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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Clerk of Supreme Court

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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93	Recorder's Transcript of Proceedings Re: Motions	04/09/21	16 17	3987–4000 4001–4058
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19	Reply in Support of Amended Motion to Remand	02/05/20	2 3	486–500 501–518
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57	Reply in Support of Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures	10/07/20	10	2337–2362
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87	Reply in Support of Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/16/21	16	3895–3909
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441	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 (Filed Under Seal)	12/24/21	115 116	28,485–28,643 28,644–28,742
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443	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18 (Filed Under Seal)	12/24/21	117	28,939–29,084
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451	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18 (Filed Under Seal)	12/24/21	122 123	30,298–30,393 30,394–30,516
452	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18 (Filed Under Seal)	12/24/21	123 124	30,517–30,643 30,644–30,677
453	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18 (Filed Under Seal)	12/24/21	124	30,678–30,835
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455	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18 (Filed Under Seal)	12/24/21	125	30,953–31,122
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460	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/20/22	127 128	31,597–31,643 31,644–31,650
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233	Trial Brief Regarding Jury Instructions on Unjust Enrichment	11/16/21	41	10,232–10,248
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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.

Electronic notification will be sent to the following:

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Attorneys for Amicus Curiae (case no. 85656)

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

The Honorable Nancy L. Allf
DISTRICT COURT JUDGE – DEPT. 27
200 Lewis Avenue
Las Vegas, Nevada 89155

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/s/ Jessie M. Helm
An Employee of Lewis Roca Rothgerber Christie LLP

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 ☒ 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 ☐ ☒

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ANDERSON MD,ERIC JOH
SIGNATURE ON FILE
SIGNED 10/09/18 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

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 (02-12)

WCMS-1500CS-12

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

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

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 13 18	07 13 18	23	X	99285		AB	1360 00	1		NPI	1619979028
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 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. ZZ207P000000X

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

FIRST FOLD WHCF-10-ENG CMS-1500 (10/05) DIV-SS

ZSZ000

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

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 11 DD 10 YY 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 MM 11 DD 10 YY 16 TO MM 11 DD 10 YY 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 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.)
BEHL DO,ANDREW
SIGNATURE ON FILE
SIGNED 11/13/18 DATE

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

33. BILLING PROVIDER INFO & PH. # (800) 562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1366429821 b. ZZ207P00000X

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

FIRST FOLD WHCF-10-ENV-SS

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 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 ☒ 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 ☒

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.)
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. 22207P00000X

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

FIRST FOLD WHCF-10-ENV MAC-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]

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

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	03 29 18	03 29 18	23	X	99291		AB	1765 00	1		NPI	1023138245
2	03 29 18	03 29 18	23	X	93010		B	67 00	1		NPI	1023138245
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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

[redacted]

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

28. TOTAL CHARGE $ 1832 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
FERGUSON MD,SCOTT RI
SIGNATURE ON FILE
SIGNED 01/16/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
3001 ST ROSE PKWY
HENDERSON,NV 89052-3839
a. 1770626426 b.

33. BILLING PROVIDER INFO & PH. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1689013161 b. ZZ207P00000X

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

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

WCMS-1500CS-12

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

[redacted]

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 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 10 DD 03 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 03 YY 18 TO MM 10 DD 03 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. 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 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.)
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

790-0118 (02-12) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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 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 MM DD YY 08 18 18 TO MM DD YY 08 18 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. 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 ☐ ☒

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.)
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 BY NCC 02/12 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 00	1		NPI	1588653125
2	08 26 18	08 26 18	23	X	99053		AB	44 00	1		NPI	1588653125
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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. 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. 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. SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 11 DD 24 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 11 DD 24 YY 18 TO MM 11 DD 24 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. 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 001			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
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

790-0118 (02-12) (OCR) 1PT.

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

[redacted]

KAISER
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

[redacted]

000260

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 MMC 60 COMM NPI FORM

[redacted]

SIERRA HEALTH
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 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 ☒ 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 ☐ ☒

26. PATIENT'S ACCOUNT NO.
[redacted]

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

28. TOTAL CHARGE $ 2882 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
LIFFERTH DO,ROBERT
SIGNATURE ON FILE
SIGNED 02/21/19

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

BAS 5251 4F OUTSOURCED BILLING

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

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

197000

[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 10 DD 13 YY 18 QUAL. 431

15. OTHER DATE QUAL. 439 MM 10 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 10 DD 13 YY 18 TO MM 10 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. 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 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.)
MARTINEZ MD, DENNIS A
SIGNED SIGNATURE ON FILE 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

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

WCMS-1500CS-12

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

PHYSICIAN OR SUPPLIER INFORMATION

[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

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

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 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.)
PHYLLIPS DO,HEBER SA
SIGNATURE ON FILE
SIGNED DATE 03/29/19

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
44-OUTSOURCED BILLING

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

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

C97000

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 04/02/19

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 09 11 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 09 11 18 TO 09 11 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ 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 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 [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.)
INGLISH DO, DANIEL JO
SIGNATURE ON FILE
SIGNED DATE 04/02/19
SRB 5231

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

WCMS-1500CS-12

[redacted]

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

HEALTH INSURANCE CLAIM FORM

[redacted]

CARRIER

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 04/02/19

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 12 06 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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 06 18 TO MM DD YY 12 06 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. E11.65 B. K31.84 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 06 18	12 06 18	23	X	99285		AB	1360 00	1		NPI	1619979028
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ANDERSON MD,ERIC JOH
SIGNATURE ON FILE
04/02/19
SIGNED 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 DILLIN

PHYSICIAN OR SUPPLIER INFORMATION

FIRST FOLD WHCF-10-DAY-NUCC-ENV-SS

000265

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

[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.)
SADEGHI MD, NICK
SIGNATURE ON FILE
04/04/19
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS, NV 89148-4844
a. 1457306359 b.

33. BILLING PROVIDER INFO & PH # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1679550149 b. ZZ207P00000X

SNV 52302 BMS 44 OUTSOURCED BILLIN

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-NV

[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 06 DD 02 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 06 DD 02 YY 18 TO MM 06 DD 02 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. 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 88-0262438 SSN ☐ EIN ☒

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.)
TANG DO, MICHAEL
SIGNATURE ON FILE 04/04/19
SIGNED DATE

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

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

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)

[redacted]

SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
Attn: Kaiser Claims
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. 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 ☒ 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 ☒

[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.)
DUNAGAN MD, CLARENCE
SIGNATURE ON FILE 04/04/19
SIGNED 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. ZZ207P000000X

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

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 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 [X] 88-0262438

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
CLARK MD, RUSSELL PAT
SIGNATURE ON FILE
SIGNED 04/16/19 DATE

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

33. BILLING PROVIDER INFO & PH# 800-582-2945
FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1366429821 b. ZZ207P00000X

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

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EXHIBIT 8

Article in the Nevada Independent

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EXHIBIT 8

Case 2:19-cv-00832-JCM-VCF Document 21-8 Filed 06/21/19 Page 2 of 6
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SISOLAK SIGNS SURPRISE EMERGENCY ROOM BILLING COMPROMISE, PRE-EXISTING CONDITION PROTECTIONS INTO LAW

MEGAN MESSERLY

MAY 15TH, 2019 - 4:15PM

Two sweeping health-care bills that would prevent patients from getting hit with surprise emergency room bills and protect Nevadans with pre-existing conditions were signed into law by Gov. Steve Sisolak on Wednesday.

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The move brings Sisolak one step closer to fulfilling the health-care agenda he touted on the campaign trail, including standing up to President Donald Trump on protections for people with pre-existing conditions and ending surprise emergency room bills. But it also represents the culmination of years of work — and for surprise billing, decades — on issues Democratic lawmakers had championed at the Legislature but were unable to bring to fruition under a Republican governor.

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"We're taking an important step to make health care more affordable and to address an issue that has plagued Nevada families for far too long," Sisolak said about the surprise billing legislation. "That stops today."

The surprise billing compromise, AB469, is the byproduct of an interim working group tasked by Assembly Speaker Jason Frierson with figuring out how to ensure that patients aren't caught in the middle of a debate between their insurance company and their provider after receiving out-of-network emergency care. The final bill they settled on holds patients harmless by

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requiring them to only pay whatever copay, coinsurance or deductible they would have been responsible for at an in-network facility for emergency care.

"This bill represents payers and providers and patient advocates coming together to try to come up with something that works for Nevada," Frierson said. "This was not an easy task, and I think that we all put our noses down and went to work, but I'm proud of what we were able to do."

The legislation, which takes effect on Jan. 1, 2020, also lays out the process by which out-of-network providers, including doctors and hospitals, will be reimbursed by insurers for care provided — a mechanism that has long been the sticking point in the surprise billing debate.

Under the legislation, if a hospital and insurer were recently in network, the insurer would be required to pay 108 or 115 percent of the previously contracted rates, depending on how long they were out of network. If they never had a contract or were out of network for more than two years, the two would be allowed to make initial offers to each other before being required to go to arbitration.

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It's a metric that neither payers nor providers were completely happy with, but that's what, in the end, they agreed made it a good piece of legislation.

"I got to tell you I wasn't sure we'd get it done at the end of the session, and I was proud of the way that we were able to come together," Frierson said.

This isn't the first time lawmakers have successfully passed surprise billing legislation, but it is the first time that a governor has signed it into law. Former Gov Brian Sandoval vetoed a measure in 2017 that would have required payers and payees to agree on a "reasonable" rate for out-of-network services provided or else take the matter ot binding arbitration,

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saying it would have forced hospitals to accept below-market rates for out-of-network care.

Assemblywoman Maggie Carlton, who has long worked on the surprise billing issue and sponsored the 2017 measure, thanked patient advocates and industry representatives for all their hours of work on the issue over the years.

"Last session we did get there, but didn't quite make it across the finish line, but this time we did, so I just want to thank everyone for really taking patients out of the middle," said Carlton, choking up during her remarks. "It truly is important."

Sisolak also signed into law on Wednesday AB170, which codifies the Affordable Care Act's protections for pre-existing conditions into state law. The legislation comes as an ongoing lawsuit challenging the Affordable Care Act's constitutionality — including its popular protections for pre-existing conditions — plays out on the federal level.

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Sandoval vetoed a similar proposal in 2017 that would have codified the Affordable Care Act's protections for pre-existing conditions into law on the ground that it would have locked into law "requirements that may be unnecessary, imprudent, or simply unaffordable in the years to come."

But Sisolak touted that the legislation would "take an extra step" in strengthening pre-existing condition protections in federal law.

"From today forward, the 1.2 million Nevadans with pre-existing conditions can rest easy knowing that their health coverage won't be ripped away regardless of the shifting political winds in Washington D.C.," Sisolak said.

The bill, sponsored by Democratic Assemblywoman Ellen Spiegel, also requires health insurance companies to provide the phone number to the

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state Office for Consumer Health Assistance of a case manager, navigator or facilitator who can help connect patients with a covered provider.

"Today is a great day for patients in Nevada," Spiegel said. "This bill is important because if you can't get insurance due to a pre-existing condition or you can't get an appointment with a provider in a timely manner, then you do not have adequate access to health care."

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- *Brian Sandoval - $150*
- *Merritt and Maggie Carlton - $375*
- *Steve Sisolak - $2,200*

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

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-JAD-VCF **REPLY IN SUPPORT OF MOTION TO REMAND**

Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") hereby files this reply (the "Reply") in support of its Motion to Remand (ECF No. 5).

MEMORANDUM OF POINTS AND AUTHORITIES

I. ARGUMENT

A. United HealthCare's Attempts to Distinguish *Gulf-To-Bay* and *Low-T Physicians Serv., P.L.L.C* Must Be Rejected.

United HealthCare[1] tries to distinguish *Gulf-To-Bay*, in which it and its affiliate are parties, by arguing that "[i]n *Gulf-to-Bay*, the second element of the *Davila* Test was not met because a

[1] Terms not defined herein shall have the meanings ascribed to them in the Motion to Remand.

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Florida statute created a legal duty independent of ERISA to pay out-of-network providers at a particular rate." This is an inaccurate reading of *Gulf-to-Bay*. ***The Court did not even consider the second part of the Davila test***. In fact, the Court noted:

> "The **first part of the Davila test** 'is satisfied if two requirements are met: (1) **the plaintiff's claim must fall within the scope of ERISA;** and (2) the plaintiff must have standing to sue under ERISA." As to the first requirement of this part…the Eleventh Circuit has adopted a distinction between two types of claims: claims challenging the "rate of payment" pursuant to a provider-insurer agreement, and those challenging the "right to payment" under the terms of an ERISA beneficiary's plan…
>
> the gist of GTB's complaint is that it was not fully compensated for those services pursuant to Florida law. The Court finds unavailing UHIC's attempt to recast through an ERISA lens GTB's entitlement to full payment for services rendered. **Consequently, the Court finds that GTB's claims fall outside the scope of section 502(a) of ERISA, and no further analysis under *Davila* is necessary.** *See HealthKeepers, Inc.*, 2018 WL 3323817, at *4 (remanding case after finding only that the defendant failed to meet the first requirement of the first prong of *Davila*)

Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc., No. 8:18-CV-233-EAK-AAS, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018) (emphasis added) (internal citations omitted). Thus, the court did just the opposite of what United HealthCare claims in its Opposition. The court only considered the first part of the *Davila* test and found that because rate of payment was the issue being addressed, the claims did not fall within the scope of ERISA and, therefore, the ***first*** part of the *Davila* test could not be satisfied. There was no discussion about the second factor at all. Just as was the case in *Gulf-to-Bay*, as a rate of payment case[2], Fremont's claims are outside the scope of ERISA and the first part of the *Davila* test cannot be satisfied.

United HealthCare also fails to accurately describe the court's decision in *Low-T Physicians Serv., P.L.L.C.* Contrary to United HealthCare's representation to this Court, that court did not find that "the second element of the *Davila* Test was also not met because the medical provider had an express written provider agreement with United Healthcare which gave rise to a duty independent of the ERISA plan." Opposition at 3:15-17. The court did not even address the

[2] Fremont has not asserted any claims relating to benefits that have been denied. Fremont's only claims are related to claims that United HealthCare has already paid. Compl. at ¶ 27. Thus, this dispute does not involve any right to payment that could arise under an ERISA plan. It solely involves the rate of payment. *Id.; see also*, Declaration of Kent Bristow (the "Bristow Decl."), attached hereto as "**Exhibit A**" at ¶ 4.

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Davila Test because it was, again, a rate of payment case. Specifically, the court noted, "the question here is not as to the *right* to ERISA benefits under a particular plan but on the *amount of payment* due under certain provider agreements. Such claims are not preempted by ERISA." *Low-T Physicians Serv., P.L.L.C. v. United Healthcare of Texas, Inc.*, No. 4:18-CV-938-A, 2019 WL 935800, at *2 (N.D. Tex. Feb. 26, 2019) (emphasis added). Both cases highlight that when the rate of payment is in dispute, such claims cannot be preempted under ERISA. As a party to these cases, United HealthCare is well aware of the deficiencies in its arguments to the contrary, yet, it continues to forward this argument in what can only be seen as a frivolous attempt to delay the proceedings and force Fremont to incur the costs of wasteful motion practice.

B. Under *Davila*, Fremont's Claims Are Not Preempted.[3]

Contrary to United HealthCare's claims, Fremont does not substitute the *Davila* test for the rate of payment vs. right to payment test. Instead, Fremont notes that many "rate of payment" decisions do not perform an extensive analysis of *Davila* because claims involving rate of payment fail to satisfy the *Davila* test. *See e.g. Premier Inpatient Partners LLC v. Aetna Health & Life Ins.* Co., 371 F. Supp. 3d 1056, 1073 (M.D. Fla. 2019) ("The Eleventh Circuit has instructed that [] 'the 'rate of payment' and 'right of payment' distinction' is dispositive of whether a claimant could have brought its claim under ERISA."); *see also* Motion to Remand at n. 5.

As is detailed below, the existence of an assignment of benefits is of no consequence here and does not satisfy the first factor of *Davila*. That, alone, mandates that this matter be remanded. Second, United HealthCare cannot fulfill burden of establishing the second *Davila* factor because Fremont's claims are based upon independent statutory and common law duties which courts have repeatedly recognized do not satisfy the second *Davila* factor. Importantly, even if this Court were to find that one of the factors is satisfied, remand would be appropriate because United

[3] As a matter of law, and contrary to the contentions set forth in United HealthCare's Opposition, even without an analysis of *Davila*, Fremont's claim for Violation of Nevada's Consumer Fraud & Deceptive Trade Practices Acts is not subject to preemption. *Hansen v. Grp. Health Coop.*, 902 F.3d 1051, 1060 (9th Cir. 2018) (finding against ERISA preemption where claim for violation of consumer protection act (concerning unfair and deceptive trade practices) "could exist whether or not insurer administered any health benefit plans at all, let alone any ERISA plans.")

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HealthCare must establish the existence of both factors in order to meet its burden for subject matter jurisdiction. Because the weight of authority mandates remand under the facts of this case, Fremont respectfully requests that this case be remanded to state court.

1. The First *Davila* Factor[4]

Notwithstanding binding precedent directly on point,[5] United HealthCare makes the false claim that an assignment of benefits converts a state law claim – not otherwise arising under an ERISA plan – into one that confers standing for purposes of the first *Davila* factor. Opposition at n. 4. This argument must be rejected in light of the *Marin* decision.

The Ninth Circuit has unequivocally held that even when providers receive an assignment of benefits and *could* bring a suit under ERISA, the mere fact of an assignment does not convert a provider's claim into claims to recover benefits under an ERISA plan. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 949 (9th Cir. 2009). Thus, so long as a provider's state law claim does not fall within § 502(a) (i.e. denial of payment/coverage, **the existence of the assignment is irrelevant to complete preemption if the provider asserts no claim under the assignment.** *Id.; see also Emergency Services of Zephyrhills, P.A.*, 281 F. Supp. 3d at 1347.

In *Marin Gen. Hosp. v. Modesto*, the Ninth Circuit considered whether the first element of the *Davila* was satisfied where the provider could have asserted a claim under an assignment of benefits. The Ninth Circuit answered in the negative. The Ninth Circuit concluded:

> 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**

[4] United HealthCare's Opposition includes two separate sections making the same arguments – that the existence of an assignment of benefits converts state law claims based on independent duties into ERISA claims satisfying the first *Davila* factor. *Compare* Opposition at IV(C) *with* (IV)(D)(1). This section will attempt to address all such arguments.

[5] United HealthCare's repeated refusal to recognize this binding precedent is concerning in light of its counsel's ethical obligations. NRPC 3.3(a)(2) ("A lawyer shall not knowingly:… (2) Fail to disclose to the tribunal legal authority in the controlling jurisdiction known to the lawyer to be directly adverse to the position of the client and not disclosed by opposing counsel").

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> **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."**
>
> We conclude that the Hospital's state-law claims based on its alleged oral contract with MBAMD 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*.**

581 F.3d at 949 (internal citations omitted). This case forecloses all of United HealthCare's arguments with respect to the first *Davila* factor. Because Fremont does not bring any claims as an assignee of benefits, it cannot assert ERISA claims in this action and the first *Davila* factor is not satisfied, requiring remand. *Id.*; *see also Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1347 (11th Cir. 2009) ("so long as the provider's state law claim does not fall within § 502(a), the existence of the assignment is irrelevant to complete preemption if the provider asserts no claim under the assignment.")

The cases cited by United HealthCare in its Opposition to Motion for Remand are also inapplicable to the facts of this case. United HealthCare erroneously argues that *Misic* is a "rate of payment" case in which the Court found that complete preemption applies. Opposition at 11:24-25. This is inaccurate. Rate of payment cases involve disputes between the provider and insurer based on an independent, implied or express agreement or course of conduct which does not relate to a benefit plan. The *Misic* case does not fall into this category. And the Ninth Circuit itself has made clear that *Misic* is not a rate of payment case:

> **It is clear in *Misic* that the provider sought, as an assignee, to recover reimbursement due to his assignors under the terms of the benefit plan**; indeed, the terms of the benefit plan were the provider's only basis for his reimbursement claim… **The dispute here is 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.

Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc., 187 F.3d 1045, 1051 (9th Cir. 1999). Indeed, in *Misic,* the insurer was being sued for failure to *cover* a claim based on the amount that was **<u>expressly required to be paid under the health plan when the beneficiary's rights were *assigned* to the medical provider.</u>** *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374, 1376 (9th Cir. 1986). Specifically, in *Misic,* under the plan, the trust/insurer was required to "reimburse **<u>beneficiaries</u>** for 80% of the cost of their dental care. Dr. Misic

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provided dental services to beneficiaries of the trust, who in return assigned Dr. Misic their rights of reimbursement from the trust." *Id*. Dr. Misic filed suit and expressly asserted a claim under ERISA based on the beneficiaries' assignments along with related state law claims. *Id*. The Court found that the related state law claims were preempted by ERISA because Misic brought his claims as an assignee. *Id*. Here, Fremont has not asserted any claims as an assignee. Fremont does not seek payment based on any provision of any health plan. *Misic* is not a rate of payment case and is inapposite.

Fremont also tries to prove a negative by arguing that "in some of the cases Fremont cites, complete preemption is not found because defendant fails to satisfy the first element of the *Davila* test due to a failure to bring forth sufficient evidence to demonstrate that an assignment of benefits occurred." Opposition at 13:15-17. The caselaw cited by Fremont in its Motion to Remand does not support United HealthCare's argument that where there is an assignment of benefits, an assignment always confers standing to bring a claim under ERISA. In fact, the court in *Med. & Chirurgical Faculty of State of Maryland* did not find that there were never any assignments as United HealthCare suggests; instead, the Court found that, just as is the case here, the providers were not bringing their claims based on an assignment of benefits and therefore such claims could not be preempted. *Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc*., 221 F. Supp. 2d 618, 621 (D. Md. 2002) ("Plaintiffs are asserting in this action an independent statutory right of health care providers to receive payment consistent with the statutory formulas, not the right to any benefits due to plan participants. It is undisputed that these statutory rights are not available to plan participants, and thus, could not be assigned by those participants."). Thus, the Court concluded that the rights asserted in the complaint by the plaintiff were not rights assigned by plan participants. *Id*.

In *California Spine*, the issue of an assignment of benefits was important because the claims raised were the type of claims that could be raised by a plan beneficiary if an assignment of benefits existed. In particular, the claims related to the following allegations:

> Defendant allegedly informed Plaintiff that the Patient had a deductible and a maximum out of pocket limit for healthcare of $6,000, of which $ 0 had been paid. Plaintiff was allegedly promised that Defendant would pay 80% of the UCR rate once the Patient met his or her deductible. Moreover, after the Patient met the

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> maximum out of pocket limit, Plaintiff was allegedly promised that Defendant would pay 100% of the UCR rate.

California Spine & Neurosurgery Inst. v. Bos. Sci. Corp., No. 18-CV-07610-LHK, 2019 WL 1974901, at *1 (N.D. Cal. May 3, 2019) (internal citations omitted). Thus, the amount of payment to the provider was directly related to the plan and if an assignment of benefits existed, the provider would have a claim which squarely falls within ERISA.

In all, as the Ninth Circuit has made clear, the existence of an assignment of benefits does not convert independent statutory based and common law claims into ones arising under ERISA. The first *Davila* factor is not satisfied only because an assignment of benefits exists when the claims asserted are based on claims arising from an insurer's independent statutory and common law duties. Because United HealthCare cannot establish the first *Davila* factor, this is dispositive to its complete preemption argument and, consequently, this entire action should be remanded.

2. The Second *Davila* Factor

In an attempt to argue that the second *Davila* factor is satisfied, United HealthCare asserts the obscure argument that the only way for the second *Davila* factor not to be met would be if one of three[6] categories of circumstances applied. Not only is this argument confusing and misleading, it ignores the decisions cited by Fremont which make clear that they are *not* limited to the categories identified by United HealthCare. Essentially, United HealthCare is attempting to create its own caselaw on this issue. There exists no caselaw which finds that a party in a rate of payment case can avoid preemption *only if* one of the three categories listed by United HealthCare is satisfied. Rather, courts across various jurisdictions have repeatedly found that cases involving disputes over the rate of payment rather than the right to payment are not preempted by ERISA and neither of the *Davila* factors can be satisfied. *See e.g. Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (claims not preempted where the dispute is over amount of payment rather than the right to payment); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 531 (5th Cir. 2009) ("A claim that implicates the rate

[6] United HealthCare actually lists four categories, but the first category concerned the assignment of benefits which relates to the first *Davila* factor.

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of payment…does not run afoul of *Davila* and is not preempted by ERISA…we adopt the reasoning of the Third and Ninth Circuits, and that of a majority of district courts in this Circuit which have relied on this distinction between 'rate of payment' and 'right of payment.'"); *Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618, 619 (D. Md. 2002) ("Courts have, with near unanimity, found that independent state law claims of third party health care providers are not preempted by ERISA.")

United HealthCare first attempts to argue that the existence of an express provider agreement somehow distinguishes certain cases from the case at hand here. It does not. In order for United HealthCare to meet its burden on the second *Davila* factor, it must establish that the claims asserted do not arise from legal duties independent of ERISA. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). In other words, it must prove that the claims asserted are dependent on ERISA. The caselaw cited by Fremont which involves express provider agreements are examples of independent legal duties of an insurer to pay a certain rate to a provider. These independent legal duties may arise from a variety of circumstances as highlighted in the caselaw cited by Fremont, including express agreements, oral agreements, statutory duties and implied in law and implied in fact agreements. Simply because a case involves one of the foregoing does not mean the Court limited the second *Davila* factor to that one instance.

In fact, many of the decisions cited by Fremont do expressly state that claims for breach of implied agreements do not satisfy the second *Davila* factor because these also would be independent legal duties not relying on an ERISA plan. For example, United HealthCare attempts to distinguish *Connecticut State Dental* by arguing that it only concerned an express agreement. Opposition at n. 16. In *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla*, the insurer attempted to do the exact same thing as United HealthCare here by arguing "the use of the language "an agreement" [in *Connecticut State Dental*] necessarily means that the test applies only in cases arising from breach of an express provider agreement between an in-network provider and the insurer." 258 F. Supp. 3d 1323, 1329 (S.D. Fla. 2017). The court rejected this argument and explained:

No part of *Connecticut State Dental* supports the proposition that an express

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> written provider agreement ***must*** be present before the rate-of-payment/right-of-payment test can apply and that, in the absence of a written agreement, any claim for payment must be preempted. In the Court's view, *Connecticut State Dental* leaves the proverbial door sufficiently open that the test could come into play in a case like this one, involving allegations of an implied "agreement"—be it implied-in-fact or implied-in-law—between an out-of-network provider and an insurer.

Id. (emphasis in original). Courts in various jurisdictions have found that implied in fact and implied in law contracts involve independent legal duties such that the second *Davila* factor cannot be satisfied. *John Muir Health v. Cement Masons Health & Welfare Tr. Fund for N. California*, 69 F. Supp. 3d 1010, 1018 (N.D. Cal. 2014) (quantum meruit claim "based on an independent legal duty", failing to satisfy *Davila's* second prong); *Galileo Surgery Ctr., L.P. v. Aetna Health & Life Ins. Co.*, No. 2:14-CV-09738-ODW, 2015 WL 898525, at *1 (C.D. Cal. Mar. 3, 2015) (promissory estoppel and unjust enrichment not preempted by ERISA); *Coast Plaza Doctors Hosp. v. Arkansas Blue Cross & Blue Shield*, No. CV 10-06927 DDP JEMX, 2011 WL 3756052, at *4 (C.D. Cal. Aug. 25, 2011) (breach of implied in fact contract not preempted); *Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618, 619 (D. Md. 2002) (conversion and quantum meruit not preempted); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, 281 F. Supp. 3d 1339, 1342 (S.D. Fla. 2017) (breach of implied-in-fact contract and unjust enrichment not preempted); *Orthopaedic Care Specialists, P.L. v. Blue Cross & Blue Shield of Fla., Inc.*, No. 12-81148-CIV, 2013 WL 12095594, at *2 (S.D. Fla. Mar. 5, 2013) (unjust enrichment/quantum meruit not preempted).

Furthermore, while some of these decisions are in states in which statutes require payments at certain rates, this distinction does not change the fact that Fremont has asserted claims completely independent of an ERISA plan. If United HealthCare believes that Fremont lacks a statutory or common law basis for bringing its claims,[7] it is free to challenge these claims in state court. However, there is no question that Fremont's claims are based on legal grounds independent of an ERISA plan and, for that reason alone, United HealthCare cannot meet its

[7] Surely United Healthcare cannot reasonably take the position that Fremont, after providing services to its insureds as required by statute, cannot be paid for its services. If United Healthcare does, which would necessarily include the position that it could pay whatever rate it unilaterally chose to pay including nothing at all, then it would take the position that Congress enacted a statute that requires involuntary servitude by Fremont in violation of the U.S. Constitution.

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burden of establishing that the second *Davila* factor is satisfied. Therefore, the Motion to Remand must be granted.

Finally, United HealthCare contends that *Marin* is different than the case at hand because there are no oral representations alleged here while *Marin* concerned an oral representation. While *Marin* did involve an oral representation that a certain rate of payment would be made, the providers in that case also asserted claims, just as is the case here, for breach of implied contract, quantum meruit and estoppel. 581 F.3d at 943. In asserting its breach of implied contract claim, the provider plaintiff alleged:

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

A true and correct copy of the Amended Complaint filed in *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, Case No. 07-cv-01027-SI, is attached hereto as "**Exhibit B**" (emphasis added). This allegation is nearly identical to the allegations here. Indeed, Fremont alleges that:

> 38. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by Fremont to the UH Parties' Patients, the parties implicitly agreed, and Fremont had a reasonable expectation and understanding, that the UH Parties would reimburse Fremont for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates the UH Parties pay for other substantially identical claims also submitted by Fremont.

Compl. at ¶ 38. The relevant facts of this case are nearly identical to the facts alleged in *Marin* and, just as was the case in *Marin,* this Court cannot find that the legal claims asserted by Fremont are dependent on ERISA. These claims are completely independent of ERISA and, therefore, the second *Davila* factor cannot be established, necessitating remand.

Finally, United HealthCare[8] relies heavily on two cases from Florida, both of which predate *Davila,* to rebut the binding *Marin* decision; however, even if *Marin* was not binding

[8] Magistrate Judge Hoffman issued an Order (ECF No. 25) denying Fremont's Motion to Stay Proceedings Pending Resolution of Motion to Remand (ECF No. 14) on June 28, 2019. In that order, the Court states, "When a defendant's duty 'to reimburse for emergency services… was necessarily dependent on the fact that plaintiff was a participant in an ERISA-governed plan,' courts have held that the claims are preempted under ERISA". Here, the claims are not dependent

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precedent, neither of these cases are applicable and United HealthCare's reliance on these decisions should be rejected. In *In Re Managed Care Litig.*, the court evaluated unpaid claims by non-participating providers' who affirmatively alleged that they sought reimbursement as assignees. *In re Managed Care Litig.,* 298 F. Supp. 2d 1259, 1291 (S.D. Fla. 2003). Thus, the outcome there has no application to the facts before this Court. In *Torrent & Ramos*, an unpublished decision, the court's analysis relied entirely on a test which, since *Davila*, is no longer applicable when addressing complete preemption. *Torrent & Ramos, M.D., P.A. v. Neighborhood Health Partnerships, Inc.*, No. 04-20858-CIV, 2004 WL 7320735, at *2 (S.D. Fla. July 1, 2004) (discussing "superpreemption" under *Butero v. Royal Maccabees*); *see also Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 121 F. Supp. 3d 950, 964 (C.D. Cal. 2015) ("this Court follows and applies the Supreme Court's *Davila* test for complete preemption and, to the extent that the *Butero* analysis is inconsistent with *Davila*, it is not controlling."). Thus, none of the authority cited by United HealthCare supports its tenuous position.

C. Jurisdictional Discovery Is Unnecessary.

United HealthCare submits the precarious argument that it should be given an opportunity to conduct discovery on which claims involve right to payment and which involve rate of payment. Fremont has repeatedly affirmed that it is not asserting causes of action for denied claims; yet,

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on an ERISA plan because United HealthCare already determined that all such claims are covered and payable. The only dispute here is the rate of payment. In *In re WellPoint, Inc.*, cited by the Court, the dispute was over the *right to payment.* Specifically, the provider plaintiffs asserted claims under ERISA based upon an assignment of benefits received from insured patients and alleged that it was entitled to reimbursement pursuant to state statute when the insurer *denied* benefits under ERISA plans. *In re WellPoint, Inc. Out-of-Network UCR Rates Litig.*, 903 F. Supp. 2d 880, 928 (C.D. Cal. 2012). Here, the dispute involves the *rate* of payment. There is no dispute that United HealthCare determined that each claim in dispute was paid and covered by United HealthCare and, therefore, there is no dispute concerning the right to payment, as in *Wellpoint*. The *Sharp Memorial Hospital* case, cited by the Court, is also a right to payment case concerning the denial of coverage under a plan and is, therefore distinguishable for the same reasons. *Sharp Mem'l Hosp. v. Regence BlueCross BlueShield of Utah*, No. 16CV2493 JM (RNB), 2018 WL 3993359, at *8 (S.D. Cal. Aug. 21, 2018) (emphasis added) (noting that "'So long as [the plaintiff's] underlying theory of the case **revolves around the denial of benefits**, [the plaintiff's] claim falls under ERISA's far-reaching preemption clause.'") In this case, Fremont does not raise any claims concerning claims which were denied by United HealthCare. Compl. at ¶ 27 ("For each of the healthcare claims at issue in this litigation, United HealthCare determined the claim was payable."); Bristow Decl. at ¶ 4 ("Fremont does not dispute or contest any claims that were denied in whole by any of the Defendants to the Litigation."). In *Sharp*, the court also applied the wrong standard for "complete preemption" and failed to even address *Davila.*

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United HealthCare thinks it should be entitled to conduct discovery to see if this is true. Such a request is ridiculous. Fremont's Complaint is clearly limited to claims which have been paid, but at an artificially reduced rate. Compl. at ¶ 27. Simply because United HealthCare would like Fremont's Complaint to assert claims relating to coverage does not change the facts actually alleged. United HealthCare has no basis to conduct discovery here.

D. Pages 25 of United HealthCare's Opposition Should Be Stricken and An Order Awarding Sanctions Against United HealthCare Is Warranted.

United HealthCare has now submitted two separate filings (ECF Nos. 4 & 21) to this Court which exceed the page limit imposed by this jurisdiction. LR 7-3. Allowing United HealthCare to continue to do this causes Fremont undue prejudice in that it must comply with this Court's page limitations while responding to United HealthCare's lengthy arguments. Thus, an order striking page 25 of the Opposition to Motion to Remand is appropriate. LR 7-3(c) ("In the absence of a court order by the deadline for the underlying motion or brief, the motion to exceed page limits is deemed denied."). Upon striking the final page of the Opposition, United HealthCare has failed to oppose Fremont's request for sanctions. Given the egregious conduct identified herein, Fremont respectfully requests that its attorneys' fees and costs be awarded. 28 U.S.C. § 1447(c).

II. CONCLUSION

Based on the foregoing, Fremont respectfully requests that its Motion to Remand be granted.

DATED the 28th day of June, 2019.

McDONALD CARANO LLP

By: */s/ Amanda M. Perach*
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and on this 28th day of June 2019, I caused a true and correct copy of the foregoing **REPLY IN SUPPORT OF 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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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/ Kimberly Kirn
An employee of McDonald Carano LLP

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INDEX OF EXHIBITS

Description	Exhibit No.
Declaration of Kent Bristow	A
First Amended Complaint for Damages filed in *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, Case No. 07-cv-01027-SI	B

4837-6612-1883, v. 4

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EXHIBIT A

Declaration of Kent Bristow

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EXHIBIT A

DECLARATION OF KENT BRISTOW

I, Kent Bristow, declare as follows:

1. I am Senior Vice President, Revenue Management for TeamHealth Holdings, Inc. Fremont is part of the TeamHealth organization.

2. I submit this declaration in support of Fremont's Reply in Support of Motion to Remand in the action entitled *Fremont Emergency Services (Mandavia), Ltd v. United HealthCare Insurance Company, Inc. et al.*, currently pending in the United States District Court, D. Nevada, Case No. 2:19-cv-00832-JAD-VCF (the "Litigation").

3. I have personal knowledge of the facts stated within this Declaration. If called as a witness, I would be competent to testify to these facts.

4. Fremont does not dispute or contest any claims that were denied in whole by any of the Defendants to the Litigation. Further, Fremont does not dispute or contest any individual evaluation and management (E/M) code that was denied as part of a claim for which Defendants otherwise deemed eligible for payment. Therefore, Fremont's Litigation claims concern the rate of payment and not the right to a payment for any E/M code for which Defendants determined eligible services were delivered.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: June 28, 2019

/s/ Kent Bristow
Kent Bristow

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EXHIBIT B

First Amended Complaint for Damages filed in *Marin Gen. Hosp. v. Modesto & Empire Traction Co.* Case No. 07-cv-01027-SI

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EXHIBIT B

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Attorneys for Plaintiff
MARIN GENERAL HOSPITAL, a non-profit California corporation

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

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

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

PARTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FACTUAL BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FIRST CAUSE OF ACTION

(Breach of Implied Contract)

(Against all defendants)

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

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

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

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

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

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

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

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

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

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

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

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

SECOND CAUSE OF ACTION

(Breach of Oral Contract)

(Against all defendants)

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

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

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

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

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

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

THIRD CAUSE OF ACTION

(Negligent Misrepresentation)

(Against all defendants)

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

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

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

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

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

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

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

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

FOURTH CAUSE OF ACTION

(Quantum Meruit)

(Against all defendants)

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

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

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

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

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

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

FIFTH CAUSE OF ACTION

(Estoppel)

(Against all defendants)

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

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

59. When promising, assuring and representing to Hospital that

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

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

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

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

PRAYER FOR RELIEF

WHEREFORE, MARIN GENERAL HOSPIRAL prays for judgment as follows:

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

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

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

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

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

Dated: 18 May 2007

STEPHENSON, ACQUISTO & COLMAN

Viola Rita Brown
Attorneys for
MARIN GENERAL HOSPITAL

PROOF OF SERVICE

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

FIRST AMENDED COMPLAINT FOR DAMAGES

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

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

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

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

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

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

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

CONSUELO MARQUEZ

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SERVICE LIST

Bradley A. Post, Esq.

BORTON PETRINI, LLP

2014 Tulare Street, Suite 631

Fresno, CA 93721

CERTIFIED RECEIPT NUMBER
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CLERK OF THE COURT

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * *

FREMONT EMERGENCY SERVICES (MANDAVIA) LTD, PLAINTIFF(S) VS. UNITED HEALTHCARE INSURANCE COMPANY, DEFENDANT(S)	CASE NO.: A-19-792978-B DEPARTMENT 27

CIVIL ORDER TO STATISTICALLY CLOSE CASE

Upon review of this matter and good cause appearing,

IT IS HEREBY ORDERED that the Clerk of the Court is hereby directed to statistically close this case for the following reason:

DISPOSITIONS:

- ☐ Default Judgment
- ☐ Judgment on Arbitration
- ☐ Stipulated Judgment
- ☐ Summary Judgment
- ☐ Involuntary Dismissal
- ☐ Motion to Dismiss by Defendant(s)
- ☐ Stipulated Dismissal
- ☐ Voluntary Dismissal
- ☒ Transferred (before trial)
- ☐ Non-Jury – Disposed After Trial Starts
- ☐ Non-Jury – Judgment Reached
- ☐ Jury – Disposed After Trial Starts
- ☐ Jury – Verdict Reached
- ☐ Other Manner of Disposition

DATED this 9th day of December, 2019.

NANCY ALLF
DISTRICT COURT JUDGE

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Attorneys for Plaintiffs

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

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*

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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

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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.

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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.

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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.

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38. The total underpayment amount for these claims is in excess of $5.7 million.

39. As stated in ¶ 34, the Insurance Companies are reimbursing Plaintiff Doctors at unacceptably low rates for services provided to some of their members. They continue to reimburse Plaintiff Doctors at more reasonable rates for services provided to other of their members. The result is that the Insurance Companies are reimbursing Plaintiff Doctors at drastically different rates for essentially the same services, provided at the same facility, to different members.

40. Upon information and belief, the Insurance Companies generally are paying the lower reimbursement rates for services provided to their fully insured members and the higher reimbursement rates for services provided to members of their administrative services only or self-insured plans.

41. Put differently, when their own money is at stake, rather than the money of one of their employer clients, the Insurance Companies pay the lower rate.

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42. The Insurance Companies have failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

43. For each of the healthcare claims at issue, the Insurance Companies determined the claim to be payable; however, they paid at an arbitrarily reduced rate. Thus, the claims at issue involve no questions of whether the claim is payable; rather, they involve only the issue of whether the Insurance Companies paid the claim at the required usual and customary rate. (They did not.)

44. Plaintiff Doctors bring this action to collect damages due to the Insurance Companies' failure to comply with Texas law and to compel the Insurance Companies to pay them the usual and customary rate for the emergency services that Plaintiff Doctors provided to their members.

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45. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

CAUSES OF ACTION

COUNT I – Violation of the Texas Insurance Code

46. The foregoing paragraphs are incorporated by reference.

47. Defendant UnitedHealthCare of Texas, Inc. is an HMO under the Texas Insurance Code. Defendant UnitedHealthCare Insurance Company is a life, health, and accident insurer under the Texas Insurance Code, and is an insurer under Chapter 1301 of the Texas Insurance Code. Plaintiff Doctors are out-of-network providers who have provided emergency care to enrollees of the Insurance Companies' plans. Section 1271.155 of the Texas Insurance Code requires an HMO to pay for emergency care provided by out-of-network providers such as Plaintiff Doctors at the usual and customary rate or at an agreed rate. Sections 1301.0053 and 1301.155 impose the same requirement on an insurer that offers preferred provider benefit plans.[2] There is no agreed rate between the parties for emergency care that has been rendered by Plaintiff Doctors to the Insurance Companies' members; therefore the Insurance Companies are obligated to pay Plaintiff Doctors at the usual and customary rate.

48. The Insurance Companies have failed to fulfill those obligations under the Texas Insurance Code by failing to pay for emergency care at the usual and customary rate on the claims

[2] Texas Department of Insurance regulations impose the same requirement, and further specify the appropriate manner in which the usual and customary rate should be calculated. *See* 28 Tex. Admin. Code §§ 11.1611(e), (f)(1) (HMO plan regulations); § 3.3708(a)(1) (PPO plans). Additionally, the Texas Department of Insurance has specifically regulated that an HMO is obligated to reimburse a non-participating hospital-based physician at the usual and customary rate if he or she treats patients at a participating hospital. 28 Tex. Admin. Code § 11.1611(a). The Insurance Companies also have violated those regulations.

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submitted by Plaintiff Doctors for emergency care.[3] Plaintiff Doctors are entitled to recover the difference between the amount the Insurance Companies have paid for emergency services that Plaintiff Doctors rendered to the Insurance Companies' enrollees and the usual and customary rate.

COUNT II – Violation of Section 541.060 of the Texas Insurance Code

49. The foregoing paragraphs are incorporated by reference.

50. Section 541.060 of the Texas Insurance Code prohibits an insurer from engaging in an unfair settlement practice "with respect to a claim by an insured." Here, Plaintiff Doctors satisfy this requirement by virtue of having received an assignment of the insured's benefits from each patient and filing claims for such benefits with the Insurance Companies as the insured's assignee. Further, as a "person" that sustained actual damages—the difference between the usual and customary rate and the amount that the Insurance Companies paid—Plaintiff Doctors are specifically authorized by Section 541.151 of the Texas Insurance Code to bring an action against the Insurance Companies for their violations of Section 541.060.

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51. One prohibited unfair claim settlement practice is "failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of: (A) a claim with respect to which the insurer's liability has become reasonably clear." Tex. Ins. Code § 541.060(a)(2)(A). As detailed in the preceding paragraphs, the Insurance Companies have failed to comply with Sections 1271.155, 1301.0053, and 1301.155 of the Texas Insurance Code by failing to pay Plaintiff Doctors the usual and customary rate for emergency care provided to the Insurance Companies' members. By failing to pay Plaintiff Doctors the usual and customary rate, as required by Texas

[3] A list of the specific healthcare claims that the Insurance Companies have underpaid will be provided to the Insurance Companies by secure encrypted transmission upon entry of an appearance. The Insurance Companies' systemic underpayment of the doctors' claims is ongoing, and the doctors reserve the right to add additional healthcare claims as those claims are identified or accrue.

law, the Insurance Companies have violated Section 541.060(a)(2)(A) and committed an unfair settlement practice.

52. Plaintiff Doctors are therefore entitled to recover the difference between the amount the Insurance Companies paid for emergency care Plaintiff Doctors rendered to their members and the usual and customary rate, plus court costs and attorneys' fees. Tex. Ins. Code § 541.152(a). Because the Insurance Companies knowingly failed to pay Plaintiff Doctors the usual and customary rate for emergency care rendered to their enrollees, they are liable for a penalty equal to three times Plaintiff Doctors' damages—that is, the difference between the amount the Insurance Companies paid for emergency care Plaintiff Doctors rendered to their plan members and the usual and customary rate. *See* Tex. Ins. Code § 541.152(b).

COUNT III – Violations of Texas Prompt Pay Statutes

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53. The foregoing paragraphs are incorporated by reference.

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54. The Texas Insurance Code requires an insurer or HMO to pay a healthcare provider's claim within 30 days of receipt of an electronically submitted clean claim. TEX. INS. CODE §§ 843.338, 1301.103. Though this requirement generally only applies to participating providers, the Texas Insurance Code extends this requirement to out-of-network providers of emergency services such as Plaintiff Doctors. TEX. INS. CODE §§ 843.351, 1301.069. Thus, for all electronically submitted claims, the Insurance Companies were obligated to pay Plaintiff Doctors the usual and customary rate within 30 days of receipt of the claim.

55. Despite this obligation, as alleged above, the Insurance Companies have failed to reimburse Plaintiff Doctors at the usual and customary rate within 30 days of the electronic submission of the claim. Indeed, the Insurance Companies failed to reimburse Plaintiff Doctors at the usual and customary rate ***at all***. Because the Insurance Companies have failed to reimburse

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Plaintiff Doctors at the usual and customary rate within thirty days of submission of the claims as the Texas Insurance Code requires, the Insurance Companies are liable to Plaintiff Doctors for statutory penalties.

56. For all claims payable by plans that the Insurance Companies insure that they failed to pay at the usual and customary rate within 30 days, the Insurance Companies are liable to Plaintiff Doctors for penalties. TEX. INS. CODE §§ 843.342, 1301.137.

57. Plaintiff Doctors seek penalties payable to them for late-paid claims under these statutes.

58. Plaintiff Doctors are also entitled to recover their reasonable attorneys' fees.

COUNT IV - Quantum Meruit

59. The foregoing paragraphs are incorporated by reference.

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60. Plaintiff Doctors rendered valuable emergency services to the Insurance Companies' members.

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61. The Insurance Companies 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.

62. As insurers, the Insurance Companies were reasonably aware that medical service providers, including Plaintiff Doctors, would expect to be paid by the Insurance Companies for the emergency services provided to their members. Indeed, as pleaded above, this obligation is codified in the Texas Insurance Code and accompanying regulations.

63. The Insurance Companies accepted the benefit of the services provided by Plaintiff Doctors to members of their health plans.

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64. Therefore, Plaintiff Doctors are entitled to quantum meruit recovery for the value of the services provided. However, the Insurance Companies have arbitrarily and unilaterally reimbursed Plaintiff Doctors at amounts far lower than required.

65. As a result of the Insurance Companies' actions, Plaintiff Doctors have been damaged in the amount in excess of the minimum jurisdictional limits of this Court. Plaintiff Doctors sue for the damages caused by the Insurance Companies' conduct and are entitled to recover the difference between the amount the Insurance Companies paid for emergency care Plaintiff Doctors rendered to their members and the reasonable value of the service that Plaintiff Doctors rendered to the Insurance Companies by discharging their obligations to their plan members.

COUNT V – Declaratory Judgment

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66. The foregoing paragraphs are incorporated by reference.

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67. As set out above, Plaintiff Doctors provide emergency care to patients who present to emergency departments in Central Texas, including the Insurance Companies' insureds. Under Texas law, the Insurance Companies are required to pay Plaintiff Doctors the usual and customary rate for that emergency care. *See* TEX. INS. CODE § 1271.155; 28 TEX. ADMIN. CODE §§ 11.1611(a), (e), (f)(1). Instead of reimbursing Plaintiff Doctors at the usual and customary rate, the Insurance Companies have reimbursed Plaintiff Doctors at reduced rates with no relation to the usual and customary rate.

68. An actual, justiciable controversy therefore exists between the Parties regarding the rate of payment for Plaintiff Doctors' emergency care that is the usual and customary rate that the Texas Insurance Code requires the Insurance Companies to pay. Plaintiff Doctors therefore request a declaration that the rates that the jury determines to be the usual and customary rates for

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the past healthcare claims asserted in the preceding Counts are the usual and customary rates that the Insurance Companies are required to pay to Plaintiff Doctors for the emergency care that Plaintiff Doctors provide to the Insurance Companies' insureds in the future.

69. Plaintiff Doctors are entitled to an award of attorney's fees pursuant to Tex. Civ. Prac. & Rem. Code § 37.009.

CONDITIONS PRECEDENT

70. All conditions precedent have been performed or have occurred.

ATTORNEYS FEES

71. Plaintiff Doctors retained the services of Waller Lansden Dortch & Davis, L.L.P. to bring and prosecute this lawsuit. Plaintiff Doctors are entitled to recover, and hereby seek, their attorneys' fees and expenses incurred in bringing and prosecuting this lawsuit, pursuant to Texas Civil Practice and Remedies Code §37.009, et seq., the above-referenced provisions of the Texas Insurance Code, and other applicable law.

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RULE 193.7 NOTICE

72. Pursuant to Rule 193.7 of the Texas Rules of Civil Procedure, Plaintiff Doctors hereby give notice to the Insurance Companies that Plaintiff Doctors intend to use all documents exchanged and produced between the parties (including, but not limited to, correspondence, pleadings, records, and discovery responses) during the trial of this matter.

RULE 194 REQUEST FOR DISCLOSURE AND DISCOVERY REQUESTS

73. Pursuant to Texas Rule of Civil Procedure 194, Plaintiff Doctors request that the Insurance Companies disclose, within 50 days of service of this request, the information or material described in Rule 194.2.

JURY DEMAND

74. Plaintiff Doctors hereby demand a trial by jury of the above-styled action pursuant to Texas Rule of Civil Procedure 216(a).

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs hereby request that Defendants UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc., be cited to appear and answer this Original Petition, and that upon final trial and determination thereof, judgment be entered in favor of Plaintiff Doctors awarding them the following relief:

A. The difference between the amount the Insurance Companies have already paid on the healthcare claims at issue and the usual and customary rate;

B. An award of penalties pursuant to Texas Insurance Code § 541.152;

C. Penalties due under Texas Insurance Code §§ 843.342, 1301.137

D. Quantum meruit recovery;

E. Declaratory judgment as requested above;

F. Reasonable attorneys' fees and court costs;

G. Prejudgment and postjudgment interest; and

H. Such other and further relief to which the Plaintiffs may be entitled.

Dated this 15th day of April, 2019.

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Respectfully submitted,

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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-JCM-VCF

DEFENDANTS' OPPOSITION TO PLAINTIFFS' AMENDED MOTION TO REMAND

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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 oppose Plaintiffs' ("Plaintiffs" or "the Providers") Amended Motion to Remand (ECF No. 49) ("Motion").

I. INTRODUCTION

Plaintiffs' Amended Motion asks this Court to adopt a rule. The proposed rule is that complete preemption under ERISA does not apply if a plaintiff's claims involve the "rate of payment" rather than the "right to payment." The proposed rule should be rejected. This alleged "rule" is (1) based on a misreading of the case law and (2) is an attempt to distract this Court from the fact that the *Davila* Test, the *only* test that governs complete preemption, is clearly satisfied for all eight of the state law claims that Plaintiffs have asserted and thus all eight claims are completely preempted.

There are only two issues the Court must decide here pursuant to the *Davila* Test. First, do the Plaintiffs have standing to bring a statutory ERISA claim? Second, do the Defendants owe any legal duties to the Plaintiffs to reimburse Plaintiffs at a particular rate, that are independent of Defendants' legal duties under the ERISA plans? If these elements are met, complete preemption applies even if Plaintiffs are only bringing "rate of payment" claims because the only document governing the rate of payment to out-of-network providers is the treated patients' ERISA plans.

The first element of the *Davila* Test is met because Plaintiffs received an assignment of benefits from Defendants' plan members that allows them to stand in their shoes and bring the same ERISA claims those members could have brought. Contrary to Plaintiffs' contentions, the only question is whether Plaintiffs *could* have brought an ERISA claim, not whether they actually pled such a claim in their Complaint.

The second element of the *Davila* Test is also met as Plaintiffs have failed to allege any facts that give rise to a legal duty independent of ERISA. Plaintiffs allege in the Complaint that

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Defendants must reimburse them "at a reasonable rate or the usual and customary rate" and that this rate is 75-90% of their billed charges.[1] However, throughout the 47 page Complaint, Plaintiffs never point to a written contract, statute or oral promise by Defendants that requires they be paid at such a rate. Plaintiffs are out-of-network providers that lack a written contract with Defendants, lack a Nevada statute requiring a specific rate of payment and lack any oral promise by Defendants to pay a particular rate. Thus, the only legal duties Defendants owe to Plaintiffs (if any) must flow from the terms of the ERISA plans and the assignments that Plaintiffs received from Defendants' plan members. Stated another way, the only connection between the Plaintiffs and Defendants in this case is that Plaintiffs treated Defendants' plan members. Thus, there can be no legal duty at issue beyond the terms of those plan members' ERISA plans.

Every single "rate of payment" case that Plaintiffs cite where courts found that complete preemption did not occur involved (1) providers who failed to receive an assignment of benefits from the plan members and thus lacked standing to bring an ERISA claim (element 1 of *Davila* Test was not met), (2) providers who had an express written agreement with the plan administrator/insurer requiring a particular rate of payment that created an independent legal duty (element 2 of *Davila* Test was not met), (3) providers who received an oral promise from the plan administrator/insurer to pay the provider at a particular rate that created an independent legal duty (element 2 of *Davila* Test was not met), or (4) a state statute requiring a particular rate of payment to out-of-network providers that created an independent legal duty (element 2 of *Davila* Test was not met). Since it is undisputed that none of these facts are present here, Plaintiffs' "rate of payment" argument is inapposite, the *Davila* Test is met and all of Plaintiffs' state law claims are completely preempted by ERISA.

II. KEY FACTS OUTSIDE OF PLAINTIFFS' FIRST AMENDED COMPLAINT DEMONSTRATE THAT ELEMENT 1 OF THE *DAVILA* TEST IS MET

[1] First Amended Complaint at ¶¶ 21, 54.

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A. Defendants Are Entitled to Introduce Evidence Outside the Four Corners of Plaintiffs' First Amended Complaint In Order to Establish that Plaintiffs' Claims Are Completely Preempted by ERISA

Plaintiffs argue that they "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," and that "[r]emoval based on federal-question jurisdiction is reviewed under the longstanding well-pleaded complaint rule." (Motion at 6:19–21, 24–25). However, the doctrine of complete preemption is an exception to this rule, and a plaintiff's complaint can be removed to federal court even though it only alleges state law claims. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209, 124 S. Ct. 2488, 2496, 159 L. Ed. 2d 312 (2004) ("the ERISA civil enforcement mechanism is one of those provisions with such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.") (internal quotations omitted) (emphasis added). This is the case here, where the Plaintiffs' First Amended Complaint is subject to complete preemption under ERISA.

Federal courts are "not bound by the labels used in the complaint . . . merely referring to labels affixed to claims to distinguish between preempted and non-preempted claims is not helpful because doing so would elevate form over substance and allow parties to evade the pre-emptive scope of ERISA.'" *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Florida, Inc.*, 813 F.3d 1333, 1337 n.2 (11th Cir. 2015) (internal quotation omitted). Thus, when considering whether complete preemption is present, federal courts regularly consider evidence outside of the complaint to determine the true nature of a plaintiff's claims. *See e.g., Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1351 (11th Cir. 2009) (considering affidavits and claims forms that were submitted to show that the plaintiffs had received an assignment of benefits from the plan members and thus had standing to sue under ERISA, meaning at least some of the claims asserted were subject to complete preemption). With complete preemption, it does not matter if the well-pleaded allegations of a complaint only set forth state common law actions. If it did matter, an artful pleader could always get around ERISA, and undermine the congressional goal of establishing a uniform federal scheme.

In sum this Court is not limited to the four corners of the Providers' First Amended

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Complaint in assessing whether that Complaint raises a federal question and is subject to complete preemption.

B. Plaintiffs' Requests to be Reimbursed by Defendants at a Particular Rate are Governed by the Terms of ERISA Employee Benefit Plans.

Plaintiffs' First Amended Complaint does not identify the plan members it treated or the health plans at issue. Rather, the Complaint only identifies the time frame during which medical services were provided to Defendants' members and claims/requests for payment were submitted to Defendants. First Amended Complaint at ¶¶ 53–55, 57, 84–87.[2] Nonetheless, Defendants have determined that nearly all of the claims for payment relate to employee benefit plans (i.e. employer sponsored health plans) that are governed by ERISA and are thus completely preempted. During the time frames discussed 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 employee benefit plans.[3] For the claims made against Oxford and SHO, all of the claims were made against employee benefit plans.[4] For the claims made against SHL, approximately 72% of the claims were made against employee benefit plans.[5] For the claims made against HPN, approximately 84% of the claims were made against employee benefit plans.[6] Taking into account all of the aforementioned claims/requests for payment, over 90% were for services provided to members of employee benefit plans governed by ERISA. Plaintiffs did not contest this key fact in their Amended

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[2] Moreover, in an implicit admission that the Plaintiffs engaged in artful pleading to avoid preemption and removal to federal court, when Counsel for Defendants requested additional information so that they could determine whether this suit is governed by ERISA, counsel refused. *See* **Exhibit 1**, May 9, 2019 email from Counsel for Plaintiffs to Defendants' Counsel).

[3] **Exhibit 2** at ¶ 7 (UHIC, UHS and UMR Declaration).

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

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

[6] *Id.* at ¶ 8.

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Motion to Remand despite being made aware of it via Defendants' original Opposition to the Motion to Remand. ECF No. 21.

C. For all of the Claims Plaintiffs are Asserting, they Represented to United that they Received an Assignment of Benefits from Defendants' Plan Members.

For all of the claims that Plaintiffs are asserting in this litigation, the Plaintiffs represented to United when they submitted their claims that they received assignments of benefits from the plan members such that Plaintiffs now stand in the shoes of each plan member and may assert a claim for reimbursement.[7] Critically, the Plaintiffs' Amended Motion to Remand does not challenge that they received an assignment of benefits for every single claim they are asserting.[8] Rather, the Providers argue 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." Motion at 12:3–5. In support of this argument, Plaintiffs look to *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*

The Plaintiffs' reliance on *Marin* is misplaced, as *Marin* merely stands for the commonsense proposition that where a provider's claim is legitimately based on a source of legal obligation outside a plan—such as an oral promise—an assignment of plan benefits is irrelevant, because the claim is not tied to the plan. In *Marin*, a benefits administrator for the defendant company was contacted by the plaintiff-provider before the member was admitted to the hospital.

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

[8] Plaintiffs do make the following statement in the Motion: "Defendants have not even attempted to demonstrate the existence, scope, or legal effectiveness of such assignments." Motion at 11:27-28. Plaintiffs appear to be operating in an alternate reality. In Defendants' original Opposition to the original Motion to Remand, they attached claim forms and declarations proving up Plaintiffs' own prior representations that they had obtained assignments of benefits. *See* ECF No. 21. To the extent Plaintiffs are feigning ignorance of the Defendants' prior arguments with the intent of introducing new responses to those prior arguments in their Reply; this would smack of transparent gamesmanship and should not be rewarded by the Court.

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That defendant-administrator orally verified the patient's coverage and treatment, and also specifically "agreed to cover 90% of the patient's medical expenses at the Hospital." *Marin Gen. Hosp*, 581 F.3d 941, 943 (9th Cir. 2009). This oral promise was above and beyond the amounts due under the member's ERISA plan, as those amounts had already been paid. *Id.* at 948. Thus, in *Marin*, there was no question that the medical provider's claims were based on a duty independent of the ERISA plan since the provider had already been paid everything owed under the plan (making the assignments irrelevant) and was basing its claims on an oral promise. *Id.*

Unlike in *Marin*, Plaintiffs do not allege an oral promise, and do not alleged that they have been paid everything owed them under the terms of the ERISA plans at issue. Accordingly, *Marin* has no bearing on the case at hand and actually supports Defendants' position.

As discussed in more detail below, the plan members' assignments of benefits to the Providers is critical because it means the Providers have standing to bring a claim under ERISA § 502(a)(1)(B), ERISA's civil enforcement statute, and thus the first element of the *Davila* Test is met.

III. KEY ADMISSIONS AND OMISSIONS IN PLAINTIFFS' FIRST AMENDED COMPLAINT SUPPORT DENYING THE MOTION TO REMAND BECAUSE THEY DEMONSTRATE THAT ELEMENT 2 OF THE *DAVILA* TEST IS MET.

The Providers admit that they do not have written agreements with any of the Defendants. First Amended Complaint at ¶ 20. The Providers further admit that they are "non-participating" or "out-of-network" providers. *Id.* The Providers also fail to cite a single Nevada statute that either (1) requires plan administrators/insurers to pay out-of-network providers or (2) requires a particular rate of payment to out-of-network providers. *See generally* First Amended Complaint. The Providers do cite to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd and NRS 439B.410. First Amended Complaint at ¶ 18. However, these statutes only relate to requirements that hospitals provide emergency services to patients regardless of the patients' ability to pay. These statutes do not require payment to out-of-network providers or say anything about a required rate of payment. Simply put, there is no required rate of payment here, apart from the rate of payment that is required by the terms of each individual plan.

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Plaintiffs also allege that they were "entitled to and expected to be paid at rates in accordance with the standards established under Nevada law." First Amended Complaint at ¶ 195. However, the Providers' allegation is vague for a reason—no rate of payment statute exists in Nevada.[9] Finally, Plaintiffs' First Amended Complaint is devoid of any allegation of an oral representation by Defendants that they would pay the Providers a particular rate for their services. *See generally* First Amended Complaint. Rather, the only allegation is that the rates at which United-administered plans previously paid Plaintiffs' submitted health claims somehow created an implied-in-fact contract with Plaintiffs by which those plans promised to continue to pay them the same rates. *Id.* at ¶¶ 20, 198, 200. But that sham claim—Plaintiffs in fact expressly admit in the First Amended Complaint that at all relevant times Plaintiffs and Defendants vociferously *disagreed* on appropriate rates, *id.* at ¶¶ 67, 70, 81—gets Plaintiffs nowhere, as the Ninth Circuit does not allow providers to use implied-in-fact contract claims to override plan terms that establish specific benefit rates, and moreover the specific implied-in-fact-contract theory that Plaintiffs advance here relies entirely on historical claim adjudications by Defendants that *applied plan terms*.

The above admissions and omissions are critical as they demonstrate that there is no legal duty independent of ERISA on which Plaintiffs can rely, and thus element 2 of the *Davila* Test is met. As discussed more fully below, courts have held that where (1) an out-of-network medical provider lacks an express written provider agreement with the plan administrator/insurer, (2) lacks any allegation of an oral promise to pay a particular rate by the insurer/plan administrator, and (3) does not rely on any state statute that requires a particular rate of payment to out-of-network providers, there is no legal duty independent of ERISA and thus the providers' rate of

[9] A special statutory rate of payment scheme did pass in the 2019 Nevada Legislative Session but the scheme will not go into effect until January 1, 2020 and is not retroactively applicable to this case. **Exhibit 8** (article in the Nevada Independent discussing the passage of AB 469 and previous failed attempts to pass similar legislation regarding the rate of payment to out-of-network providers); *see also* AB 469 at § 29(2) (2019 Nevada Legislative Session) (stating that law does not go into effect until January 1, 2020).

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payment claims are completely preempted.[10]

IV. DEFENDANTS HAVE SATISFIED BOTH ELEMENTS OF THE *DAVILA* TEST AND THUS ALL OF PLAINTIFFS' CLAIMS ARE SUBJECT TO COMPLETE PREEMPTION

A. Legal Standard for a Motion to Remand

"The burden of establishing federal jurisdiction is upon the party seeking removal and the removal statute is strictly construed against removal jurisdiction." *Emrich v. Touche Ross & Co.*, 846 F.2d 1190, 1195 (9th Cir. 1988). Nonetheless, a defendant only needs to prove that removal was proper by a "preponderance of the evidence." *Selimaj v. City of Henderson*, 2008 WL 979045, at *1 (D. Nev. Apr. 9, 2008) (applying preponderance of the evidence standard to a federal question removal); *Cerros v. N. Las Vegas Police Dep't*, No. 2006 WL 3257164, at *1 (D. Nev. Nov. 9, 2006) (same).

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

The doctrine of complete preemption[11] 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. *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. The Employee Retirement Income Security Act ("ERISA") is a "comprehensive legislative scheme" enacted to protect the interests of participants and beneficiaries in these employee benefit plans and completely preempts state law claims. 29 U.S.C. § 1001(b); *Davila*, 542 U.S. at 209/

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[10] Courts have never found that federal and state statutes requiring hospitals to provide emergency services to *patients* create a legal duty on the part of plan administrators/insurers that is independent of ERISA.

[11] Plaintiffs spill extensive ink explaining the difference between complete preemption and conflict preemption and appear to accuse Defendants of trying to remove this case based on conflict preemption (which would be improper). This is a straw man argument concocted by Plaintiffs. Defendants were clear in both their Notice of Removal and their original Opposition to the Motion to Remand that they understood the difference between these concepts and that the sole basis for removal was that all of Plaintiffs' claims are completely preempted, not conflict preempted. *See* ECF Nos. 1 and 21.

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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)[12] and permits a "participant or beneficiary" to bring a special statutory ERISA claim over which federal courts have original jurisdiction. The statute reads as follows:

> A civil action may be brought—(1) by a participant or beneficiary— . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B). The U.S. Supreme Court has found that this statute evidences congressional intent to completely preempt state law claims related to ERISA plans. A finding of complete preemption has two important consequences for a plaintiff's lawsuit.

First, it means that a complaint filed in state court asserting only state law claims will still be removable to federal court under federal question jurisdiction if it is properly characterized as a claim to require an ERISA plan to pay plan benefits. The U.S. Supreme Court has held that "the ERISA civil enforcement mechanism [i.e. 29 U.S.C. § 1132(a)] is one of those provisions with such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Davila*, 542 U.S. at 209, 124 S. Ct. at 2496. Thus, state law claims that relate to an employee benefit plan are properly removed to federal court even where the complaint does not facially state an ERISA cause of action. *Tingey v. Pixley-Richards W., Inc.*, 953 F.2d 1124, 1130 (9th Cir. 1992).

Second, complete preemption means that the Plaintiffs' state law claims are barred and the plaintiff will only be permitted to assert a statutory cause of action under 29 U.S.C. § 1132(a)(1)(B). *Davila*, 542 U.S. at 209, 124 S. Ct. at 2495 ("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.").

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[12] This section is also commonly referred to as § 502(a) of ERISA in case law discussing the issue.

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The second consequence is why, in addition to removing this action, Defendants are also moving to dismiss Plaintiffs' claims based on the doctrine of complete preemption.[13]

C. The *Davila* Test Is the Only Test for Determining Whether a State Law Claim is Completely Preempted and Defendants Have Satisfied It

Contrary to Plaintiffs' contention in their Amended Motion to Remand—where they seek to substitute an alleged "rate of payment vs. right to payment test" for the *Davila* Test—the *Davila* Test remains the only test that Defendants must satisfy to prove that the Providers' claims are subject to complete preemption under ERISA. Under the *Davila* test, 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 an employee plan member paid for a covered medical treatment herself, subsequently received only partial reimbursement from the insurer/plan administrator, and then brought suit against the health plan administrator seeking additional reimbursement. *Id.* at 211, 124 S. Ct. 2497. 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 no other state law claims, however labeled, would be permitted that effectively sought reimbursement from the plan for that medical treatment. The employee's only remedy would be a statutory ERISA claim.

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

[13] Given the similarities between the arguments made in the Motion to Remand and Defendants' coming Motion to Dismiss, it likely makes sense for the Court to consider the motions at the same time.

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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).

The Providers vaguely argue that *Misic* is inapposite.[14] This is wrong. ***Misic* was a so-called "rate of payment" case** and the Court found complete preemption was appropriate. In *Misic*, just as the Providers allege here, the insurer/administrator paid a portion of the amounts billed by the medical provider but not the entire amount. *Misic*, 789 F.2d at 1376 ("The trust paid a portion of the amount billed, but less than the full 80%."). The Court found that the terms of the ERISA plan (requiring that the plan member be reimbursed at 80% of the usual and customary cost of medical services) were the only thing that governed the rate of payment and thus complete preemption applied. *Id.* The result should be the same here as the ERISA plans at issue *do* require a particular rate of payment to plan members for services from out-of-network providers.

D. Plaintiffs' "Rate of Payment" Case Law is Not Applicable to the Facts of This Case

Plaintiffs have cited a number of ERISA preemption cases in their Amended Motion to Remand that purport to discuss the importance of the distinction between claims involving the "right to payment" (which Plaintiffs admit are completely preempted) versus the "rate of payment" (which Plaintiffs contend are not completely preempted). However, the "right to payment" versus "rate of payment" distinction that Plaintiffs focus on is *only* relevant to claims brought by in-network providers that arise under provider contracts, in which case whether a given medical service qualifies as a "covered service" for which plan benefits are provided remains governed by the terms of the plan and thus remains completely preempted, but the amount of payment to which the provider is entitled for rendering covered medical services is

[14] The Providers also take issue with Defendants' decision to cite to the *Tingey*, *Gables* and *Cleghorn* cases in the Notice of Removal. However, this is another straw man argument. Defendants did not cite to these cases because they match all the facts here but rather to set forth basic principles of complete preemption under ERISA. Cases that do precisely match the facts here are cited in this Opposition.

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established by the provider contract, which is governed by state law and not subject to preemption. It has no application whatsoever to out-of-network providers such as Plaintiffs who admit they have no provider contract, and who have no right to be paid amounts other than what the terms of the health plans at issue provide.

As explained below, every single case cited by Plaintiffs where courts found that complete preemption did not occur involved (1) providers who failed to receive an assignment of benefits from the plan members, (2) providers who had an express written agreement with the plan administrator/insurer, (3) providers who received an oral promise from the plan administrator/insurer that it would pay the out-of-network provider at a particular rate, or (4) a state statute requiring a particular rate of payment to out-of-network providers.

The lack of an assignment of benefits would mean that the first element of the *Davila* Test is not met since the medical provider would lack standing to bring an ERISA claim (i.e. since only "beneficiaries" and "participants" can bring claims under ERISA). The presence of a written agreement between the provider and the insurer or an oral promise by the insurer to the out-of-network provider regarding the rate of payment would mean the second element of the *Davila* Test is not met since each of these things creates a legal duty on the part of the plan administrator/insurer that is independent of the duties owed under the ERISA plan. Finally, the presence of a state rate of payment statute (to the extent the statute itself is not preempted by ERISA) can also create a duty independent of the plan.

Critically, it is undisputed that none of these facts are alleged in Complaint and thus the *Davila* Test is met and all of Plaintiffs' state law claims are completely preempted by ERISA. Each of Plaintiffs' allegedly favorable cases are discussed in turn below.

1. <u>Cases Where No Assignment of Benefits Occurred or Insufficient Evidence of an Assignment Was Presented Such that the Provider Lacked Standing to Bring an ERISA Claim</u>

In some of the cases Plaintiffs cite, complete preemption is not found because the defendant fails to satisfy the first element of the *Davila* test due to a failure to bring forth sufficient evidence to demonstrate that an assignment of benefits occurred. *See e.g., Med. &*

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Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc., 221 F. Supp. 2d 618 (D. Md. 2002) (court found that the patients had not assigned their right to bring an ERISA claim to the out-of-network medical providers); *California Spine & Neurosurgery Inst. v. Bos. Sci. Corp.*, 2019 WL 1974901, at *1 (N.D. Cal. May 3, 2019) (case remanded only because "there is no evidence in the record that the Patient ever assigned his or her rights to Plaintiff, the medical provider.").

Here, it is undisputed that Plaintiffs received an assignment of benefits for all of the claims they seeks to litigate in this suit.[15] Thus, there is no question that Plaintiffs stand in the shoes of Defendants' plan members and have standing to bring a statutory ERISA claim. Thus, the first element of the *Davila* test is undisputedly met.

2. Cases Where an Express Written Provider Agreement Exists That Creates a Legal Duty Independent of the ERISA Plan

When a medical provider receives an assignment of benefits but also has a separate written agreement with the insurer/plan administrator (often called a "provider agreement") that governs the rate of reimbursement owed to that medical provider, the second element of the *Davila* test is often not met.[16] The reason is that the provider agreement creates legal duties

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[15] See Declarations and claim forms attached to this Motion. Plaintiffs also fail to challenge the sufficiency of the assignments in their Motion to Remand.

[16] *Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1052 (9th Cir. 1999) (The court found that the medical providers' claims were not preempted because they had an express written provider agreement with the insurer. That agreement created duties independent of the employee benefit plan and thus ERISA preemption did not apply. The court distinguished the facts before it from the facts in *Misic* (cited *supra*) where the claims were preempted because the medical provider did not have a written provider agreement with the insurer and thus was deemed to be suing on an ERISA employee benefit plan); *see also Windisch v. Hometown Health Plan, Inc.*, No. 308-CV-00664-RJC-RAM, 2010 WL 786518, at *1 (D. Nev. Mar. 5, 2010) (plaintiff had written provider agreement that created independent legal duty); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 530 (5th Cir. 2009) (same) ("determination of the rate that Aetna owes Lone Star under the Provider Agreement does not require any kind of benefit determination under the ERISA plan. The fee schedules in the Member Plans in this case all refer back to the Provider Agreement."); *Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1353 (11th Cir. 2009) (medical providers had a written provider agreement with the insurer that governed rate of payment and created independent duty); *Christ Hosp. v. Local 1102 Health & Ben. Fund*, 2011 WL 5042062, at *4 (D.N.J. Oct. 24, 2011) (finding that the second prong of the *Davila* Test was not satisfied because the medical provider's claims arose out of third party contract which provided for discounted rates).

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concerning payment rates for covered medical services that are independent of the employee ERISA plan. Here, Plaintiffs admit in their First Amended Complaint that they are out-of-network providers and that there "is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation. . . ." First Amended Complaint at ¶ 20. Thus, this Court should disregard any case law cited by Plaintiffs where a written provider agreement existed because Plaintiffs admit that there are no written agreements here. The only legal duties owed by Defendants (if any) flow from the rights Plaintiffs have as the assignees of Defendants' plan members. Since those rights are directly based on and related to employee benefit plans governed by ERISA, Defendants' claims are completely preempted.

3. Cases Where a Legal Duty Independent of the ERISA Plan is Created by an Oral Representation by the Plan Administrator/Insurer

Legal duties independent of those owed under an ERISA plan can also sometimes be created by oral representations such as those that allegedly occurred in the *Marin* case that Plaintiffs rely on. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 950–51 (9th Cir. 2009). In *Marin*, the patient assigned his right to seek payment from the ERISA plan administrator to a hospital. The hospital was then paid the money owed to the patient under the ERISA plan. Then, the hospital sued the plan administrator seeking more money based on a phone conversation with the plan administrator where it allegedly offered to pay 90% of the medical expenses even though this was more than the rate of payment called for in the ERISA plan. *Id.* at 947 ("All of these claims arise out of the telephone conversation in which MBAMD allegedly agreed to pay 90% of the patient's hospital charges."). Thus, the court found that the claims were not preempted by ERISA since the medical provider was clearly not suing on the ERISA plan (indeed it had already been paid everything it was owed under the plan). *Id.* at 951.

Similar situations were present in *McCulloch*, *Bay Area Surgical*, and *Christ Hospital*, cited by Plaintiffs at 13:21–14:5. *See McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 144 (2d Cir. 2017) (the representative stated that McCulloch would be reimbursed at seventy percent (70%) of the usual, customary, and reasonable rate); *Bay Area Surgical Mgmt., LLC. v. United Healthcare Ins. Co.*, 2012 WL 3235999, at *1 (N.D. Cal. Aug. 6,

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2012) (claims stem from a telephone conversation between a BASM employee and a United employee, during which United allegedly authorized and orally agreed to compensate BASM for 70% of the approved surgical procedures).

Here, in contrast to *Marin*, *McCulloch*, and *Bay Area Surgical*, Plaintiffs' First Amended Complaint does not allege that Defendants ever made any oral representations that they would reimburse the Providers at any particular rate (or at all for that matter). The Providers have also not alleged that they have been paid everything owed under the terms of the ERISA plans. Thus, Plaintiffs' only right to reimbursement (if any) flows from the assignment they received from Defendants' plan members and its claims are subject to complete preemption.

4. Cases Where a Legal Duty Independent of the ERISA Plan is Allegedly Created by a State Statute Requiring a Particular Rate of Payment to a Medical Provider

Plaintiffs invoke numerous cases holder that provider claims are not preempted when they are directly governed by state law statutes, because those state statutes (to the extent they are not themselves preempted) constitute a source of independent legal obligation outside the plan. These cases have no application here, as Plaintiffs do not identify any Nevada statute that purports to override plan benefit provisions by setting the relevant rates of payment.[17]

[17] *Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc*., 221 F. Supp. 2d 618 (D. Md. 2002) (Maryland had special statutory scheme requiring insurers to pay out-of-network providers for services provided to their insureds at a particular rate. Thus, there was no need to refer to the ERISA plans to determine the appropriate rate of reimbursement and complete preemption did not apply); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc*., 281 F. Supp. 3d 1339 (S.D. Fla. 2017) ("The Florida statutes confer a private right of action exclusively on out-of-network emergency medical providers" and thus complete preemption did not apply); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc*., 258 F. Supp. 3d 1323 (S.D. Fla. 2017) (no preemption of implied-in-fact contract claim because Florida statute created special duty independent of ERISA that supported the claim); *New Jersey Carpenters & the Trustees Thereof v. Tishman Const. Corp. of New Jersey* 760 F.3d 297, 305 (3d Cir. 2014) (the New Jersey Prevailing Wage Act created an independent legal duty regarding rates to be paid); *Wurtz v. Rawlings Co., LLC*, 761 F.3d 232, 236 (2d Cir. 2014) (a New York statute limiting reimbursement and subrogation claims created an independent duty") (The *Wurtz* case was also been recently criticized by the Ninth Circuit in *Rudel v. Hawai'i Mgmt. All. Ass'n*, 937 F.3d 1262, 1271 (9th Cir. 2019)).

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In *Gulf-to-Bay*,[18] for example, cited by Plaintiffs at 10:4–6, the Court held that the second element of the *Davila* Test was not met because a Florida statute created a legal duty independent of ERISA to pay out-of-network providers at a particular rate. Here, Plaintiffs admit that Nevada does not have a rate of payment statute and thus Defendants have no legal duty independent of their duties under the ERISA plans. Specifically, there is no Nevada statute that either (1) requires plan administrators/insurers to pay out-of-network providers or (2) requires a particular rate of payment to out-of-network providers. Indeed, while such schemes have been proposed by the Nevada Legislature in the past, they failed to pass or were vetoed prior to the 2019 Legislative Session.[19] Simply put, Plaintiffs lack a Nevada statute that could create a legal duty independent of Plaintiffs' rights as assignees of the Defendants' plan members.

Plaintiffs may argue in response that the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd and NRS 439B.410, cited in their First Amended Complaint, provide the independent duty they need to create an implied-in-fact contract and defeat element 2 of the *Davila* Test. However, these statutes only relate to requirements that hospitals provide emergency services to patients regardless of the patients' ability to pay. These statutes do not require payment by insurers to out-of-network providers or say anything about the required rate of payment. Further, no court has found that federal and state statutes requiring hospitals to provide emergency services to *patients* somehow create a legal duty on the part of plan administrators/insurers that is independent of ERISA and Plaintiffs have not cited any case law in this regard.

5. In Cases Where the Out-of-Network Medical Provider (1) Receives an Assignment of Benefits and (2) Lacks an Express Written Agreement, Lacks a Special State Statute Governing the Rate of Payment and Lacks an Oral Promise to Pay by the Plan Administrator that Would Create a Duty Independent of ERISA, Courts Find the Medical Providers' Claims are Completely Preempted

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[18] *Gulf-to-Bay Anesthesiology Assoc., LLC, v. UnitedHealthcare of Florida, Inc.*, No. 8:18-cv-00233-EAK-AAS, 2018 WL 3640405 (M.D. Fla. July 20, 2018).

[19] *See supra*, at fn. 9.

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Unsurprisingly, Plaintiffs did not cite to the numerous cases with facts similar to this one where the out-of-network providers' state law claims relating to the rate of payment were found to be completely preempted because they received an assignment of benefits. The Ninth Circuit's *Misic* case (discussed *supra*) is one example and additional examples are set forth here.[20]

In *Hill Country*, out-of-network emergency medical providers raised the same "rate of payment vs. right to payment argument" that the Plaintiffs raise here. *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). The Court rejected the argument and denied the motion to remand. The Court reasoned that the "rate of payment vs. right to payment" distinction is only relevant where medical providers have a separate provider agreement with the insurer that specifies a particular rate of reimbursement. Like here, the providers in *Hill Country* lacked a written agreement and/or oral promise to pay and thus the only legal duties owed to them sprang from the terms of the ERISA plans. Plaintiffs' acknowledge that if this Court accepts the reasoning set forth in *Hill Country* it must deny the Motion to Remand.

In *In Re Managed Care Litig*., the court differentiated between different plaintiffs' claims based on whether they had an express written contract with the insurer and whether they had an assignment of benefits from the plan members. *In Re Managed Care Litig*., 298 F. Supp. 2d 1259, 1292 (S.D. Fla. 2003). The court held that the in-network providers' contractual claims were not completely preempted because they were suing under their independent contracts with the insurer. In contrast, the court found that the out-of-network providers' implied contract claims <u>were subject to complete preemption</u> because they received an assignment of benefits from the plan members and thus had standing to sue under ERISA. As to out-of-network providers who did not receive an assignment, the court found that their implied contract claims

[20] *See e.g., Melamed v. Blue Cross of Cal*., 557 F. App'x 659, 660 (9th Cir. 2014) (concluding that a healthcare provider's "breach of implied contract claim [was] completely preempted because through that claim, [the provider sought] reimbursement for benefits that exist 'only because of [the defendant's] administration of ERISA-regulated benefit plans.'").

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were not completely preempted.

Here, Plaintiffs' situation is similar to that of the out-of-network providers in *In Re Managed Care* whose implied contract rate of payment claims were preempted because the Providers allege that they lack a written contract with Defendants, received an assignment of benefits, and yet are attempting to escape ERISA preemption via artfully pleading an implied-in-fact contract claim. The *In Re Managed Care* Court noted that the plaintiffs' situation was not a close call, stating that "[v]irtually every court to consider this question has held that reimbursement and related claims involving services provided to ERISA beneficiaries on a non-participating basis [i.e. out-of-network providers like Plaintiffs here] may be pursued only through ERISA's civil enforcement provision." *Id.* at 1291 (emphasis added) (collecting cases).

Similarly, in *Torrent & Ramos* the Court found that an out-of-network provider's implied-in-fact contract and unjust enrichment rate of payment claims were completely preempted. The provider argued that preemption should not apply since the HMO had already deemed the claims payable and thus only the rate of payment was at issue. *Torrent & Ramos, M.D., P.A. v. Neighborhood Health Partnerships, Inc.*, 2004 WL 7320735, at *4 (S.D. Fla. July 1, 2004). The court rejected this "rate of payment" argument, stating that it was:

> simply a suit for benefits under an ERISA plan where a provider rendered certain emergency services to an ERISA [plan member], submitted claim forms to the various ERISA plans, and failed to receive the payment it expected. Pathologists' attempt to recast its claim as one of implied contract does not change this reality.

Id. (emphasis added). Like the plaintiff in *Torrent & Ramos*, Plaintiffs cannot "recast" their ERISA reimbursement claim as an implied-in-fact contract claim, unjust enrichment claim or anything else. Plaintiffs received an assignment of benefits for every claim they submitted to Defendants and lacks a written contract or Nevada rate of payment statute that would create duties independent of the ERISA plan. Thus, the *Davila* test is met and complete preemption applies.

E. The Specific Claims Asserted by Plaintiffs Have Repeatedly Been Found to be Subject to Complete Preemption

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1. Plaintiffs' Implied-in-Fact Contract Claims are Subject to Complete Preemption

An implied-in-fact contract claim is subject to complete preemption. *Melamed*, 557 F. App'x at 661 ("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."). *Parlanti v. MGM Mirage*, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (finding complete preemption for an implied-in-fact contract claim that sought to recover benefits under an ERISA plan); *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.*, 2004 WL 7320735, at *4 (same).

This is supported not only by law, but by common sense. Plaintiffs are attempting to compel hundreds and perhaps thousands of different ERISA-governed plans administered by United to all pay them the same rate—75-90% of their billed charges—without regard to the specific benefit rates established by the terms of each individual plan, and without any of the plans ever having agreed to pay anything other than the plan benefit rates. If, for example, a plan that was newly hired by United in 2019 to administer benefit claims expressly stated that it would pay all medical claims at 150% of the rate that would be paid by Medicare, Plaintiffs would ask the Court to apply their implied-in-fact contract logic to compel that plan to instead pay them 75-90% of their billed charges. That is a textbook case of the kind of claim that is completely preempted under *Davila*, and no court in the Ninth Circuit has ever allowed a state law claim of this kind to proceed.

2. Plaintiffs' Claim for Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing is Subject to Complete Preemption

This claim attempts to "duplicate" or "supplement" the ERISA civil enforcement mechanism by seeking punitive damages against a plan administrator. First Amended Complaint at ¶ 214. Such claims are completely preempted. *Tingey*, 953 F.2d at 1131 (holding that claims against employer for breach of the implied covenant of good faith and fair dealing and insurance bad faith, among other state law claims, were preempted by ERISA); *Estate of Burgard v. Bank of America, N.A.*, 2017 WL 127386. Nev. March 31, 2017) ("[I]t is well established that breach

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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" under state law which seek non-ERISA damages are "clearly" preempted under 29 U.S.C. § 1132(a)(1)(B) of ERISA).

3. Plaintiffs' Claim for Unjust Enrichment is Subject to Complete Preemption

Courts have specifically held that this claim is 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).

4. Plaintiffs' Claim for a Violation of NRS 686A.020 and 686A.310 is Subject to Complete 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…"); *see also Thrall v. Prudential Ins. Co., 2005 WL 8161321, at *2* (claim for violation of Nevada Unfair Claim Practices was preempted).

5. Plaintiffs' Claim for a Violation of Nevada's Prompt Pay Statutes and Regulations is Subject to Complete Preemption

This claim alleges that Defendants violated the Nevada prompt pay statutes, including NRS 683A.0879, NRS 689A.410, NRS 689B.255, NRS 689C.485, NRS 695C.185, and NAC 686A.675, by failing to reimburse the Providers within 30 days of receipt of a claim. First Amended Complaint at ¶ 236. As a remedy for this alleged violation, Plaintiffs seek to recover

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Nevada statutory penalties. *Id.* at ¶ 240.

This claim is completely preempted for several reasons. First, ERISA already provides a remedy for a plan administrator's failure to promptly pay out on 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 participant or beneficiary of an ERISA plan, for example, 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. Since Plaintiffs are assignees of plan participants or beneficiaries, Plaintiffs too have the right to seek an injunction under ERISA.

Second, courts addressing ERISA preemption of claims under similar state "prompt pay" statutes find preemption unless the medical provider lacks an assignment of benefits. *Compare Schoedinger v. United Healthcare of Midwest, Inc.*, 557 F.3d 872, 875–76 (8th Cir. 2009) (finding provider's claim for interest under Missouri prompt payment statute was preempted because provider received an assignment of benefits from the plan member); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F.Supp.2d 901, 938 (M.D. Tenn. 2013) (finding Tennessee Prompt Pay Act claim was preempted because provider brought it as assignee of plan participant) *with In re Managed Care Litig.*, 298 F.Supp.2d 1259, 1294 (S.D. Fla. 2003) (finding no preemption of providers' prompt pay claims because they did not receive an assignment of benefits).

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*

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Healthcare Sys. v. Contech Constr. Prod. Inc.Group Comprehensive Health Care, No. 1:13-CV-01554-SLDJEH, 2014 WL 4724394, at *7 (C.D. Ill. Sept. 23, 2014) (Illinois prompt-pay statute preempted by ERISA as having an "impermissible connection to an ERISA plan."). There is no significant distinction between Nevada's prompt pay statute and those of other states that have been found to be preempted. These statutes seek to regulate the processing of claims under employee benefit plans which infringes on the field occupied by ERISA. This Court should adopt the above courts' reasoning and find that Nevada's prompt pay statute is preempted as well.

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

6. Plaintiffs' Claim for a Violation of Nevada's Consumer Fraud & Deceptive Trade Practices Acts is Subject to Complete Preemption

There is no reason for this Court to deviate from other courts' decisions on this issue. *Peterson v. American Fidelity Assur. Co.*, 2013 WL 6047183 (D. Nev. Nov. 13, 2013) (finding plaintiff's claim for deceptive trade practices preempted by ERISA); *Pachuta v. Unumprovident Corp.*, 242 F. Supp. 2d 752, 764 (D. Hawaii, March 19, 2002) (finding Plaintiff's statutory claim for deceptive trade practices did not come within the ERISA savings clause as it was not specifically directed at insurance companies and was thus 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 preempted); *Davidian v. S. Cal. Meat Cutters Union*, 859 F.2d 134, 135 (9th Cir. 1988) (claim challenging incorrect description of the insurance benefits of an ERISA plan is preempted).

7. Plaintiffs' Claim for a Declaratory Judgment 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*

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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 it performed on Defendants' members. First Amended Complaint at ¶¶ 251–260. Such a claim clearly duplicates the relief provided by 29 U.S.C. § 1132(a)(1)(B) of ERISA and therefore is completely preempted. Again, since Plaintiffs possess assignments of benefits, they could have brought a declaratory judgment ERISA claim.

8. Plaintiffs' Claim for Violation of NRS 207.350 et seq. is Subject to Complete Preemption

Finally, Plaintiffs' RICO claim is also preempted under ERISA. *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); *Mehling v. New York Life Insurance Co.*, 413 F.Supp.2d 476 (E.D. Pa. 2005) (Dismissing plaintiffs' RICO claims in view of the existence of an ERISA remedy).

F. Defendants Only Need to Prove that One of Plaintiffs' State Law Claims is Completely Preempted to Defeat Plaintiffs' Amended Motion to Remand Under the Doctrine of Supplemental Jurisdiction

Assuming *arguendo* that this Court found some of Plaintiffs' claims were completely preempted but others were not, the non-preempted claims would still fall within this Court's supplemental jurisdiction because they are so related to the other claims that they form part of the same case or controversy under Article III of the United States Constitution. 28 U.S.C. §1367(a); *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8, 123 S. Ct. 2058, 2063, n. 3 (2003) ("Of course, a state claim can also be removed through the use of the supplemental jurisdiction statute, 28 U.S.C. § 1367(a), provided that another claim in the complaint is removable."); *see also Gaming Corp. of Am. v. Dorsey & Whitney*, 88 F.3d 536, 543 (8th Cir. 1996) ("Only those claims that fall within the preemptive scope of the particular statute, or treaty, are considered to make out federal questions, but the presence of even one federal claim gives the defendant the right to remove the entire case to federal court.") (internal citations omitted); *Milwaukee*

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Carpenter's District Council Health Fund v. Philip Morris, 70 F.Supp.2d 888 (E.D. Wisc. 1999) (denying remand while noting that "[s]o long as any one claim concerned a federal question, the entire case could be removed" under the ERISA complete preemption doctrine). In sum, for Plaintiffs to prevail on their Amended Motion to Remand they must show that none of their eight state law claims for relief are completely preempted by ERISA. They cannot do so.

V. THE PROVIDERS' REQUEST FOR SANCTIONS SHOULD BE DENIED

A Court has discretion to award attorney's fees and costs under 28 U.S.C. § 1447(c) only where the removing party lacked an objectively reasonable basis for seeking removal. As demonstrated throughout this Opposition, removal was proper, and the Amended Motion to Remand should be denied. Further, the statute does not permit an automatic award of attorney's fees even if a case is remanded. *Martin v. Franklin Capital Corp.*, 546 U.S. 132, 141 (2005) (citation omitted); *Paul v. Kaiser Foundation Health Plan of Ohio*, 701 F.3d 514, 523 (6th Cir. 2012) (refusing to award fees where complete preemption was a "close one.").

Moreover, if Defendants' removal arguments are so frivolous, why did Plaintiffs elect to *completely rewrite* their original Motion to Remand and abandon vast swathes of the "rate of payment" case law cited therein after Defendants refuted those arguments in the original Opposition to the Motion? *Compare* ECF Nos. 5 and 49. Plaintiffs' request for sanctions is nothing more than an attempt to conceal that, despite two full rounds of briefing, they have yet to land on a supportable legal theory that will allow their claims to escape complete preemption.

VI. CONCLUSION

For all the above reasons, Defendants request that the Court deny Plaintiffs' Amended Motion to Remand.

Dated this 29th day of January, 2020.

/s/ Colby L. Balkenbush

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Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
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Attorneys for Defendants

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CERTIFICATE OF SERVICE

I hereby certify that on the 29th day of January, 2020, a true and correct copy of the foregoing **DEFENDANTS' OPPOSITION TO PLAINTIFFS' AMENDED MOTION TO REMAND** was served and filed electronically through CM/ECF to the following:

Pat Lundvall, Esq.
Kristen T. Gallagher, Esq.
Amanda M. Perach, Esq.
McDonald Carano LLP
2300 W. Sahara Ave., Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com
Attorneys for Plaintiffs

/s/ Colby L. Balkenbush
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC

WEINBERG WHEELER HUDGINS GUNN & DIAL

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EXHIBIT 1

Email – May 9, 2019

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EXHIBIT 1

From: Kristen T. Gallagher [mailto:kgallagher@mcdonaldcarano.com]
Sent: Thursday, May 09, 2019 5:39 PM
To: Balkenbush, Colby; Pat Lundvall; Amanda Perach
Cc: Roberts, Lee; Bowman, Cindy S.
Subject: RE: Fremont Emergency Services v. United Healthcare Insurance, et. al.

Thank you for your message.

As you likely noted from review of the Complaint, Fremont Emergency Services does not assert any causes of action with respect to defendants' insureds/participants whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA), nor does it assert any claims relating to defendants' managed Medicaid business. Additionally, the claims at issue concern a dispute over the amount paid, not whether the claim was payable because defendants already determined the subject claims were payable. As a result, there is no basis to remove the action to federal court under federal question jurisdiction. Once defendants have filed a response to the Complaint, we can discuss next steps.

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Regards,

Kristen T. Gallagher Partner
McDONALD CARANO
P: 702.873.4100 **E:** kgallagher@mcdonaldcarano.com

From: Balkenbush, Colby <CBalkenbush@wwhgd.com>
Sent: Tuesday, May 7, 2019 12:02 PM
To: Pat Lundvall <plundvall@mcdonaldcarano.com>; Kristen T. Gallagher <kgallagher@mcdonaldcarano.com>; Amanda Perach <aperach@mcdonaldcarano.com>
Cc: Roberts, Lee <LRoberts@wwhgd.com>; Bowman, Cindy S. <CBowman@wwhgd.com>
Subject: Fremont Emergency Services v. United Healthcare Insurance, et. al.

Pat, Kristen, Amanda,

Lee and I represent the defendants in the attached complaint and are preparing a response. The Complaint alleges that Fremont provided treatment to more than 10,800 Patients who were members of United HealthCare's Health Plans. *See* Complaint at ¶ 25. Would you be willing to provide the Patients' names, dates of birth and/or a social security numbers so we can determine whether these are United's insureds/participants and which benefit plans are involved? We

understand that Fremont has no obligation to provide this information at this stage but it certainly would be among one of the first things we would seek when discovery begins.

Best,

Colby

WEINBERG WHEELER
HUDGINS GUNN & DIAL
TRIAL LAWYERS

Colby Balkenbush, Attorney
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89118
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The information contained in this message may contain privileged client confidential information. If you have received this message in error, please delete it and any copies immediately.

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EXHIBIT 2

UHIC, UHS and UMR Declaration

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EXHIBIT 2

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

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

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

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

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

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

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

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

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

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

29 U.S.C. § 1002.

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

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

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

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

DATED this 20th day of June, 2019.

Jane Stalinski

Jane Stalinski

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EXHIBIT 3

Oxford Declaration

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EXHIBIT 3

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

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

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

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

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

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

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

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

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

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

29 U.S.C. § 1002.

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

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

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

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

DATED this 21 day of June, 2019.

Maryann Britto

Maryann Britto

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EXHIBIT 4

SHO Declaration

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EXHIBIT 4

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

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

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

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

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

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

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

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

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

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

29 U.S.C. § 1002.

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

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

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

DATED this ___ day of June, 2019.

Shawna Reed

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EXHIBIT 5

SHL and HPN Declaration

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EXHIBIT 5

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WEINBERG WHEELER HUDGINS GUNN & DIAL

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

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

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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

Ellen Sinclair

WEINBERG WHEELER HUDGINS GUNN & DIAL

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EXHIBIT 6

Sample Claim Forms for Fremont to UMR

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EXHIBIT 6

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

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

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

HEALTH INSURANCE CLAIM FORM

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

[ ] PICA

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

000395

000395

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)

[redacted]

b. OTHER CLAIM ID(Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/02/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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

15. OTHER DATE 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 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.)

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)

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 [X]
880262438

26. PATIENT ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 505 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
LEONG, JOEANN
1104011527
207P00000X
SIGNED DATE

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

LASVEGAS,NV 89128-0436

a. b.

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

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

a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

000397

000397

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 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. 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)

000398

000398

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 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. 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)

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 880262438 SSN [ ] EIN [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)

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)

000401

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)

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

[redacted]

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

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. R1084 B. K529 C. D72829 D. R030
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	07 17 17	07 17 17	23		99285		A,B,C,D	1,295 00	1			1972505675
2												
3												
4												
5												
6												

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

000403

000403

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 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 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. 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)

000404

000404

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 SSN [ ] EIN [X] 880262438

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 :
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 08/26/17

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 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. 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 SSN [ ] EIN [X] 880262438

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)

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)

000407

000407

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)

[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
880262438 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.)
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)

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]

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: 880262438 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.)

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)

[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 01/01/18

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 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.)
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)

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 880262438 SSN [ ] EIN [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.)

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)

000411

000411

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 [X]
880262438

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)

000412

000412

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)

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 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.)

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)

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)	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 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

000414

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 SSN EIN 880262438 ☐ [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.		

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)

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? PLACE (State) YES NO

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
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

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)

000415

000415

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:

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.

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 : $1,360.00

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)

[redacted]

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)

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 03/23/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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

15. OTHER DATE 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. R0789 B. I2510 C. E876 D. R000
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 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 [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.)
WRIGHT, BROOKS E
1336574250
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 #
FREMOT EMER SVC MANDAVIA LTD
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)

000418

000418

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)

[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 03/31/18

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 [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.)
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)

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 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	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.

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)

000422

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
880262438 X

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)

000423

000423

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

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

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

A. R1031 B. 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.

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)

000424

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 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. 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 [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)

000425

000425

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

PICA

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

[redacted]

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

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 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. 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 880262438 X

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT 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 : 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)

000427

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

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	01 14 19	01 14 19	23		99285	DESC: EMERGENCY DEPT VISIT - 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 : 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? [ ] 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.

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

000429

000429

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)

000430

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 MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

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

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

A. K5900 B. 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)

000431

000431

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.

000432

000432

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		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. R1013 B. K529 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 09 19	03 09 19	23		99285		A,B	1,295 00	1			1366865206
2	03 09 19	03 09 19	23		99053		A,B	42 00	1			1366865206
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 [ ] [X]	[redacted]	[X] YES [ ] NO	$ 1,337 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
LUNDBERG, MICHAEL 1366865206 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3325 SOUTH FORT APACHE LAS VEGAS,NV 89117-6360 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1679550149 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

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)

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 03/11/19

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

A. M25562 B. M25462 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	03 11 19	03 11 19	23		99283		A, B	484 00	1			1114286077
2												
3												
4												
5												
6												

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

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT [X] YES [ ] NO

28. TOTAL CHARGE $ 484 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

32. SERVICE FACILITY LOCATION INFORMATION
FREMONT EMERGENCY SERVICES MAN
7207 ALIANTE PKWY
NORTH LAS VEGAS,NV 89084-2373
a. 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 : 752297429-10036 (UHC 837 MEDICAL)

000434

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#) | OTHE [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 03/18/19

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)

000435

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 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. 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)

000436

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#) | 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 03/24/19

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		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. H6691 B. B974 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 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)

000437

000437

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.

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)

000438

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:

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 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. 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)

000439

000439

EXHIBIT 7

Sample Claim Forms for SHO

000440

EXHIBIT 7

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE NUCC 02/12

[redacted] 8/1/13 [redacted]

MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTH [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 also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE DATE 12/28/17

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

	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 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 PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
WRIGHT DO, BROOKS
SIGNATURE ON FILE
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

SRS 5231 44 OUTSOURCED BILLIN

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

VICMS 1500CS-12

SIERRA HEALTHCARE OPTIONS%\

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE DATE 01/02/18

SIGNATURE ON FILE

01 14 17 431

OTHER DATE MM DD YY

17a.

17b. NPI

ICD Ind 0

I21.3

1	01 14 17	01 14 17	23	X	99291	218.00	A	1601 001				1104168293
2												
3												
4												
5												
6												

88-0262438 X [redacted] X YES NO 1601 00 0 00

800-562-2945

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

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

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

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, INJURY, or PREGNANCY (LMP) MM DD YY
05 14 17 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
05 14 17 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

24. A. DATE(S) OF SERVICE From 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.	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 05 14 17 05 14 17	23	X	99285	213.00	A	1233 001			NPI	1366766099
2 05 14 17 05 14 17	23	X	99053	Ø	A	40 001			NPI	1366766099
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 are true, correct and complete.)
TRUAX DO,GREG FERMIN
SIGNATURE ON FILE
01/08/18
SIGNED DATE
STE 52601

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
3001 ST ROSE PKWY
HENDERSON,NV 89052-3839
1770626426 b.

33. BILLING PROVIDER INFO & PH # (800-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
1689013161 b. ZZ207P00000X
44-OUTSOURCED-BILLIN

PHYSICIAN OR SUPPLIER INFORMATION

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

VICMF 1500CS 12

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

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNATURE ON FILE 01/18/18

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)

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	223.00	A	64 00	1		NPI	1629294004
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 $ 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)

[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.
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 MM 08 DD 19 YY 17 TO MM 08 DD 19 YY 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 07 DD 18 YY 17 QUAL. 431

15. OTHER DATE QUAL. 439 MM 07 DD 18 YY 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 07 DD 18 YY 17 TO MM 07 DD 18 YY 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

[redacted]

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

HEALTH INSURANCE CLAIM FORM

[redacted]

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 01/26/18
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 (First symptom) OR INJURY (Accident) 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 ☒ 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 ☒
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For Govt. Claims, see back) ☒ 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
AA OUTSOURCED BILLING

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WCMS 1500CS 12

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

000447

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 ... benefits either to myself or to the party who accepts assignment

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) 08 06 17 QUAL 431

15. OTHER DATE QUAL MM DD YY

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 08 06 17 TO 08 06 17

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. I47.2 B. R00.2 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 06 17	08 06 17	23	X	99285	228.00	AB	1295 00	1			1063462364
2 08 06 17	08 06 17	23	X	99053	Ø	AB	42 00	1			1063462364
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN 88-0262438 X
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO
28. TOTAL CHARGE $ 1337 00
29. AMOUNT PAID $ 0 00
30. BALANCE DUE

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 SSN EIN 88-0262438 X
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) X YES NO
28. TOTAL CHARGE $ 1681.00
29. AMOUNT PAID $ 0.00
30. 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 DATE 02/22/18
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

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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

CARRIER

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE 02/26/18

SIGNATURE ON FILE

12 28 17 431

R07.89 R51 R94.31 0

1	12 28 17	12 28 17	23	X	99284		ABC	927 001		NPI	1649569583
2	12 28 17	12 28 17	23	X	99053		ABC	44 001		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

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

SRS 5231

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

NUCC 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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED SIGNATURE ON FILE DATE 04/19/18 SIGNED SIGNATURE ON FILE

08 17 17 QUAL 431

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a

08 17 17 08 17 17

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

I21.3 G51.0 I16.0 0

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	001			1972505675
2											
3											
4											
5											
6											

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

26 PATIENT'S ACCOUNT NO. [redacted]

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

28 TOTAL CHARGE $ 1681 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.
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
1104870187

33 BILLING PROVIDER INFO & PH # 800-562-2945
FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
1366429821 77207P000000X

NUCC instruction manual available at: www.nucc.org PLEASE PRINT OR TYPE CKK 60 COMM NPI FORM

MOA 5290

000452

[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
SIGNED 04/30/18 DATE

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

33. BILLING PROVIDER INFO & PH. # ( ) ~~800 562 2945~~
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. ~~1518120971~~ b. ~~ZZ207P00000X~~
~~44 OUTSOURCED BILLIN~~

PHYSICIAN OR SUPPLIER INFORMATION

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

000453

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

SECOND FOLD

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 [X] $ 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

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

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06 17 17	06 17 17	23	X	99291		AB	1681 00	1		NPI	1205940756
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1681 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
LASRY MD, JASON
SIGNATURE ON FILE
SIGNED 06/05/18

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
3001 ST ROSE PKWY
HENDERSON, NV 89052-3839
a 1770626426 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

000454

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WCMS-1500CS-12

SIE 52601 44 OUTSOURCED BILLIN

[redacted]

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

CARRIER

HEALTH INSURANCE CLAIM FORM

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

[redacted]

PATIENT AND INSURED INFORMATION

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 11 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 MM 11 DD 19 YY 17 TO MM 11 DD 19 YY 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 88-0262438 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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

[redacted]

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

CARRIER

HEALTH INSURANCE CLAIM FORM

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

[redacted]

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 07/30/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 05 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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

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. #
06 05 18	06 05 18	23	X	99291		A	1765 00	1		NPI	1194131854
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1765 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

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

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 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 [ ] NO [X] CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. R07.2 B. R79.89 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT FAMILY PLAN	I. ID QUAL	J. RENDERING PROVIDER ID #
02 09 18	02 09 18	23	X	99285		AB	1360 00	1		NPI	1114212743
										NPI	
										NPI	
										NPI	
										NPI	
										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.)
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

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44 OUTSOURCED BILLING

SNV 52302

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 — SIGNED — DATE 08/16/18

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

SIGNATURE ON FILE — SIGNED

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] $ CHARGES

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

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.
11 17 17	11 17 17	23	X	99285		ABCD	1295 00	1		NPI	1285898049
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [ ] [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 SIGNATURE ON FILE

000459

02 17 18 431

02 17 18 02 17 18

X

R06.00 J18.1 E87.2 0

02 17 18	02 17 18	23	X	99285		ABC	1360 001	1437398476

88-0262438 X [redacted] X 1360 00 0 00

800-562-2945

LO DO, JOSEPH
SIGNATURE ON FILE
09/25/18

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

FREMONT EMERGENCY SERVICES M
PO BOX 638972
CINCINNATI, OH 45263-8972
1689013161 ZZ207P00000X

PLEASE PRINT OR TYPE

000459

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.
SIGNED SIGNATURE ON FILE DATE 10/04/18

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 08 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 08 DD 11 YY 18 TO MM 08 DD 11 YY 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 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 $ 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. 2220700000X

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WCMS-1500CS-12

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

[redacted]

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 [ ] NO [X] $ 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 DATE

[redacted]ORMATION
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

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

WCMS-1500CS-12

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

PHYSICIAN OR SUPPLIER INFORMATION

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. 2220700000X

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

CARRIER

HEALTH INSURANCE CLAIM FORM

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

[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 11/13/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 11 DD 10 YY 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 MM 11 DD 10 YY 16 TO MM 11 DD 10 YY 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
SIGNATURE ON FILE
SIGNED 11/13/18 DATE

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

33. BILLING PROVIDER INFO & PH. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1366429821 b. ZZ207P00000X

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]

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	

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.)
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

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

CARRIER

HEALTH INSURANCE CLAIM FORM

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

[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 ☒ 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 ☐ ☒

[redacted]

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

28. TOTAL CHARGE $ 1832 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
FERGUSON MD,SCOTT RI
SIGNATURE ON FILE
SIGNED 01/16/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST ROSE DOMINICAN HOSPI
3001 ST ROSE PKWY
HENDERSON,NV 89052-3839
a. 1770626426 b.

33. BILLING PROVIDER INFO & PH. # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI,OH 45263-8972
a. 1689013161 b. ZZ207P00000X

PHYSICIAN OR SUPPLIER INFORMATION

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

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

WCMS-1500CS-12

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

[redacted]

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 01/30/19

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

	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 [X] 88-0262438

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1765 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
CHAN MD, STEPHANIE
SIGNATURE ON FILE
SIGNED 01/30/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION
SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS, NV 89148-4844
a. 1457306359 b.

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. 1679550149 b. ZZ207P00000X

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

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 ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. K85.90 B. R03.0 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	08 18 18	08 18 18	23	X	99285		AB	1360 00	1		NPI	1831518406
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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

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.)
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

PHYSICIAN OR SUPPLIER INFORMATION

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

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 26 18	08 26 18	23	X	99285		AB	1360 00	1		NPI	1588653125
2	08 26 18	08 26 18	23	X	99053		AB	44 00	1		NPI	1588653125
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1404 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SPENCE MD, ROBERT LEW
SIGNATURE ON FILE
SIGNED 01/30/19 DATE

32. SERVICE FACILITY 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 [X] 88-0262438

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 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]

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 52800 PLEASE PRINT OR TYPE MMB 60 COMM NPI FORM

000470

000470

[redacted]

SIERRA HEALTH
PO BOX 15392
LAS VEGAS NV 89114

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 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

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

	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	

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 $ 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 DATE

[redacted]FORMATION
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 5331 44 OUTSOURCED BILLIN

WCMS-1500CS-12

[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 ☒ 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 ☐ ☒

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.)
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

000472

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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 [ ] NO [X] $ 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

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	17	18	10	17	18	23	X	99291		AB	1765 00	1		NPI	1205063286
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER 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 DATE 03/29/19

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

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

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-S3

000474

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

WCMS-1500CS-12

[redacted]

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

HEALTH INSURANCE CLAIM FORM

[redacted]

CARRIER

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 04/02/19
SIGNED ____ DATE ____

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 12 DD 06 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 12 DD 06 YY 18 TO MM 12 DD 06 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. 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	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 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 SOH
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

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

SIERRA HEALTHCARE OPTIONS%\

[redacted]

SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
Attn: Kaiser Claims
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. 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.)
SADESHI MD, NICK
SIGNATURE ON FILE
04/04/19
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SOUTHERN HILLS HOSPITAL
9300 W SUNSET RD
LAS VEGAS, NV 89148-4844
a. 1457306359 b.

33. BILLING PROVIDER INFO & PH # (800)-562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
1679550149 b. ZZ207P00000X

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

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SIERRA HEALTHCARE OPTIONS%

[redacted]

SIERRA HEALTHCARE OPTIONS-NV P
PO BOX 15392
Attn: Kaiser Claims
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. 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 06 DD 02 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 06 DD 02 YY 18 TO MM 06 DD 02 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. 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	

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1765 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
TANG DO, MICHAEL
SIGNATURE ON FILE
SIGNED 04/04/19 DATE

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

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SIERRA HEALTHCARE OPTIONS/

[redacted]

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

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HEALTH INSURANCE CLAIM FORM

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

[redacted]

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SIGNED _____ DATE _____

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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.)
DUNCAN MD, CLARENCE
SIGNATURE ON FILE
SIGNED 04/04/19 DATE

[redacted]

ORMATION
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. ZZ207P000000X

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

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SIERRA HEALTHCARE OPTIONS-NV

[redacted]

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

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HEALTH INSURANCE CLAIM FORM

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

[redacted]

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SIGNED SIGNATURE ON FILE DATE 04/16/19

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SIGNED SIGNATURE ON FILE

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15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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

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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.

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EXHIBIT 8

Article in Nevada Independent

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EXHIBIT 8

SISOLAK SIGNS SURPRISE EMERGENCY ROOM BILLING COMPROMISE, PRE-EXISTING CONDITION PROTECTIONS INTO LAW

MEGAN MESSERLY

MAY 15TH, 2019 - 4:15PM

Two sweeping health-care bills that would prevent patients from getting hit with surprise emergency room bills and protect Nevadans with pre-existing conditions were signed into law by Gov. Steve Sisolak on Wednesday.

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The move brings Sisolak one step closer to fulfilling the health-care agenda he touted on the campaign trail, including standing up to President Donald Trump on protections for people with pre-existing conditions and ending surprise emergency room bills. But it also represents the culmination of years of work — and for surprise billing, decades — on issues Democratic lawmakers had championed at the Legislature but were unable to bring to fruition under a Republican governor.

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"We're taking an important step to make health care more affordable and to address an issue that has plagued Nevada families for far too long," Sisolak said about the surprise billing legislation. "That stops today."

The surprise billing compromise, AB469, is the byproduct of an interim working group tasked by Assembly Speaker Jason Frierson with figuring out how to ensure that patients aren't caught in the middle of a debate between their insurance company and their provider after receiving out-of-network emergency care. The final bill they settled on holds patients harmless by

requiring them to only pay whatever copay, coinsurance or deductible they would have been responsible for at an in-network facility for emergency care.

"This bill represents payers and providers and patient advocates coming together to try to come up with something that works for Nevada," Frierson said. "This was not an easy task, and I think that we all put our noses down and went to work, but I'm proud of what we were able to do."

The legislation, which takes effect on Jan. 1, 2020, also lays out the process by which out-of-network providers, including doctors and hospitals, will be reimbursed by insurers for care provided — a mechanism that has long been the sticking point in the surprise billing debate.

Under the legislation, if a hospital and insurer were recently in network, the insurer would be required to pay 108 or 115 percent of the previously contracted rates, depending on how long they were out of network. If they never had a contract or were out of network for more than two years, the two would be allowed to make initial offers to each other before being required to go to arbitration.

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It's a metric that neither payers nor providers were completely happy with, but that's what, in the end, they agreed made it a good piece of legislation.

"I got to tell you I wasn't sure we'd get it done at the end of the session, and I was proud of the way that we were able to come together," Frierson said.

This isn't the first time lawmakers have successfully passed surprise billing legislation, but it is the first time that a governor has signed it into law. Former Gov Brian Sandoval vetoed a measure in 2017 that would have required payers and payees to agree on a "reasonable" rate for out-of-network services provided or else take the matter ot binding arbitration,

saying it would have forced hospitals to accept below-market rates for out-of-network care.

Assemblywoman Maggie Carlton, who has long worked on the surprise billing issue and sponsored the 2017 measure, thanked patient advocates and industry representatives for all their hours of work on the issue over the years.

"Last session we did get there, but didn't quite make it across the finish line, but this time we did, so I just want to thank everyone for really taking patients out of the middle," said Carlton, choking up during her remarks. "It truly is important."

Sisolak also signed into law on Wednesday AB170, which codifies the Affordable Care Act's protections for pre-existing conditions into state law. The legislation comes as an ongoing lawsuit challenging the Affordable Care Act's constitutionality — including its popular protections for pre-existing conditions — plays out on the federal level.

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Sandoval vetoed a similar proposal in 2017 that would have codified the Affordable Care Act's protections for pre-existing conditions into law on the ground that it would have locked into law "requirements that may be unnecessary, imprudent, or simply unaffordable in the years to come."

But Sisolak touted that the legislation would "take an extra step" in strengthening pre-existing condition protections in federal law.

"From today forward, the 1.2 million Nevadans with pre-existing conditions can rest easy knowing that their health coverage won't be ripped away regardless of the shifting political winds in Washington D.C.," Sisolak said.

The bill, sponsored by Democratic Assemblywoman Ellen Spiegel, also requires health insurance companies to provide the phone number to the

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state Office for Consumer Health Assistance of a case manager, navigator or facilitator who can help connect patients with a covered provider.

"Today is a great day for patients in Nevada," Spiegel said. "This bill is important because if you can't get insurance due to a pre-existing condition or you can't get an appointment with a provider in a timely manner, then you do not have adequate access to health care."

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- *Brian Sandoval - $150*
- *Merritt and Maggie Carlton - $375*
- *Steve Sisolak - $2,200*

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kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

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-JCM-VCF **REPLY IN SUPPORT OF 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") submit this Reply

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in support of its Amended Motion to Remand (ECF No. 49)

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Adjudication of the Amended Motion to Remand is straightforward: rate of payment cases are not completely preempted by ERISA Section 502(a). There is Ninth Circuit precedent binds the Court in this regard, as well as near-uniformity in result from other jurisdictions in cases with the same facts as the case at bar. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 949 (9th Cir. 2009); *see e.g. New Jersey Brain & Spine Ctr. v. United Healthcare Ins. Co.*, No. CV1815631SDWLDW, 2019 WL 6317390, at *5 (D.N.J. Nov. 25, 2019), report and recommendation adopted, No. 18-15631 (SDW) (LDW), 2019 WL 6721652 (D.N.J. Dec. 10, 2019); *Crescent City Surgical Ctr. v. United Healthcare of La., Inc.*, No. CV 19-12586, 2019 WL 6112706, at *1 (E.D. La. Nov. 18, 2019). And this outcome has been reached applying the two-prong test required by *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

II. LEGAL ARGUMENT

A. United's Attempts to Distinguish the Health Care Providers' Cases Must Be Rejected.

To claim the case at bar is ERISA-preempted United makes the unsupported argument that a provider can only maintain a rate of payment action if there is as a written provider agreement, oral agreement, or applicable statute. Opposition at 13:5-10. To reach that conclusion, United ignores the clear mandate of *Marin Gen. Hosp.* and the other legal authority finding rate of payment cases outside the scope of ERISA since they cannot satisfy either of the two-prong test set forth in *Davila*, 542 U.S. at 210. *See also Premier Inpatient Partners LLC v. Aetna Health & Life Ins. Co.*, 371 F. Supp. 3d 1056, 1073 (M.D. Fla. 2019) (the "rate of payment and right of payment distinction is dispositive..."); *Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (noting that ERISA did not preempt the state law claims because "[t]he dispute here is 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."); *Windisch v. Hometown Health Plan, Inc.*, No. 3:08-

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cv-00664-RJC-RAM, 2010 WL 786518, at *5 (D. Nev. Mar. 5, 2010) ("Plaintiff has affirmatively taken the position that he is only challenging Defendants' adjudication and payment of claims that have already been determined to be covered…ERISA does not preempt Plaintiff's claims because they do not require the Court to interpret ERISA plans.").

In support of its quest to bypass these cases and *Davila*, United tries to distinguish *Gulf-To-Bay*, in which it and its affiliate are parties, by arguing that a Florida statute created a legal duty independent of ERISA to pay out-of-network providers at a particular rate – which only concerns the second factor of the *Davila* test. This is an inaccurate reading of *Gulf-to-Bay* because that court did not even consider the second part of the *Davila* test:

> The **first part of the Davila test** is satisfied if two requirements are met: (1) **the plaintiff's claim must fall within the scope of ERISA;** and (2) the plaintiff must have standing to sue under ERISA. As to the first requirement of this part…the Eleventh Circuit has adopted a distinction between two types of claims: claims challenging the "rate of payment" pursuant to a provider-insurer agreement, and those challenging the "right to payment" under the terms of an ERISA beneficiary's plan….The Court finds unavailing UHIC's attempt to recast through an ERISA lens [plaintiff's] entitlement to full payment for services rendered. **Consequently, the Court finds that [plaintiff's] claims fall outside the scope of section 502(a) of ERISA, and no further analysis under *Davila* is necessary.**

Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc., No. 8:18-CV-233-EAK-AAS, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018) (emphasis added) (internal citations omitted). Because the *Gulf-to-Bay* dispute involved rate of payment, the claims did not fall within the scope of ERISA and, therefore, the ***first*** part of the *Davila* test could not be satisfied. There was no discussion about the second factor at all. Like *Gulf-to-Bay*, the Health Care Providers' claims are outside the scope of ERISA and *Davila's* first element is not satisfied.

The Health Care Providers have not asserted any claims relating to benefits that have been denied; their only claims are related to claims that United has already paid. First Amended Complaint ("Am. Compl.") at ¶ 43. Thus, this dispute does not involve any right to payment that could arise under an ERISA plan. It solely involves the rate of payment. *Id.*; *see* Reply in Support of Motion to Remand, Ex. A, Bristow Decl. ¶ 4 (ECF No. 26-1).

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There are numerous cases involving United or its affiliates where courts have rejected the same arguments United forwards here and some of these cases squarely underscore that courts have routinely remanded rate-of-payment cases involving implied-in-fact contracts. *See e.g. Gulf-to-Bay*, 2018 WL 3640405 at *3; *Low-T Physicians Serv., P.L.L.C. v. United Healthcare of Texas, Inc.*, No. 4:18-CV-938-A, 2019 WL 935800, at *2 (N.D. Tex. Feb. 26, 2019); *Sobertec LLC v. UnitedHealth Grp., Inc.,* No. SACV191206JVSMRWX, 2019 WL 4201081, at *4 (C.D. Cal. Sept. 5, 2019) (claims for an implied-in-fact agreement not preempted by ERISA); *New Jersey Brain & Spine Ctr.*, 2019 WL 6317390, at *5; *Bay Area Surgical Mgmt., LLC. v. United Healthcare Ins. Co.*, No. C 12-01421 SI, 2012 WL 3235999, at *4 (N.D. Cal. Aug. 6, 2012) (oral contract and promises between provider and United not preempted by ERISA); *Regents for Univ. of California ex rel. its San Diego Med. Ctr. v. United Healthcare Ins. Co.*, No. 12-CV-0588 BEN BGS, 2012 WL 4471416, at *4 (S.D. Cal. Sept. 25, 2012) (claims including of breach of implied-in-fact contract and unjust enrichment not preempted under ERISA); *Temple Hosp. Corp. v. Gomez, United Healthcare Services, Inc*. No. 2:14-CV-01342-ODW, 2014 WL 953445, at *2 (C.D. Cal. Mar. 11, 2014) (claims of breach of oral contract, promissory estoppel, and implied equitable indemnity not preempted by ERISA); *Ghosh v. Aetna Health of Cal., Inc.*, 2012 WL 4548173 (S.D. Cal. Oct. 2, 2012) (claims based on misappropriations, misrepresentations, and interference in his contractual relationship against, inter alia, United Healthcare of California relating to underpayment of provider claims not preempted by ERISA); *Crescent City Surgical Ctr.*, 2019 WL 6112706 at *1 (claims of breach of contract, violations of the Louisiana Unfair Trade Practices Act, detrimental reliance, fraud, and negligent misrepresentation not preempted by ERISA).

B. Analysis Under Davila's Two Prongs Does Not Trigger Complete Preemption

Contrary to United's claims, the Health Care Providers do not substitute the *Davila* test for the rate of payment vs. right to payment test. Opposition at 11:4-7. Instead, the Health Care Providers note that many "rate of payment" decisions do not perform an extensive analysis of *Davila* because claims involving rate of payment fail to satisfy either prong of the *Davila* test. *See e.g. Premier Inpatient Partners LLC*, 371 F. Supp. 3d at 1073 ("The Eleventh Circuit has instructed that [] 'the 'rate of payment' and 'right of payment' distinction' is dispositive of whether a claimant

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could have brought its claim under ERISA."). Federal courts in other jurisdictions likewise have determined that ERISA does not completely preempt claims based on statutory or other common law rate-payment obligations and two recent decisions involving United underscore this point. *New Jersey Brain & Spine Ctr.*, 2019 WL 6317390 at *5; *Crescent City Surgical Ctr.*, 2019 WL 6112706 at *1; *see also Coast Plaza Doctors Hosp. v. Ark. Blue Cross & Blue Shield*, No. CV 10-6927 DDP (JEMx), 2011 WL 3756052, at *4 (C.D. Cal. Aug. 25, 2011); *Med. & Chirurgical Faculty of Md. v. Aetna U.S. Healthcare, Inc.,* 221 F. Supp. 2d 618, 619 & n.1 (D. Md. 2002*); Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, --- F. Supp. 3d ----, Case No. 16-25193, 2017 WL 6548019, at *5 (S.D. Fla. Apr. 5, 2017) (remanding out-of-network provider's claims for underpayment, breach of implied-in-fact contract and unjust enrichment where plaintiff alleged violation of Florida rate payment statute); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 53 (5th Cir. 2009) ("A claim that implicates the rate of payment as set out in the Provider Agreement, rather than the right to payment under the terms of the benefit plan, does not run afoul of *Davila* and is not preempted by ERISA.").[1]

As is detailed below, the existence of an assignment of benefits is of no consequence here and does not satisfy the first factor of *Davila*. That, alone, mandates that this matter be remanded. Further, United cannot fulfill its burden of establishing the second *Davila* factor because the Health Care Providers' claims are based upon independent statutory and common law duties which courts have repeatedly recognized do not satisfy the second *Davila* factor.

[1] In *New Jersey Brain & Spine Ctr.*, the court remanded a rate-of-payment case where plaintiff's claims were related to the amount of payment received and founded upon implied agreements and representations that allegedly arose in the course of dealings between the parties, and not claims seeking coverage under a given health plan. 2019 WL 6317390 at *5. "Where a plaintiff does not challenge the type, scope or provision of benefits under [an ERISA] healthcare plan, ***any disputes over the amount of reimbursement are not preempted by ERISA***." *Id.* (internal quotations omitted). The "growing trend" in that district is to remand this type of provider reimbursement claim. *Id.* at * 6. In *Crescent City Surgical Ctr.*, like the Health Care Providers here, that plaintiff could have brought derivative claims under an assignment of benefits, but specifically disavowed pursuing ERISA claims assigned by United's insured. Rather, that plaintiff, like here, elected to pursue claims that are solely based on United's breach of its agreement to pay certain amounts, independent of any coverage arrangement that United had with its insured. Both *New Jersey Brain & Spine Ctr.* and *Crescent City Surgical Ctr.* provide further support that rate-of-payment cases are not completely preempted by ERISA.

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1. The First *Davila* Factor[2]

Notwithstanding binding precedent directly on point, United makes the unsupported claim that the mere existence of an assignment of benefits converts a state law claim – not otherwise arising under an ERISA plan – into one that confers standing for purposes of the first *Davila* factor. *See e.g.* Opposition at 7:11-14. This argument must be rejected in light of the *Marin* decision.

The Ninth Circuit has unequivocally held that even when providers receive an assignment of benefits and *could* bring a suit under ERISA, the mere fact of an assignment does not convert a provider's claim into claims to recover benefits under an ERISA plan. *Marin Gen. Hosp.*, 581 F.3d at 949. Thus, so long as a provider's state law claim does not fall within § 502(a) (i.e. denial of payment/coverage, **the existence of the assignment is irrelevant to complete preemption if the provider asserts no claim under the assignment.** *Id.; see also Emergency Services of Zephyrhills, P.A.*, 281 F. Supp. 3d at 1347.

In *Marin Gen. Hosp.*, the Ninth Circuit considered whether the first element of the *Davila* test was satisfied where the provider could have asserted a claim under an assignment of benefits, but chose not to do so. The Ninth Circuit answered in the negative. The Ninth Circuit concluded:

> 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."**
>
> We conclude that the Hospital's state-law claims based on its alleged oral contract with MBAMD 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*.**

581 F.3d at 949 (internal citations omitted). This case forecloses all of United's arguments with

[2] This section addresses United's two separate sections making the same arguments – i.e. that the existence of an assignment of benefits converts state law claims based on independent duties into ERISA claims satisfying the first *Davila* factor. *Compare* Opposition at IV(C) *with* (IV)(D)(1).

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respect to the first *Davila* factor. Because the Health Care Providers do not bring any claims as assignees of benefits, it cannot assert ERISA claims in this action and the first *Davila* factor is not satisfied, requiring remand. *Id.*; *see also Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1347 (11th Cir. 2009) ("so long as the provider's state law claim does not fall within § 502(a), the existence of the assignment is irrelevant to complete preemption if the provider asserts no claim under the assignment.")

The cases cited by United in its Opposition are also inapplicable to the facts of this case. United erroneously argues that *Misic* is a "rate of payment" case in which the Court found that complete preemption applies. Opposition at 12:4-13. Rate of payment cases involve disputes between the provider and insurer based on an independent, implied or express agreement or course of conduct which does not relate to a benefit plan. The *Misic* case does not fall into this category and the Ninth Circuit itself has made clear that *Misic* is not a rate of payment case:

> **It is clear in *Misic* that the provider sought, <u>as an assignee</u>, to recover reimbursement due to his assignors under the terms of the benefit plan**; indeed, the terms of the benefit plan were the provider's only basis for his reimbursement claim… **The dispute here is 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.

Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc., 187 F.3d 1045, 1051 (9th Cir. 1999). There, 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). Here, the Health Care Providers have not asserted any claims as assignees, nor do they seek payment based on any provision of any health plan. *Misic* is not a rate of payment case and is inapposite.

United also tries to prove a negative by arguing that "in some of the cases Plaintiffs cite, complete preemption is not found because defendant fails to satisfy the first element of the *Davila* test due to a failure to bring forth sufficient evidence to demonstrate that an assignment of benefits occurred." Opposition at 13:26-28. The caselaw cited by the Health Care Providers in the Amended Motion to Remand does not support United's argument that where there is an

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assignment of benefits, an assignment always confers standing to bring a claim under ERISA. In fact, the court in *Med. & Chirurgical Faculty of State of Maryland* did not find that there were never any assignments as United suggests; instead, the Court found that, just as is the case here, the providers were not bringing their claims based on an assignment of benefits and therefore such claims could not be preempted. *Med. & Chirurgical Faculty of State of Maryland*, 221 F. Supp. at 621 ("Plaintiffs are asserting in this action an independent statutory right of health care providers to receive payment consistent with the statutory formulas, not the right to any benefits due to plan participants. It is undisputed that these statutory rights are not available to plan participants, and thus, could not be assigned by those participants."). Thus, the Court concluded that the rights asserted in the complaint by the plaintiff were not rights assigned by plan participants. *Id*.

In *California Spine*, the issue of an assignment of benefits was important because the claims raised were the type of claims that could be raised by a plan beneficiary if an assignment of benefits existed. In particular, the claims related to the following allegations:

> Defendant allegedly informed Plaintiff that the Patient had a deductible and a maximum out of pocket limit for healthcare of $6,000, of which $ 0 had been paid. Plaintiff was allegedly promised that Defendant would pay 80% of the UCR rate once the Patient met his or her deductible. Moreover, after the Patient met the maximum out of pocket limit, Plaintiff was allegedly promised that Defendant would pay 100% of the UCR rate.

California Spine & Neurosurgery Inst. v. Bos. Sci. Corp., No. 18-CV-07610-LHK, 2019 WL 1974901, at *1 (N.D. Cal. May 3, 2019) (internal citations omitted). Thus, the amount of payment to the provider was directly related to the plan and if an assignment of benefits existed, the provider would have a claim which squarely falls within ERISA.

The first *Davila* factor is not satisfied only because an assignment of benefits exists when the claims asserted are based on claims arising from an insurer's independent statutory and common law duties. Because United cannot establish the first *Davila* factor, this is dispositive.

2. The Second *Davila* Factor

In an attempt to argue that the second *Davila* factor is satisfied, United asserts the obscure argument that the only way for the second *Davila* factor not to be met would be if certain categories

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of circumstances applied, i.e. the existence of an express written contract, oral representation or statute. This argument ignores the decisions cited by the Health Care Providers which make clear that they are *not* limited to the categories identified by United. Essentially, United is attempting to create its own caselaw on this issue. **To be clear: no caselaw exists which finds that a party in a rate of payment case can avoid preemption *only if* one of the three foregoing categories is satisfied.** Rather, courts across various jurisdictions have repeatedly found that cases involving disputes over the rate of payment rather than the right to payment are not preempted by ERISA and neither of the *Davila* factors can be satisfied. *See e.g. Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (claims not preempted where the dispute is over amount of payment rather than the right to payment)*; Lone Star OB/GYN Assocs.*, 579 F.3d at 53 ("A claim that implicates the rate of payment…does not run afoul of *Davila* and is not preempted by ERISA…we adopt the reasoning of the Third and Ninth Circuits, and that of a majority of district courts in this Circuit which have relied on this distinction between 'rate of payment' and 'right of payment.'"); *Med. & Chirurgical Faculty of State of Maryland*, 221 F. Supp. 2d at 619 ("Courts have, with near unanimity, found that independent state law claims of third party health care providers are not preempted by ERISA.").

United next argues that the existence of an express provider agreement somehow distinguishes certain cases from the case at hand. It does not because an implied-in-fact contract is on equal footing with an express written agreement. *Tucker v. Mayor, etc., of Virginia City*, 4 Nev. 20, 30 (1868) ("defendants are as completely bound by implied as by written contracts."); *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

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manifestation of assent; both types are based upon the expressed or apparent intention of the parties."). This attempt by United to denigrate the legal effect of an implied-in-fact contract is squarely contrary to Nevada law and must be rejected.

In order for United to meet its burden on the second *Davila* factor, it must establish that the claims asserted do not arise from legal duties independent of ERISA. *Davila*, 542 U.S. at 210. In other words, it must prove that the claims asserted are dependent on ERISA. The caselaw cited by the Health Care Providers which involves express provider agreements are examples of independent legal duties of an insurer to pay a certain rate to a provider. These independent legal duties may arise from a variety of circumstances as highlighted in the caselaw cited by the Health Care Providers, including express agreements, oral agreements, statutory duties and implied in law and implied in fact agreements. Simply because a case involves one of the foregoing does not mean the Court limited the second *Davila* factor to that one instance.

In fact, many of the decisions cited by the Health Care Providers do expressly state that claims for breach of implied agreements do not satisfy the second *Davila* factor because these also would be independent legal duties not relying on an ERISA plan. For example, United tries to distinguish *Connecticut State Dental* by arguing that it only concerned an express agreement. Opposition at n. 16. In *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla*, the insurer tried to do the exact same thing as United by arguing "the use of the language "an agreement" [in *Connecticut State Dental*] necessarily means that the test applies only in cases arising from breach of an express provider agreement between an in-network provider and the insurer." 258 F. Supp. 3d 1323, 1329 (S.D. Fla. 2017). The court rejected this argument and explained:

> No part of *Connecticut State Dental* supports the proposition that an express written provider agreement ***must*** be present before the rate-of-payment/right-of-payment test can apply and that, in the absence of a written agreement, any claim for payment must be preempted. In the Court's view, *Connecticut State Dental* leaves the proverbial door sufficiently open that the test could come into play in a case like this one, involving allegations of an implied "agreement"—be it implied-in-fact or implied-in-law—between an out-of-network provider and an insurer.

Id. (emphasis in original). Courts in various jurisdictions have found that implied in fact and implied in law contracts involve independent legal duties such that the second *Davila* factor cannot

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be satisfied. *John Muir Health v. Cement Masons Health & Welfare Tr. Fund for N. California*, 69 F. Supp. 3d 1010, 1018 (N.D. Cal. 2014) (quantum meruit claim "based on an independent legal duty", failing to satisfy *Davila's* second prong); *Galileo Surgery Ctr., L.P. v. Aetna Health & Life Ins. Co.*, No. 2:14-CV-09738-ODW, 2015 WL 898525, at *1 (C.D. Cal. Mar. 3, 2015) (promissory estoppel and unjust enrichment not preempted by ERISA); *Coast Plaza Doctors Hosp.*, 2011 WL 3756052 at *4 (breach of implied in fact contract not preempted); *Med. & Chirurgical Faculty of State of Maryland*, 221 F. Supp. 2d at 619 (conversion and quantum meruit not preempted); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, 281 F. Supp. 3d 1339, 1342 (S.D. Fla. 2017) (breach of implied-in-fact contract and unjust enrichment not preempted); *Orthopaedic Care Specialists, P.L. v. Blue Cross & Blue Shield of Fla., Inc.*, No. 12-81148-CIV, 2013 WL 12095594, at *2 (S.D. Fla. Mar. 5, 2013) (unjust enrichment/quantum meruit not preempted).

Furthermore, while some of these decisions are in states in which statutes require payments at certain rates, this distinction does not change the fact that the Health Care Providers have asserted claims completely independent of an ERISA plan. If United believes that the Health Care Providers lack a statutory or common law basis for bringing its claims, it is free to challenge these claims in state court. However, there is no question that the Health Care Providers claims are based on legal grounds independent of an ERISA plan and, for that reason alone, United cannot meet its burden of establishing that the second *Davila* factor is satisfied. Therefore, the Amended Motion to Remand must be granted.

Next, United contends that *Marin* is different than the case at hand because there are no oral representations alleged here while *Marin* concerned an oral representation. While *Marin* did involve an oral representation that a certain rate of payment would be made, the providers in that case also asserted claims, just as is the case here, for breach of implied contract, quantum meruit and estoppel. 581 F.3d at 943. In asserting its breach of implied contract claim, the provider plaintiff alleged:

> 30. **As a result of the custom and practice in the healthcare field, and prior dealings between the parties Hospital** and defendants understood that, because defendants authorized and made a representations of coverage

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> upon which Hospital reasonably relied, by providing medically necessary services, Hospital would be paid by defendants for such medical services, supplies and equipment provided to patient S.M. at a 10% discount from its total billings.

A true and correct copy of the Amended Complaint filed in *Marin Gen. Hosp.*, Case No. 07-cv-01027-SI, is attached hereto as **Exhibit 1** (emphasis added). This allegation is nearly identical to the allegations here. The Health Care Providers allege:

> 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.

Am. Compl. ¶ 197. The relevant facts of this case are nearly identical to the facts alleged in *Marin* and, just as was the case in *Marin,* this Court cannot find that the legal claims asserted by the Health Care Providers are dependent on ERISA. These claims are completely independent of ERISA and, therefore, the second *Davila* factor cannot be established, necessitating remand.

Finally, United relies heavily on two cases from Florida, both of which predate *Davila,* to rebut the binding *Marin* decision; however, even if *Marin* was not binding precedent, neither of these cases are applicable and United's reliance on these decisions should be rejected. In *In Re Managed Care Litig.*, the court evaluated <u>unpaid</u> claims by non-participating providers' who affirmatively alleged that they sought reimbursement as assignees. *In re Managed Care Litig.,* 298 F. Supp. 2d 1259, 1291 (S.D. Fla. 2003). Thus, the outcome there has no application to the facts before this Court. In *Torrent & Ramos*, an unpublished decision, the court's analysis relied entirely on a test which, since *Davila*, is no longer applicable when addressing complete preemption. *Torrent & Ramos, M.D., P.A. v. Neighborhood Health Partnerships, Inc.*, No. 04-20858-CIV, 2004 WL 7320735, at *2 (S.D. Fla. July 1, 2004) (discussing "superpreemption" under *Butero v. Royal Maccabees*); *see also Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 121 F. Supp. 3d 950, 964 (C.D. Cal. 2015) ("this Court follows and applies the Supreme Court's *Davila* test for complete preemption and, to the extent that the *Butero*

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analysis is inconsistent with *Davila*, it is not controlling."). Thus, none of the authority cited by United supports its tenuous position.

C. United's Other Legal Authority is Either Distinguishable or Irrelevant Because it Concerns Conflict Preemption, Not Complete Preemption

United cites to non-analogous cases in support of its contention that all of the Health Care Providers' claims are preempted,[3] but many of the cases cited turn on whether the claim is conflict preempted, not completely preempted. *Marin Gen. Hosp.*, 581 F.3d at 949. This is misleading because the question of 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). A defense of conflict preemption under § 514(a) does ***not*** provide a basis for federal question jurisdiction under either § 1331(a) or § 1441(a). Therefore the Court can disregard United's attempt to rely on cases that rely on a "relates to" analysis for a defense of conflict preemption.[4]

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[3] United relies on *Parlanti v. MGM Mirage*, No. 2:05-cv-1259-ECR-RJJ, 2006 WL 8442532, at *4 (D. Nev. Feb. 15, 2006) for the proposition that an implied-in-fact contract is completely preempted by ERISA, which is misleading. Opposition at 20:5-7. There, plaintiffs filed a lawsuit in connection with ***rights*** to benefits under a supplemental executive retirement plan ("SERP") given in connection with an employment contract. *Id.* at *1. The *Parlanti* court examined "the thrust" of plaintiffs' claims, determining that the state law causes of action related to allegations that they were entitled to benefits as stated in the SERP and that they were denied those benefits. *Id.* at *4. Next, in *Estate of Burgard v. Bank of Am., N.A.*, No. 2:15-cv-00833-RFB-PAL, 2017 WL 1273869, at *8 (D. Nev. Mar. 31, 2017), plaintiff sought recovery of benefits due under an ERISA plan and to enforce rights under the plan. This is not analogous to this rate of payment case. Nor is *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1077, 864 P.2d 288, 290 (1993) analogous. There, an administrator of a decedent's estate brought suit against an insurance company under various theories of liability (breach of the covenant of good faith and fair dealing, breach of fiduciary duties, common law fraud, and breach of NRS 686A.310) for the alleged failure to pay all benefits under a long term disability policy. The court found conflict preemption existed, not complete preemption. And *Hill v. Opus Corp.*, 841 F. Supp. 2d 1070, 1085 (C.D. Cal. 2011) is different because plaintiffs' state law claims sought return of benefits purportedly due under the ERISA plan at issue there related to compensation and deferred compensation. In *Thrall v. Prudential Ins. Co. of Am.*, No. CV-N-050067-HDM-RAM, 2005 WL 8161321, at *1 (D. Nev. Aug. 11, 2005), a beneficiary of a decedent's accounts, retirement plans, and life insurance policies filed a lawsuit against defendants for failing to transfer the decedent's accounts, retirement plans, and life insurance policies to plaintiff. *Id.* The *Thrall* court found the beneficiaries' claims preempted because the claims asserted were for rights to benefits. Next, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001) is a right to benefits case because it involved claims stemming from defendants' alleged failure to provide benefits due under an ERISA plan.

[4] *See e.g. Schoedinger v. United Healthcare of Midwest, Inc.*, 557 F.3d 872, 875 (8th Cir. 2009) (court dismissed claims for violation of prompt pay statutes based on conflict preemption under §

III. COSTS AND FEES

Should the Court grant this Motion, it should also 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). 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.

IV. 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 attorneys' fees pursuant to 28 U.S.C. § 1447(c).

DATED this 5th day of February, 2020.

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514(a)); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F. Supp. 2d 901, 938 (M.D. Tenn. 2013), (court found conflict preemption, while noting that "[o]ther courts have found that particular prompt pay act claims are not preempted by ERISA under certain circumstances, typically where a provider sues pursuant to a separate contractual agreement with the insurer, not pursuant to a patient assignment."); *Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1334 (11th Cir. 2014) (prompt pay statutes were preempted by ERISA § 514, not § 502(a)).

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 5th day of February, 2020, I caused a true and correct copy of the foregoing **REPLY IN SUPPORT OF 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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