedules and live in or commute to far-flung locations in order to ensure patients' access to emergency care.

21. Emergency medicine physicians represent 4% of physicians in this country but provide 67% of unreimbursed care.

22. On average, an emergency medicine physician provides almost $140,000 of charity care every year, and a third of emergency physicians provide more than 30 hours of charity care each week.

23. Almost 1 in 5 emergency patients has no ability to pay, and 3 out of 4 emergency room visits are reimbursed below cost.

24. In recognition of the challenges unique to the practice of emergency medicine, the Texas Legislature explicitly requires insurers and HMOs to reimburse healthcare providers of emergency services at either the usual and customary rate or an agreed rate. Tex. Ins. Code § 1271.155 (HMO plans); Tex. Ins. Code § 1301.0053 (POS plans); § 1301.155 (PPO plans).

25. The usual and customary rate is the general prevailing cost of a service within a geographic area.

26. These provisions are imperative to ensuring that emergency medicine physicians remain able to offer high quality services to Texas residents. They account for the expenses associated with emergency medicine physicians' education and continued training and incentivize emergency medicine physicians to move to underserved areas, ensuring that emergency medical services are available across the state.

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The Insurance Companies Underpaid the Plaintiffs for Emergency Services

27. The Insurance Companies operate an HMO under Chapter 843 of the Texas Insurance Code and as an insurer under Chapter 1301 of the Texas Insurance Code. The Insurance Companies provide, either directly or through arrangements with providers such as hospitals and Plaintiff Doctors, healthcare benefits to their subscribers.

28. In spite of the essential role emergency medicine physicians such as Plaintiff Doctors play in the United States healthcare system, the Insurance Companies have refused to offer sustainable provider contracts to Plaintiff Doctors.

29. Because there is no contract between the Insurance Companies and any of Plaintiff Doctors for the healthcare claims at issue in this litigation, Plaintiff Doctors are designated as "non-participating" or "out-of-network" for all of the claims at issue in this litigation.

30. Because Plaintiff Doctors did not participate in the Insurance Companies' provider network, there was no agreed rate. The Insurance Companies are therefore obligated to reimburse Plaintiff Doctors at the usual and customary rate for emergency services Plaintiff Doctors provided to their patients.

31. Despite not participating in the Insurance Companies' provider network for the time at issue, Plaintiff Doctors regularly provide emergency services to the Insurance Companies' health plan enrollees.

32. From January 2016 to September 2018, Plaintiff Doctors have provided emergency medical services to thousands of the Insurance Companies' health plan enrollees.

33. The Insurance Companies' members have received a wide variety of emergency services (in some instances, life-saving services) from Plaintiff Doctors, including treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric distress and obstetrical distress.

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34. In recent years, the Insurance Companies dramatically decreased the reimbursements to Plaintiff Doctors for services provided to certain of their members.

35. Despite the Insurance Companies' obligation under the Texas Insurance Code, these new reimbursement levels were significantly less than the usual and customary rate for the services provided.

36. From January 2016 to September 2018, Plaintiff Doctors have identified more than 7,000 emergency service claims that the Insurance Companies paid at unacceptably low rates, in violation of the above-referenced sections of the Texas Insurance Code.

37. On average, the Insurance Companies allowed approximately 150% of the Medicare allowable amount for these claims.