Case Nos. 85525 & 85656

In the Supreme Court of Nevada

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

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

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

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

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

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

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

CERTIFICATE OF SERVICE

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

Electronic notification will be sent to the following:

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Kristen T. Gallagher
Amanda M. Perach
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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

Respondent (case no. 85656)

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

EXHIBIT 1

May 9, 2019 Email

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.

012502

012502

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.

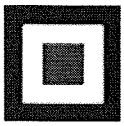
Pat, Kristen, Amanda,

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



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012503

012503

012503

EXHIBIT 2

UHIC, UHS and UMR Declaration

012504

012504

EXHIBIT 2

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

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation,

Plaintiff,

vs.

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

Defendants.

Case No.: 2:19-cv-00832

DECLARATION OF JANE STALINSKI IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND

012505

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,

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

EXHIBIT 3

Oxford Declaration

EXHIBIT 3

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

012509

012509

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

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

EXHIBIT 4

SHO Declaration

EXHIBIT 4

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

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation,

Plaintiff,

vs.

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

Defendants.

Case No.: 2:19-cv-00832

DECLARATION OF SHAWNA REED IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND

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).

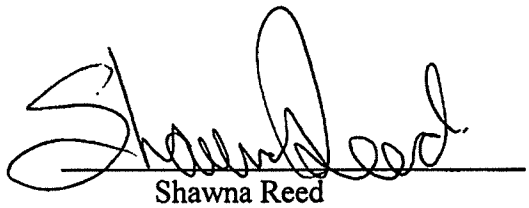
29 U.S.C. § 1002.

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.

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

EXHIBIT 5

SHL and HPN Declaration

EXHIBIT 5

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

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation,

Plaintiff,

vs.

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

Defendants.

Case No.: 2:19-cv-00832

DECLARATION OF ELLEN SINCLAIR IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND

012517

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

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

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

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

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

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

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

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

29 U.S.C. § 1002.

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

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

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

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

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

DATED this 20 day of June, 2019.

Ellen Sinclair

Ellen Sinclair

EXHIBIT 6

Sample Claim Forms for Fremont Claims to UMR

EXHIBIT 6

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

8. RESERVED FOR NUCC USE

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

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

c. OTHER ACCIDENT? ☒ YES ☐ NO

10d. CLAIM CODES(Designated by NUCC)

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

012521

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 TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A. S161XXA	B. M5412	C. R030	D. X58XXXA
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. 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: 880262438 ☐ ☒

26. PATIENT ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT ☒ 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 : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

5. RESERVED FOR NUCC USE

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. CLAIM CODES(Designated by NUCC)

[redacted]

b. OTHER CLAIM ID(Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/02/17

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

012522

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? YES NO $ CHARGES

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

A.	B.	C.	D.
S098XXA	S0083XA	F10129	W228XXA
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE: 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 07 02 17	07 02 17	23		99285		A,B,C,D	1,295 00	1			1063462364
2											
3											
4											
5											
6											

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

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

LOVINGER, AARON
1063462364
207P00000X
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FREMONT EMERGENCY SERVICES MAN
3186 S MARYLAND PKWY

LASVEGAS,NV 89109-2317

a. b.

33. BILLING PROVIDER INFO & PH #

FREMONT EMERGENCY SERVICES MAN
PO BOX 638972

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

a. 1518120971 b.

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

[redacted]

8. RESERVED FOR NUCC USE

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/03/17

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

012523

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. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 505 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 #
LEONG, JOEANN 1104011527 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LASVEGAS,NV 89128-0436 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a 1366429821 b.

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

9. 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

012524

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

A.	B.	C.	D.
R42	R55	E860	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. ID. 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 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)

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

PICA

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/09/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012525

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HI=		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R1031 B. N200 C. N3001 D. R112 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	07 09 17	07 09 17	23		99285		A,B,C,D	1,295 00	1			1558317354
2												
3												
4												
5												
6												

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

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

Submitter : COBA (MEDICARE COBA MEDICAL)

1500

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

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 ☒ (ID#)

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012526

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

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

A. J189 B. A419 C. R0902 D. I10
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 07 10 17 07 10 17	23		99291	DESC: CRITICAL CARE FIRST HOUR - 99291	A,B,C,D	1,681 00	1			1023391026
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ ☒	[redacted]	☒ YES ☐ NO	$ 1,681 00	$	

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012527

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

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

A. R0789	B. R0600	C. R042	D. R918
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL.	J. RENDERING PROVIDER I.D. #
1 07 12 17	07 12 17	23		99285		A,B,C,D	1,295 00	1			1114286077
2											
3											
4											
5											
6											

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

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

NUCC Instruction Manual at: www.nucc.org

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

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/15/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012528

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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X YES NO	$ 1,295 00	$	

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

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

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

[redacted]

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

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

012529

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R1084 B. K529 C. D72829 D. R030 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 ☐ ☒	26. PATIENT ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT ☒ 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.		

Submitter : 201736437 (FIRST HEALTH/CCN ROUTED 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 (ID#)
						X

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/29/17

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

012530

012530

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
07 29 17 QUAL.	QUAL.	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. S0502XA B. R030 C. W228XXA D. E. F. G. H. I. J.		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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X YES NO	$ 463 00	$	

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

NUCC Instruction Manual at: www.nucc.org

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

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

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 (ID#)
						X

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 08/14/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012531

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. M5412 B. R030 C. F419 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	08 14 17	08 14 17	23		99283		A,B,C	463 00	1			1619979028
2												
3												
4												
5												
6												

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

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

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

[redacted]

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

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

012532

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

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

A. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ ☒	[redacted]	☒ YES ☐ NO	$ 64 00	$	

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

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 11/10/17

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012533 012533

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. 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 SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ ☒	[redacted]	☒ YES ☐ NO	$ 883 00	$	

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

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

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012534

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. 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. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 11 11 17 11 11 17	23		99285		A,B,C,D	1,295 00	1			1285898049
2										
3										
4										
5										
6										

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

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

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

[redacted]

ZIP CODE	TELEPHONE (Include Area Code)
79119	

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

[redacted]

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012535

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE MM DD YY QUAL.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0	
A. O200 B. O2341 C. R102 D. Z3A01	
E. F. G. H.	
I. J. K. L.	

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
20. OUTSIDE LAB? ☐ YES ☐ NO	$ CHARGES
22. RESUBMISSION CODE 1	ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER	

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	12 08 17	12 08 17	23		99284		A,B,C,D	883 00	1			1720375322
2												
3												
4												
5												
6												

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

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

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 (ID#)
						X [redacted]

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 01/01/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012536

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

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

A. N390 B. R030 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 01 01 18 01 01 18	23		99283		A,B	463 00	1			1578786877
2										
3										
4										
5										
6										

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

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

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

PICA

[redacted]

ZIP CODE: 89108
TELEPHONE (Include Area Code):

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):
10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER:
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY: 08 27 74 SEX: M F X
b. RESERVED FOR NUCC USE:
b. AUTO ACCIDENT? YES NO PLACE (State):
b. OTHER CLAIM ID(Designated by NUCC):
c. RESERVED FOR NUCC USE:
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:
10d. CLAIM CODES(Designated by NUCC):
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO if yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 01/04/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012537

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

A. R102 B. N83201 C. R030 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: 1 ORIGINAL REF. NO.:
23. PRIOR AUTHORIZATION NUMBER:

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 01 04 18	01 04 18	23		99285		A,B,C	1,360 00	1			1720375322
2											
3											
4											
5											
6											

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

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

[redacted]

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

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

012538

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HAL=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. K625 B. K8590 C. I10 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24.A DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	01 08 18	01 08 18	23		99284		A,B,C	927 00	1			1073933057
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ ☒	[redacted]	☒ 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.) 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.

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

012539

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

	24 A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	01 16 18 01 16 18	23		99285		A,B,C	1,360 00	1			1326294844
2											
3											
4											
5											
6											

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

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

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

Submitter : 383384800 (HOVS MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012540

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

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 01 19 18	01 19 18	23		99285		A,B,C,D	1,360 00	1			1518387885
2											
3											
4											
5											
6											

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
NUSSBAUM, CHRISTIN 1518387885 SIGNED DATE	MOUNTAINVIEW HOSPITAL 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. 1104870187 b.	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

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

[redacted]

PICA

[redacted]

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

c. OTHER ACCIDENT? [ ] YES [ ] NO

10d. CLAIM CODES(Designated by NUCC)

a. INSURED'S DATE OF BIRTH MM DD YY SEX [ ] M [ ] F

b. OTHER CLAIM ID(Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 01/24/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012541

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Referral#= REF= H/L=

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

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

A. R0789 B. I10 C. R05 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	01 24 18	01 24 18	23		99285		A,B,C	1,360 00	1			1548425259
2												
3												
4												
5												
6												

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 01/26/18

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

012542

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
01 26 18 QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 929 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 #
NEVAREZ, CHRISTOPHER 1972690592 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LASVEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

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)	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 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

012543

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

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

A. R1011 B. K8050 C. E6601 D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 02 22 18 02 22 18	23		99285		A,B,C	1,360 00	1			1558317354
2										
3										
4										
5										
6										

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

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

Submitter : COBA (MEDICARE COBA MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 03/23/18

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

012544

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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,360 00	$	

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

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

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

012545

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

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

A. F10129	B. R4182	C. R739	D.
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 03 31 18 03 31 18	23		99285		A,B,C	1,360 00	1			1063462364
2 03 31 18 03 31 18	23		99053		A,B,C	44 00	1			1063462364
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X YES NO	$ 1,404 00	$	

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

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 (ID#)
						X

[redacted]

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 04/26/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012546

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

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

A. K0889 B. K047 C. L03211 D. R030
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 04 26 18	04 26 18	23		99284	25	A,B,C,D	927 00	1			1558599050
2 04 26 18	04 26 18	23		40800		B	1,029 00	1			1558599050
3											
4											
5											
6											

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

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

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 (ID#)
						X [redacted]

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 05/16/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY	15. OTHER DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
05 16 18 QUAL.	QUAL.	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X YES NO	$ 927 00	$	

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 06/07/18

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

SIGNED AUTHORIZED SIGNATURE ON FILE

012548

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06 07 18 QUAL.		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0		22. RESUBMISSION CODE 1 ORIGINAL REF. NO.
A. S80211A B. S80212A C. M542 D. R1011		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H. I. J. K. L.		

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1	06 07 18	06 07 18	23		99284	SA	A,B,C,D	927 00	1			1255799227
2												
3												
4												
5												
6												

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

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

PICA

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below.
SIGNED AUTHORIZED SIGNATURE ON FILE DATE 07/15/18

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

012549

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

	24.A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER I.D. #
1	07 15 18	07 15 18	23		99285	25	A,B,C,D	1,360 00	1			1790787497
2	07 15 18	07 15 18	23		12002		B	443 00	1			1790787497
3												
4												
5												
6												

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

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

PICA

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012550

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

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

A. R1031	B. E860	C. N390	D.
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 07 25 18	07 25 18	23		99284		A,B,C	927 00	1			1013357102
2											
3											
4											
5											
6											

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

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

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

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012551

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 EIN X	[redacted]	X YES NO	$ 1,353 00	$	

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

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 [X] (ID#)

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012552

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HRI=		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. ID. QUAL	J. RENDERING PROVIDER I.D. #
1	01 02 19 / 01 02 19	23		99283		A,B	486 00	1			1336574250
2	01 02 19 / 01 02 19	23		99053		A,B	44 00	1			1336574250
3											
4											
5											
6											

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

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

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 611358935 (ZIRMED 837 MEDICAL VIA OPTUMINSIGHT)

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

PICA

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 01/12/19

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

012553

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

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

A. R509	B. J09X2	C. J3489	D.
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE	ORIGINAL REF. NO.
1	

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 01 12 19	01 12 19	23		99284		A,B,C	927 00	1			1508055765
2											
3											
4											
5											
6											

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

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

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Submitter : COBA (MEDICARE COBA MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012554

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

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

A. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 ☐ X	[redacted]	X YES ☐ NO	$ 1,360 00	$	

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

PICA

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 02/25/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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

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

A. R569 B. R4182 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1 02 25 19 02 25 19	23		99285		A,B	1,360 00	1			1104087287
2										
3										
4										
5										
6										

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

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

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

 Submitter : 752297429-10036 (UHC 837 MEDICAL)

012555

012555 012555

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 03/04/19

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

012556

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

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

A. 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. ID. QUAL	J. RENDERING PROVIDER I.D. #
1	03 04 19	03 04 19	23		99285		A,B,C	1,360 00	1			1235431388
2												
3												
4												
5												
6												

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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
GOMEZ, ADRIAN 1235431388 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

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 (ID#)
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[X]

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 03/05/19

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

012557

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

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

A. K5900	B. R339	C. N390	D.
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1 03 05 19	03 05 19	23		99285		A,B,C	1,360 00	1			1548425259
2											
3											
4											
5											
6											

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

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

NUCC Instruction Manual at: www.nucc.org

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

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

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
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 03/06/19

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

012558

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= HA=		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. R1011 B. R1013 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER I.D. #
1	03 06 19	03 06 19	23		99285		A,B	1,360 00	1			1972505675
2												
3												
4												
5												
6												

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

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

NUCC Instruction Manual at: www.nucc.org

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

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

012558

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

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

[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S DATE OF BIRTH MM DD YY / SEX
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	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

012559

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

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

A. R1013 B. K529 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE 1 ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24.A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	03 09 19	03 09 19	23		99285		A,B	1,295 00	1			1366865206
2	03 09 19	03 09 19	23		99053		A,B	42 00	1			1366865206
3												
4												
5												
6												

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

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 03/11/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Referral#= REF= H/L=		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 0 A. M25562 B. M25462 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 [ ] [X]	[redacted]	[X] YES [ ] NO	$ 484 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
MACEDO, MARK 1114286077 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 7207 ALIANTE PKWY NORTH LAS VEGAS,NV 89084-2373 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1316488141 b.

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

Submitter : 752297429-10036 (UHC 837 MEDICAL)

Submitter : 133068979 (PHCS ROUTED 837 MEDICAL)

1500

Claim TPA ID : [redacted]
Claim Total : $1,428.00

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 03/18/19

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

012561

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

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

A. 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	26. PATIENT ACCOUNT NO	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	[redacted]	X YES NO	$ 1,428 00	$	

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

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 : $1,474.00

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 03/19/19

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

012562

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

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

A. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438	[redacted]	X YES NO	$ 1,474 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
WALKER, JAMES 1851592497 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3186 S MARYLAND PKWY LAS VEGAS,NV 89109-2317 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1518120971 b.

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 : $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:	
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 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. H6691 B. B974 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE 1 ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24 A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. I.D. QUAL	J. RENDERING PROVIDER I.D. #
1	03 24 19	03 24 19	23		99284		A,B	964 00	1			1578786877
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN 880262438 [ ] [X]	26. PATIENT ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT [X] YES [ ] NO	28. TOTAL CHARGE $ 964 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 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)

1500

Claim TPA ID : [redacted]
Claim Total : $1,853.00

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

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

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

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 03/28/19

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

SIGNED AUTHORIZED SIGNATURE ON FILE

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

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

A. K5900	B. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X YES NO	$ 1,853 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
CHANG, WILLIS 1609253103 207P00000X SIGNED DATE	FREMONT EMERGENCY SERVICES MAN 3100 N TENAYA WAY LAS VEGAS,NV 89128-0436 a. b.	FREMONT EMERGENCY SERVICES MAN PO BOX 638972 CINCINNATI,OH 45263-8972 (888) 952-6772 a. 1366429821 b.

Submitter : 752297429-10036 (UHC 837 MEDICAL)

1500

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

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

PICA

[redacted]

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING FORM.

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

SIGNED AUTHORIZED SIGNATURE ON FILE DATE 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

012565

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

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

A. 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. ID. 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	26. PATIENT ACCOUNT NO.	27. ACCEPT ASSIGNMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
880262438 X	[redacted]	X YES NO	$ 927 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
RAY, ROBERT 1790981462 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)

012565

EXHIBIT 7

Sample Claim Forms for SHO

EXHIBIT 7

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

HEALTH INSURANCE CLAIM FORM

[redacted]

8/1/13

[redacted]

[redacted]

SIGNATURE ON FILE 12/28/17

SIGNATURE ON FILE

08 26 17 431

08 26 17 TO 08 26 17

R03.0

DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	ID. QUAL	RENDERING PROVIDER ID #
08 26 17	08 26 17	23	X	99285		A	1295 00	1	NPI	1336574250
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

88-0262438 X

[redacted]

1295 00 0 00

(800)562-2945

WRIGHT DO,BROOKS
SIGNATURE ON FILE
12/28/17

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

SRS 5231

44 OUTSOURCED BILLIN

012567

SIERRA HEALTHCARE OPTIONS%\

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNATURE ON FILE DATE 01/02/18

SIGNED SIGNATURE ON FILE

01 14 17 431

IS OTHER DATE MM DD YY

17a.

17b. NPI

FROM 01 14 17 TO 01 14 17

I21.3

ICD Ind 0

DATE(S) OF SERVICE From MM DD YY	To MM DD YY	PLACE OF SERVICE	EMG	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
01 14 17	01 14 17	23	X	99291		A	1601 00	1			1104168293

218.00

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

800-562-2945

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

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

MOA 5230 PLEASE PRINT OR TYPE SZR 60 COMMNPI FORM

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

HEALTH INSURANCE CLAIM FORM

PICA

[redacted]

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNATURE ON FILE 01/08/18
DATE
SIGNATURE ON FILE
SIGNED

05 14 17 431
OTHER DATE QUAL MM DD YY
PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17a. NPI
HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 05 14 17 TO 05 14 17
OUTSIDE LAB? YES [X] NO $ CHARGES

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.
RESUBMISSION CODE ORIGINAL REF. NO.
PRIOR AUTHORIZATION NUMBER

24A DATE(S) OF SERVICE From To	PLACE OF SERVICE	EMG	24B PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	24C DIAGNOSIS POINTER	24D $ CHARGES	24E DAYS OR UNITS	24F EPSDT Family Plan	24G ID QUAL	24H 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	0	A	40	001		NPI	1366766099
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 88-0262438 [X]
26. PATIENT'S ACCOUNT NO.: [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE $ 1273 00
29. AMOUNT PAID $ 0 00
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
TRUAX DO,GREG FERMIN
SIGNATURE ON FILE
01/08/18

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

SIE 52601

PHYSICIAN OR SUPPLIER INFORMATION

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

012569

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

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — DATE 01/18/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 15 17 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM 08 15 17 TO 08 15 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 08 15 17	08 15 17	23	X	99285		A	1295 001			NPI	1629294004
2 08 15 17	08 15 17	23	X	93010	223.00	A	64 001			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
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

PLEASE PRINT OR TYPE

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

012570

012571

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

[redacted]

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 01/19/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 19 17 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 19 17 TO 08 19 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. R55 B. N93.9 C. R00.0 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 19 17	08 19 17	23	X	99291	22.00	ABC	1681	001		NPI	1740625946
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.)
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

012571

012572

SUNRISE HEALTH SOLUTIONS
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 01/25/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 18 17 QUAL: 431

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM: 07 18 17 TO: 07 18 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ 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	99.00	ABC	1295 00	1		NPI	CJ264Z 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

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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]

PICA — CARRIER — PATIENT AND INSURED INFORMATION

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

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

15. OTHER DATE QUAL. MM DD YY

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) — ICD Ind. 0
A. I48.3 B. I50.9 C. R79.89 D. F17.200
E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 22 17	11 22 17	23	X	99291	25	ABCD	1681	001		NPI	1366555708
2 11 22 17	11 22 17	23	X	92960		A	925	001		NPI	1366555708
3 11 22 17	11 22 17	23	X	93010		A	256	004		NPI	1366555708
4 11 22 17	11 22 17	23	X	99152		A	93	001		NPI	1366555708
5										NPI	
6										NPI	

983.00

25. FEDERAL TAX I.D. NUMBER: 88-0262438 — SSN EIN: ☐ X
26. PATIENT'S ACCOUNT NO.: [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO
28. TOTAL CHARGE: $ 2955 00
29. AMOUNT PAID: $ 0 00
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
PENDLETON MD,DANIEL
SIGNATURE ON FILE
01/26/18
SIGNED DATE
SRD 52600

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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WCMS 1500CS 12

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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.

SIGNATURE ON FILE — DATE 02/01/18

SIGNATURE ON FILE — SIGNED

08 06 17 — QUAL 431

I47.2 R00.2

DATE(S) OF SERVICE From MM DD YY	To MM DD YY	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID QUAL	RENDERING PROVIDER ID #
08 06 17	08 06 17	23	X	99285	220.00	AB	1295	001			1063462364
08 06 17	08 06 17	23	X	99053	0	AB	42	001			1063462364

88-0262438 X — PATIENT'S ACCOUNT NO. [redacted] — 27. ACCEPT ASSIGNMENT? X YES NO

28. TOTAL CHARGE $ 1337 00 — 29. AMOUNT PAID $ 0 00

LOVINGER MD,AARON VI
SIGNATURE ON FILE
02/01/18

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

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

SRS 5231

PLEASE PRINT OR TYPE

APPROVED BY NUCC 02/12

4 PROUTSOURCED BILLIN

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

HEALTH INSURANCE CLAIM FORM

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

PICA

[redacted]

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 02/22/18
SIGNED DATE

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
09 29 17 QUAL 431

15. OTHER DATE MM DD YY QUAL

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A I21.3 B I10 C D
E F G H
I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 29 17	09 29 17	23	X	99291		AB	1681 00	1		NPI	1285898049
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

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

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

28. TOTAL CHARGE $ 1681 00 29. AMOUNT PAID $ 0 00 30. 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 02/22/18 DATE

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

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

SRS 5231

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WCMS-1500CS-12

PHYSICIAN OR SUPPLIER INFORMATION

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

HEALTH INSURANCE CLAIM FORM

CARRIER

[redacted]

SIGNATURE ON FILE 02/26/18	SIGNATURE ON FILE
12 28 17 431	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 28 17 TO 12 28 17
	OUTSIDE LAB? NO X $ CHARGES
R07.89 R51 R94.31 0	RESUBMISSION CODE ORIGINAL REF NO
	PRIOR AUTHORIZATION NUMBER

	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	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 28 17	12 28 17	23	X	99284		ABC	927 00	1		NPI	1649569583
2	12 28 17	12 28 17	23	X	99053		ABC	44 00	1		NPI	1649569583
3											NPI	
4											NPI	
5											NPI	
6											NPI	

88-0262438	X	[redacted]	X YES NO	971 00	0 00

MARTIN DO,JARED T SIGNATURE ON FILE 02/26/18	SUNRISE HOSPITAL AND ME 3186 S MARYLAND PKWY LAS VEGAS,NV 89109-2317 1861439952	(800)562-2945 FREMONT EMERGENCY SERVICES MA PO BOX 638972 CINCINNATI,OH 45263-8972 1518120971 ZZ207P00000X

SRS 52311 PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 (02-12)

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

HEALTH INSURANCE CLAIM FORM

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

CARRIER

[redacted]

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 03/06/18
SIGNED DATE

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
12 16 17 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 12 16 17 TO 12 16 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. R53.1 B. I63.9 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
12 16 17	12 16 17	23	X	99285		AB	1360 00	1		NPI	1003869504
12 16 17	12 16 17	23	X	93010		A	67 00	1		NPI	1003869504
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO.
[redacted]

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

28. TOTAL CHARGE $ 1427 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

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

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WCMS-1500CS-12

SIERRA HEALTHCARE OPTIONS%

[redacted]

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

HEALTH INSURANCE CLAIM FORM

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED SIGNATURE ON FILE DATE 04/19/18

SIGNED SIGNATURE ON FILE

08 17 17 QUAL 431

08 17 17 08 17 17

A. I21.3 B. G51.0 C. I16.0 D.

24A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
08 17 17	08 17 17	23	X	99291		ABC	1681 001				1972505675

88-0262438 X [redacted] X YES NO $ 1681 00 0 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) I certify that the statements on the reverse apply to the bill and are made a part thereof.)
DUNAGAN MD, CLARENCE
SIGNED SIGNATURE ON FILE 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

MOA 5200 PLEASE PRINT OR TYPE CKK 60 COMM NPI FORM

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[redacted]

KAISER PPO
PO BOX 14392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

PICA

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 04/30/18
SIGNED _____ DATE _____

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 13 18 QUAL. 431

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____

17b. NPI _____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 13 18 TO 04 13 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ 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 SSN EIN ☐ ☒ 88-0262438

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1809 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
TANG DO,MICHAEL
SIGNATURE ON FILE
04/30/18
SIGNED DATE

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

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

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WCMS-1500CS-12

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[redacted]

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

HEALTH INSURANCE CLAIM FORM

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

PICA

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06/05/18

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

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. M46.1 B. A41.9 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1681 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

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

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

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

SECOND FOLD

FIRST FOLD WHCF-1500 (02-12) ENV:SS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

WCMS-1500CS-12

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[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 06/12/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 19 17 QUAL: 431

15. OTHER DATE QUAL: MM DD YY

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

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

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 19 17 TO 11 19 17

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. I46.9 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 19 17	11 19 17	23	X	99291	25	A	1681 00	1		NPI	1508055765
11 19 17	11 19 17	23	X	31500		A	1022 00	1		NPI	1508055765
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]
26. PATIENT'S ACCOUNT NO.: [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE $ 2703 00
29. AMOUNT PAID $ 0 00
30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
RUSHTON MD,JOHN MATT
SIGNATURE ON FILE
SIGNED 06/12/18

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

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

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

SRS 5231 44 OUTSOURCED BILLIN

WCMS-1500CS-12

012581

012582

[redacted]

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

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

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

15. OTHER DATE QUAL MM DD YY

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. J96.90 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06 05 18	06 05 18	23	X	99291		A	1765 00	1		NPI	1194131854
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 [X]
26. PATIENT'S ACCOUNT NO. [redacted]
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE $ 1765 00
29. AMOUNT PAID $ 0 00
30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
LIN MD,CHARLES
SIGNED SIGNATURE ON FILE 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 (NUCC) 02/12

WCMS-1500CS-12

[redacted]

KAISER
POB 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

[redacted]

PICA | CARRIER

PATIENT AND INSURED INFORMATION

012583

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 08/10/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 09 18 QUAL: 431

15. OTHER DATE QUAL: MM DD YY:

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] 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	RENDERING PROVIDER ID. #
02	09	18	02	09	18	23	X	99285		AB	1360	001		NP	1114212743
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	

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

26. PATIENT'S ACCOUNT NO.: [redacted]

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

012583

NSN 0-23-02 Instructions manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED BY NUCC 02/12

WCMS-1500CS-12

012584

[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

012584

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 08/16/18

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
11 17 17 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY 11 17 17

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO

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

A. S09.8XXA B. S03.2XXA C. S00.83XA D. Y93.89
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.
11 17 17	11 17 17	23	X	99285		ABCD	1295 00	1			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. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
I certify that the statements on the reverse apply to this bill and are made a part thereof.
CRAVEN MD,IAN ANDREW
SIGNATURE ON FILE
SIGNED 08/16/18

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

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

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197

SRS 5231 4 OUTSOURCED BILLIN

WCMS-1500CS-12

012584

012585

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

HEALTH INSURANCE CLAIM FORM

[redacted]

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

02 17 18 431 02 17 18 02 17 18

X

0

R06.00 J18.1 E87.2

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

SRD 52600 PLEASE PRINT OR TYPE DAA

012585

KAISER
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

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

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 11 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A. R17 B. E87.1 C. R74.0 D. D72.829
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 08 11 18	08 11 18	23	X	99285		ABCD	1360 00	1		NPI	1437398476
2 08 11 18	08 11 18	23	X	93010		B	67 00	1		NPI	1437398476
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

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. 22207P00000X

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

WCMS-1500CS-12

012587

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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. K57.92 B. R03.0 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	22	18	04	22	18	23	X	99285		AB	1360 00	1		NPI 1619979028
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

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

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

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

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

WCMS-1500CS-12

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

PHYSICIAN OR SUPPLIER INFORMATION

012588

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 DD YY: 07 13 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [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 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 10/26/18 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 22207P000000X

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

WCMS-1500CS-12

012588

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

HEALTH INSURANCE CLAIM FORM

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

[redacted]

PICA

CARRIER

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 11/13/18

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 11 10 16 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 10 16 TO 11 10 16

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

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

A. I20.8 B. R00.2 C. E11.65 D. I99.8
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	10	16	11	10	16	23	X	99285		ABCD	1233 00	1		NPI 1760458053
2	11	10	16	11	10	16	23	X	99053		ABCD	40 00	1		NPI 1760458053
3															NPI
4															NPI
5															NPI
6															NPI

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 $ 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

012590

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 DD YY: 07 29 18 QUAL. 431

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

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

A. S72.012A B. W01.0XXA C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 29 18	07 29 18	23	X	99285		AB	1360 00	1		NPI	1194131854
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

[redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
LIN MD,CHARLES
SIGNED SIGNATURE ON FILE DATE 12/27/18

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. 2Z207P00000X

PHYSICIAN OR SUPPLIER INFORMATION

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

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

WCMS-1500CS-12

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[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

012591

012591 WHCF-10-ENV / WHCF-10-ENV-SS

FIRST 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 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 DD YY: 03 29 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 03 29 18 TO 03 29 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. I61.9 B. I10 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 29 18	03 29 18	23	X	99291		AB	1765 00	1		NPI	1023138245
2 03 29 18	03 29 18	23	X	93010		B	67 00	1		NPI	1023138245
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

[redacted]

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

28. TOTAL CHARGE $ 1832 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC use

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

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

WCMS-1500CS-12

012591

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

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

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

A. I48.91 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 03 18	10 03 18	23	X	99291		A	1765 00			NPI	1548425259
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.

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

28. TOTAL CHARGE $ 1765 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

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

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

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

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

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[redacted]

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

HEALTH INSURANCE CLAIM FORM

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

PICA

[redacted]

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 01/30/19

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 18 18 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. K85.90 B. R03.0 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

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

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

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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

012593

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012593

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

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE GMS APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 FORM 1500 (02-12)

012593

012594

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

012594

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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 26 18 TO 08 26 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. S72.012A B. W07.XXXA C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

PHYSICIAN OR SUPPLIER INFORMATION

012594

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

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

012594

012595

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

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 01/30/19
SIGNED _____ DATE _____

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 11 24 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____

17b. NPI _____

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 24 18 TO 11 24 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

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

A. I69.320 B. I69.351 C. _____ D. _____
E. _____ F. _____ G. _____ H. _____
I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER _____

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 11 24 18	11 24 18	23	X	99285		AB	1360 00	1		NPI	1962883280
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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.)
GRUNSETH MD, AARON
SIGNATURE ON FILE
SIGNED 01/30/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION
SUNRISE HOSPITAL AND ME
3186 S MARYLAND PKWY
LAS VEGAS, NV 89109-2317
a. f1861439952 b.

33. BILLING PROVIDER INFO & PH # (800)562-2945
FREMONT EMERGENCY SERVICES MA
PO BOX 638972
CINCINNATI, OH 45263-8972
a. f1518120971 b. ZZ207P00000X

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

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KAISER
PO BOX 15392
LAS VEGAS NV 89114

HEALTH INSURANCE CLAIM FORM

[redacted]

012596

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 ZZ207P000000X

SRD 52600 PLEASE PRINT OR TYPE MMIS 60 COMM NPI FORM

012596

012597

SIERRA HEALTH
PO BOX 15392
LAS VEGAS NV 89114

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 02/21/19

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 26 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 26 18 TO 10 26 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. I61.9 B. R03.0 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 26 18	10 26 18	23	X	99291	25	AB	1765 00	1		NPI	1932529609
2 10 26 18	10 26 18	23	X	31500		A	1073 00	1		NPI	1932529609
3 10 26 18	10 26 18	23	X	99053		AB	44 00	1		NPI	1932529609
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO. [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

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

WCMS-1500CS-12

4F OUTSOURCED BILLIN

012597

012598

[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]

PICA

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ 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
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

PHYSICIAN OR SUPPLIER INFORMATION

FIRST FOLD WHCF-10-ENV-WCF-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

012598

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[redacted]

KAISER
POB 15392
LAS VEGAS NV 89114

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

payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE
SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 17 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

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

A. I48.91 B. F10.129 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 17 18	10 17 18	23	X	99291		AB	1765 00	1		NPI	1205063286
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 88-0262438 ☐ ☒
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.)
PHILLIPS DO,HEBER SA
SIGNATURE ON FILE
SIGNED 03/29/19 DATE

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

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

PHYSICIAN OR SUPPLIER INFORMATION

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

WCMS-1500CS-12

012599

012600

[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.

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

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. 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	

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.)
INGLISH DO, DANIEL JO
SIGNATURE ON FILE
SIGNED 04/02/19 DATE
SRS 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

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

WCMS-1500CS-12

0002710

012600

012600

012601

[redacted]

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

CARRIER

HEALTH INSURANCE CLAIM FORM

[redacted]

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 04/02/19

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) 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 12 06 18 TO 12 06 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. 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. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. 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 [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 OOH
SIGNATURE ON FILE
SIGNED MOA 5230 DATE 04/02/19

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

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

FIRST FOLD WHCF-10-EA(NV)CE-10-ENV-SS 0071

012601

012602

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

[redacted]

HEALTH INSURANCE CLAIM FORM

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

PICA

[redacted]

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 04 18 TO 08 04 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ 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	

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.)
SIGNATURE ON FILE
SIGNED 04/04/19 DATE

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

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

PHYSICIAN OR SUPPLIER INFORMATION

012602

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 _____

012603

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 02 18 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 02 18 TO 06 02 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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

A. I21.4 B. R56.9 C. R73.9 D. G92
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 06 02 18	06 02 18	23	X	99291		ABCD	1765 00			NPI	1073933057
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1765 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

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

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

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

FORM 6231 GMS 4/ OUTSOURCED BILLING

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

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

012604

[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

PICA

[redacted]

CARRIER

PATIENT AND INSURED INFORMATION

012604

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: 10 17 18 QUAL. 431

15. OTHER DATE QUAL. _____ MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. _____

17b. NPI _____

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ 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 SSN EIN: 88-0262438 ☐ ☒

[redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

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

012605

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.
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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 08 02 18 TO 08 02 18

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. I50.9 B. I48.91 C. R09.02 D. R06.00
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 02 18	08 02 18	23	X	99285		ABCD	1360 00	1		NPI 1790787497
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

PHYSICIAN OR SUPPLIER INFORMATION

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

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1360 00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

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

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

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

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

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EXHIBIT 8

Article in the Nevada Independent

012606

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.

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.

“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.

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.

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

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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EXHIBIT 5

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EXHIBIT 5

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

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

FIRST AMENDED COMPLAINT

Jury Trial Demanded

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" and collectively the "Health Care Providers") as and

for their First Amended Complaint against defendants UnitedHealth Group, Inc. ("UHG"), and its subsidiaries and/or affiliates United Healthcare Insurance Company ("UHCIC") United Health Care Services Inc. dba UnitedHealthcare ("UHC Services"); UMR, Inc. dba United Medical Resources ("UMR"); Oxford Benefit Management, Inc. ("Oxford" together with UHG, UHC Services and UMR, the "UHC Affiliates" and with UHCIC, the "UH Parties"); Sierra Health and Life Insurance Company, Inc. ("Sierra Health"); Sierra Health-Care Options, Inc. ("Sierra Options" and together with Sierra Health, the "Sierra Affiliates"); Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants") hereby complain and allege as follows:

NATURE OF THIS ACTION

1. This action arises out of a dispute concerning the rate at which Defendants reimburse the Health Care Providers for the emergency medicine services they have already provided, and continue to provide, to patients covered under the health plans underwritten, operated, and/or administered by Defendants (the "Health Plans") (Health Plan beneficiaries for whom the Health Care Providers performed covered services that were not reimbursed correctly shall be referred to as "Patients" or "Members").[1] Collectively, Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their third party payment rates to defraud the Health Care Providers, to deny them reasonable payment for their services which the law requires, and to coerce or extort the Health Care Providers into contracts that only provide for manipulated rates. Defendants have reaped millions of dollars from their illegal, coercive, unfair, fraudulent conduct and will reap millions more if their conduct is not stopped.

2. Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their payment rates to defraud the Health Care Providers and deny them reasonable payment for services, which the law requires.

[1] The Health Care Providers 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). The Health Care Providers also do not assert any claims relating to Defendants' managed Medicaid business or with respect to the right to payment under any ERISA plan. Finally, the Health Care Providers do not assert claims that are dependent on the existence of an assignment of benefits ("AOB") from any of Defendants' Members. Thus, there is – and was – no basis to remove this lawsuit to federal court under federal question jurisdiction.

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PARTIES

3. Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") is a professional emergency medicine services group practice that staffs the emergency departments at ER at Aliante; ER at The Lakes; Mountainview Hospital; Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus; Dignity Health – St. Rose Dominican Hospitals, San Martin Campus; Dignity Health – St. Rose Dominican Hospitals, Siena Campus; Southern Hills Hospital and Medical Center; and Sunrise Hospital and Medical Center located throughout Clark County, Nevada. Fremont is part of the TeamHealth Holdings, Inc. ("TeamHealth") organization.

4. Plaintiff Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians") is a professional emergency medicine services group practice that staffs the emergency department at Banner Churchill Community Hospital in Fallon, Nevada.

5. Plaintiff Crum, Stefanko And Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") is a professional emergency medicine services group practice that staffs the emergency department at Northeastern Nevada Regional Hospital in Elko, Nevada.

6. Defendant UnitedHealth Group, Inc. ("UHG") is the largest single health carrier in the United States and is a Delaware corporation with its principal place of business in Minnesota. UHG is a publicly-traded holding company that is dependent upon monies (including dividends and administrative expense reimbursements) from its subsidiaries and affiliates which include all of the other Defendant entities named herein.

7. Defendant United HealthCare Insurance Company ("UHCIC") is a Connecticut corporation with its principal place of business in Connecticut. UHCIC is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, United HealthCare Insurance Company is a licensed Nevada health and life insurance company.

8. Defendant United HealthCare Services, Inc. dba UnitedHealthcare ("UHC Services") is a Minnesota corporation with its principal place of business in Connecticut and affiliate of UHCIC. UHC Services is responsible for administering and/or paying for certain

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emergency medical services at issue in the litigation. On information and belief, United HealthCare Services, Inc. is a licensed Nevada health insurance company.

9. Defendant UMR, Inc. dba United Medical Resources ("UMR") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. UMR is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, UMR is a licensed Nevada health insurance company.

10. Defendant Oxford Health Plans, Inc. ("Oxford") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. Oxford is responsible for administering and/or paying for certain emergency medical services at issue in the litigation.

11. Defendant Sierra Health and Life Insurance Company, Inc. is a Nevada corporation and affiliate of UHCIC. Sierra Health is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Health is a licensed Nevada health insurance company.

12. Defendant Sierra Health-Care Options, Inc. ("Sierra Options") is a Nevada corporation and affiliate of UHCIC. Sierra Options is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Options is a licensed Nevada health insurance company.

13. Defendant Health Plan of Nevada, Inc. ("HPN") is a Nevada corporation and affiliate of UHCIC. HPN is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, HPN is a licensed Nevada Health Maintenance Organization ("HMO").

14. There may be other persons or entities, whether individuals, corporations, associations, or otherwise, who are or may be legally responsible for the acts, omissions, circumstances, happenings, and/or the damages or other relief requested by this Complaint. The true names and capacities of Does 1-10 and Roes Entities 11-20 are unknown to the Health Care Providers, who sues those defendants by such fictitious names. The Health Care Providers will seek leave of this Court to amend this Complaint to insert the proper names of the defendant

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Doe and Roe Entities when such names and capacities become known to the Health Care Providers.

JURISDICTION AND VENUE

15. The amount in controversy exceeds the sum of fifteen thousand dollars ($15,000.00), exclusive of interest, attorneys' fees and costs.

16. The Eighth Judicial District Court, Clark County, has subject matter jurisdiction over the matters alleged herein since only state law claims have been asserted and no diversity of citizenship exists. The Health Care Providers contest this Court's subject matter jurisdiction over the matters alleged herein and have moved to remand. *See* Motion to Remand (ECF No. 5). The Health Care Providers do not waive their continued objection to Defendants' removal based on alleged preemption under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). Venue is proper in Clark County, Nevada.

FACTS COMMON TO ALL CAUSES OF ACTION

The Health Care Providers Provide Necessary Emergency Care to Patients

17. The Health Care Providers are professional practice groups of emergency medicine physicians and healthcare providers that provides emergency medicine services 24 hours per day, 7 days per week to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by the Health Care Providers. The Health Care Providers provide emergency department services throughout the State of Nevada.

18. The Health Care Providers and the hospitals whose emergency departments they staff are obligated by both federal and Nevada law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *See* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. The Health Care Providers fulfill this obligation for the hospitals which they staff. In this role, the Health Care Providers' physicians provide emergency medicine services to all patients, regardless of insurance coverage or ability to pay, including to Patients with insurance coverage issued, administered and/or underwritten by Defendants.

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19. Upon information and belief, Defendants operate as an HMO under NRS Chapter 695C, and is an insurer under NRS Chapters 679A, 689A (Individual Health Insurance), 689B (Group and Blanket Health Insurance), 689C (Health Insurance for Small Employers) and 695G (Managed Care Organization). Defendants provide, either directly or through arrangements with providers such as hospitals and the Health Care Providers, healthcare benefits to its members.

20. There is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation; the Health Care Providers are therefore designated as a "non-participating" or "out-of-network" provider for all of the claims at issue. An implied-in-fact agreement exists between the Health Care Providers and Defendants, however.

21. Because federal and state law requires that emergency services be provided to individuals by the Health Care Providers without regard to insurance status or ability to pay, the law protects emergency service providers -- like Fremont here -- from predatory conduct by payors, including the kind of conduct in which Defendants have engaged leading to this dispute. If the law did not do so, emergency service providers would be at the mercy of such payors. the Health Care Providers would be forced to accept payment at any rate or no rate at all dictated by insurers under threat of receiving no payment, and then the Health Care Providers would be forced to transfer the financial burden of care in whole or in part onto Patients. The Health Care Providers are protected by law, which requires that for the claims at issue, the insurer must reimburse the Health Care Providers at a reasonable rate or the usual and customary rate for services they provide.

22. The Health Care Providers regularly provide emergency services to Defendants' Patients.

23. Defendants are contractually and legally responsible for ensuring that Patients receive emergency services without obtaining prior approval and without regard to the "in network" or "out-of-network" status of the emergency services provider.

24. The uhc.com website state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are

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> provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

25. Relevant to this action:

a. From July 1, 2017 through the present, Fremont has provided emergency medicine services to Defendants' Members as an out-of-network provider of emergency services as follows: ER at Aliante (approximately July 2017-present); ER at The Lakes (approximately July 2017-present); Mountainview Hospital (approximately July 2017-present); Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus (approximately July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, San Martin Campus approximately (July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, Siena Campus (approximately July 2017-October 2018); Southern Hills Hospital and Medical Center (approximately July 2017-present); and Sunrise Hospital and Medical Center (approximately July 2017-present).

b. At all times relevant hereto, Team Physicians and Ruby Crest have provided emergency medicine services to Defendants' Members as out-of-network providers of emergency services at Banner Churchill Community Hospital in Fallon, Nevada and Northeastern Nevada Regional Hospital in Elko, Nevada, respectively.

26. Defendants have generally adjudicated and paid claims with dates of service through July 31, 2019. As the claims continue to accrue, so do the Health Care Providers' damages. For each of the claims for which the Health Care Providers seek damages, Defendants have already determined the claim was covered and payable.

The Relationship Between the Health Care Providers and Defendants

27. Defendants provide health insurance to their members (*i.e.*, their insureds).

28. In exchange for premiums, fees, and/or other compensation, Defendants are responsible for paying for health care services rendered to members covered by their health plans.

…

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29. In addition, Defendants provide services to their Members, such as building participating provider networks and negotiating rates with providers who join their networks.

30. Defendants offer a range of health insurance plans. Plans generally fall into one of two categories.

31. "Fully Funded" plans are plans in which Defendants collect premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums.

32. "Employer Funded" plans are plans in which Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

33. Defendants provide coverage for emergency medical services under both types of plans.

34. Defendants are contractually and legally responsible for ensuring that their members can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider.

35. Defendants highlight such coverage in marketing their insurance products.

36. For example, on the "patient protections" section of Defendants' website, uhc.com, Defendants state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

37. Payors typically demand a lower payment rate from contracted participating providers.

38. In return, payors offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

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39. For all claims at issue in this lawsuit, the Health Care Providers were non-participating providers, meaning they did not have an express contract with Defendants to accept or be bound by Defendants' reimbursement policies or in-network rates.

40. Specifically, the reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) at rates below the billed charges and a reasonable payment for the services rendered, (d) as measured by the community where they were performed and by the person who provided them. These claims are collectively referred to herein as the "Non-Participating Claims."

41. The Non-Participating Claims involve only commercial and Exchange Products operated, insured, or administered by the insurance company Defendants. They do not involve Medicare Advantage or Medicaid products.

42. Further, the Non-Participating Claims at issue do not involve coverage determinations under any health plan that may be subject to the federal Employee Retirement Income Security Act of 1974, or claims for benefits based on assignment of benefits.[2]

43. Those counts concern the *rate* of payment to which the Health Care Providers are entitled, not whether a *right* to receive payment exists.

44. Defendants bear responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

45. Defendants understand and expressly acknowledge that their members will seek emergency treatment from non-participating providers and that Defendants are obligated to pay for those services.

…

…

[2] The Health Care Providers understand, in any event, that Defendants do not require or rely upon assignments from their members in order to pay claims for services provided by the Health Care Providers to their members.

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The Reasonable Rate for Non-Participating Emergency Services is Well-Established

46. Defendants have traditionally allowed payment at 75-90% of billed charges for the Health Care Providers' emergency services.

47. Defendants have done so largely through the use of rental networks, which establish a reasonable rate for out-of-network provider services through arms-length negotiations between the rental network and providers on the one hand, and the rental network and health insurance companies on the other.

48. Rental networks act as "brokers" between non-participating providers and health insurance companies.

49. A rental network will secure a contract with a provider to discount its out-of-network charges.

50. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates.

51. As such, rental networks' negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

52. For many years, the Health Care Providers' respective contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from the Health Care Providers' billed charges for claims adjudicated through the rental network agreement.

53. In practice, nearly all of the Health Care Providers' non-participating provider claims submitted under Employer Funded plans from 2008 to 2017 were paid at between 75-90% of billed charges, including the Non-Participating Claims submitted to Defendants.

54. This longstanding history establishes that a reasonable reimbursement rate for the Health Care Providers' Non-Participating Claims for emergency services is 75-90% of the Health Care Providers' billed charge.

55. Beginning in approximately January 2019, Defendants have further slashed their reimbursement rate for Non-Participating Claims to less than 60%, and to as low as 12% of the

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charges billed for professional services, rates that are well-below reasonable reimbursement rates.

56. Defendants' drastic payment cuts are entirely inconsistent with the established rate and history between the parties.

Defendants Paid the Health Care Providers Unreasonable Rates

57. Defendants arbitrarily began manipulating the rate of payment for claims submitted by the Health Care Providers. Defendants drastically reduced the rates at which they paid the Health Care Providers for emergency services for some claims, but not others. Instead of paying a usual and customary rate of the charges billed by the Health Care Providers, Defendants paid some of the claims for emergency services rendered by the Health Care Providers at far below the usual and customary rates. Yet, Defendants paid other substantially identical claims (e.g. claims billed with the same Current Procedural Terminology (CPT) Code, as maintained by American Medical Association) submitted by the Health Care Providers at higher rates and in some instances at 100% of the billed charge.

a. For example, on October 10, 2017, Defendants' Member #1, presented to the emergency department at Southern Hills Hospital and was treated by Fremont's providers. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants allowed and paid $223.00, which is just 17% of the charges billed. By contrast, on October 9, 2017, Defendants' Member #2 presented to the emergency department at St. Rose Dominican Hospitals, Siena Campus. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants paid $1,295.00, 100% of the charges billed.

b. By way of further example, between January 9 and 31, 2019, Defendants' Members #3, #4, #5 all presented to emergency departments staffed by Fremont's providers. In each instance the professional services were billed with CPT Code 99285 and Defendants paid nearly all or 100% of the billed charges. By contrast, on February 26, 2019, Defendants' Members #6, #7 and #8 all presented to emergency departments staffed by Fremont. In each instance the professional services were billed with CPT Code 99285 in the amount of $1,360.00 and Defendants only paid $185.00, a mere 13.6% of the billed charges in each instance.

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c. Further, Fremont's providers treated Member #9 on March 3, 2019. The professional services were billed at $971.00 (CPT 99284) and Defendants allowed $217.53, which is 22% of billed charges.

d. The Health Care Providers do not assert any of the foregoing claims pursuant to, or in reliance on, any assignment of benefit by Defendants' Members. Upon information and belief, Defendants do not require or rely upon assignment of benefits from their Members in order to pay claims for services provided by the Health Care Providers.

58. Defendants generally paid lower reimbursement rates for services provided to Members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to Members of employer funded plans or those plans under which they provide administrator services only.

59. The Health Care Providers have continued to provide emergency medicine treatment, as required by law, to Patients covered by Defendants' plans who seek care at the emergency departments where they provide coverage.

60. Defendants bear responsibility for paying for emergency medical care provided to their Members regardless of whether the treating physician is an in-network or out-of-network provider.

61. Defendants expressly acknowledge that their Members will seek emergency treatment from non-participating providers and that they are obligated to pay for those services.

62. In emergency situations, individuals go to the nearest hospital for care, particularly if they are transported by ambulance. Patients facing an emergency situation are unlikely to have the opportunity to determine in advance which hospitals and physicians are in-network under their health plan. Defendants are obligated to reimburse the Health Care Providers at the usual and customary rate for emergency services the Health Care Providers provided to their Patients, or alternatively for the reasonable value of the services provided.

63. Defendants' Members received a wide variety of emergency services (in some instances, life-saving services) from the Health Care Providers' physicians: treatment of

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conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

64. As alleged herein, the Health Care Providers provided treatment on an out-of-network basis for emergency services to thousands of Patients who were Members in Defendants' Health Plans. The total underpayment amount for these related claims is in excess of $15,000.00 and continues to grow. Defendants have likewise failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

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

66. Defendants failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of the subject claims as legally required.

67. The Health Care Providers contested the unsatisfactory rate of payment received from Defendants in connection with the claims that are the subject of this action.

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

69. The Health Care Providers bring this action to compel Defendants to pay it the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services for the emergency services that it provided and will continue to provide Patients and to stop Defendants from profiting from their manipulation of payment rate data.

Defendants' Prior Manipulation of Reimbursement Rates

70. Defendants have a history of manipulating their reimbursement rates for non-participating providers to maximize their own profits at the expense of others, including their own Members.

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71. In 2009, defendant UnitedHealth Group, Inc. was investigated by the New York Attorney General for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

72. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

73. Defendant UnitedHealth Group, Inc. ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

74. In a press release announcing the settlement, the New York Attorney General noted that: "For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry."

75. Also in 2009, for the same conduct, defendants UnitedHealth Group, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc. paid $350 million to settle class action claims alleging that they underpaid non-participating providers for services in *The American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

76. Since its inception, FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers.

77. For example, the State of Connecticut uses FAIR Health's database to determine reimbursement for non-participating providers' emergency services under the state's consumer protection law.

78. Defendants tout the use of FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website.

79. As stated on Defendants' website (https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits) for non-participating provider claims, the relevant United

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Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment on what health care providers in the geographic area are charging.

80. While Defendants give the appearance of remitting reimbursement to non-participating providers that meet usual and customary rates and/or the reasonable value of services based on geography that is measured from independent benchmark services such as the FAIR Health database, Defendants have found other ways to manipulate the reimbursement rate downward from a usual and customary or reasonable rate in order to maximize profits at the expense of the Health Care Providers.

81. During the relevant time, Defendants imposed significant cuts to the Health Care Providers' reimbursement rate for out-of-network claims under Defendants' fully funded plans, without rationale or justification.

82. Defendants pay claims under fully funded plans out of their own pool of funds, so every dollar that is not paid to the Health Care Providers is a dollar retained by Defendants for their own use.

83. Defendants' detrimental approach to payments for members in fully funded plans continues today, Defendants have made payments to the Health Care Providers at rates as low as 20% of billed charges.

84. Team Physicians' providers treated Member #10 on March 15, 2019 and the professional services (CPT 99285) were billed in the amount of $1,138.00, but Defendants allowed $435.20 which is just 38% of the billed charges.

85. In another example, Team Physicians' providers treated Member #11 on February 9, 2019 and the professional services (CPT 99285) were billed in the amount of $1,084.00, but Defendants allowed $609.28 which is just 56% of the billed charges.

86. Further, Fremont's providers treated Member #12 on April 17, 2019 and the professional services were billed in the amount of $1,428.00 (CPT 99285), but defendants allowed $435.20 which is 30% of the billed charges.

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87. Fremont also treated Member #13 on March 25, 2019 and the professional services were billed in the amount of $973.00, but defendants allowed $214.51 which is 22% of the billed charges.

88. As a result of these deep cuts in payments for services provided to Members of fully funded plans, Defendants have not paid the Health Care Providers a reasonable rate for those services since early 2019.

89. In so doing, Defendants have illegally retained those funds.

Defendants' Current Schemes

90. In 2017, Defendants also attempted to pay less than a reasonable rate on their employer funded plans, further exacerbating the financial damages to the Health Care Providers.

91. From late 2017 to 2018, over the course of multiple meetings in person, by phone, and by email correspondence, the Health Care Providers' representatives tried to negotiate with Defendants to become participating, in-network providers.

92. As part of these negotiations, the Health Care Providers' representatives met with Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthCare Services, Inc.

93. Around December 2017, Mr. Rosenthal told the Health Care Providers' representatives that Defendants intended to implement a new benchmark pricing program specifically for their employer funded plans to decrease the rate at which such claims were to be paid.

94. Defendants then proposed a contractual rate for their employer funded plans that was roughly half the average reasonable rate at which Defendants have historically reimbursed providers – a drastic and unjustified discount from what Defendants have been paying the Health Care Providers on their non-participating claims in these plans, and an amount materially less than what Defendants were paying other contracted providers in the same market.

95. Defendants' proposed rate was neither reasonable nor fair.

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96. In May 2018, Mr. Rosenthal escalated his threats, making clear during a meeting that, if the Health Care Providers did not agree to contract for the drastically reduced rates, Defendants would implement benchmark pricing that would reduce the Health Care Providers' non-participating reimbursement by 33%.

97. Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare Inc. and part of the Office of the Chief Executive of Defendant UnitedHealth Group, Inc., said that, by April 2019, Defendants would cut the Health Care Providers' non-participating reimbursement by 50%.

98. Asked why Defendants were forcing such dramatic cuts on the Health Care Providers' reimbursement, Mr. Schumacher said simply "because we can."

99. Defendants made good on their threats and knowingly engaged in a fraudulent scheme to slash reimbursement rates paid to the Health Care Providers for non-participating claims submitted under their employer funded plans to levels at, or even below, what they had threatened in 2018.

100. Defendants falsely claim that their new rates comply with the law because they contracted with a purportedly objective and transparent third party, Data iSight, to process the Health Care Providers' claims and to determine reasonable reimbursement rates.

101. Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' Members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since as early as June 1, 2016 with some of the Health Care Providers to secure reasonable rates from payors for the Health Care Providers' non-participating emergency services. The Health Care Providers have no contract with Data iSight, and the Non-

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Participating Claims identified in this action are not adjudicated pursuant to the MultiPlan agreement.

102. Since January 2019, Defendants have engaged in a scheme and conspired with Data iSight to impose arbitrary and unreasonable payment rates on the Health Care Providers under the guise of utilizing an independent, objective database purportedly created by Data iSight to dictate the rates imposed by Defendants.

103. Defendants also continued to advance this scheme on the negotiation front.

104. On July 7, 2019, Mr. Schumacher advised, in a phone call, that Defendants planned to cut the Health Care Providers' rates over three years to just 42% of the average and reasonable rate of reimbursement that the Health Care Providers had received in 2018 if the Health Care Providers did not formally contract with them at the rate dictated by Defendants.

105. Mr. Schumacher additionally advised that leadership across the Defendant entities were aware and supportive of the drastic cuts and provided no objective basis for them.

106. The next day, Angie Nierman, a Vice President of Networks at UnitedHealth Group, Inc., sent a written proposal reflecting Mr. Schumacher's stated cuts.

107. In addition to denying the Health Care Providers what is owed to them for the Non-Participating Claims, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

108. As further evidence of Defendants' scheme to use their market power to the detriment of the Health Care Providers and other emergency provider groups that are part of the TeamHealth organization, in August 2019, UHG advised at least one Florida medical surgical facility (the "Florida Facility") that Defendants will not continue negotiating an in-network agreement unless the Florida Facility identifies an in-network anesthesia provider. The current out-of-network anesthesia provider is part of the TeamHealth organization. Defendants' threats to discontinue contract negotiations prompted the Florida Facility's Chief Operating Officer to send TeamHealth a "Letter of Concern" on August 14, 2019. Defendants' threats and leverage are aimed at intentionally interfering with existing contracts and with a goal of reducing TeamHealth's market participation.

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109. Additionally, Defendants first threatened, and then, on or about July 9, 2019, globally terminated all existing in-network contracts with medical providers that are part of the TeamHealth organization, including the Health Care Providers, in an effort to widen the scale of the scheme to deprive the Health Care Providers of reasonable reimbursement rates through its manipulation of reimbursement rate data.

Defendants' Fraudulent Schemes to Deprive the Health Care Providers of Reasonable Reimbursement Violates Nevada's Civil Racketeering Statute

110. Each Defendant, UnitedHealth Group, Inc., United Healthcare Insurance Company, United Health Care Services Inc., UMR, Inc., Oxford Benefit Management, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., Health Plan of Nevada, Inc. (collectively "Defendants") violated NRS 207.350 *et seq.* by committing the following crimes related to racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) and that the Defendants devised, conducted, and participated in with unnamed third parties, including, but not limited to, Data iSight.

111. The Enterprise, as defined in NRS 207.380 consists of the Defendants, non-parties Data iSight and other entities that develop software used in reimbursement determinations used by the Defendants (the "Enterprise"). The participants of the Enterprise are associated, upon information and belief, by virtue of contractual agreement(s) and/or other arrangement(s) wherein they have agreed to undertake a common goal of reducing payments to the Health Care Providers for the benefit of the Enterprise. The Enterprise participants communicate routinely through telephonic and electronic means as they unilaterally impose reimbursement rates based on their manipulated "data" but which is nothing more than a transparent attempt to impose artificially reduced reimbursement rates that the Defendants threatened during business-to-business negotiations.

112. The Defendants illegally conduct the affairs of the Enterprise, and/or control the Enterprise, that includes Data iSight, through a pattern of unlawful activity.

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113. As part of this scheme, the Defendants prepared to, and did knowingly and unlawfully, reduce the Health Care Providers' reimbursement rates for the non-participating claims to amounts significantly below the reasonable rate for services rendered to Defendants' Members, to the detriment of the Health Care Providers and to the benefit and financial gain of Defendants and Data iSight.

114. To carry out the scheme and in furtherance of the conspiracy, Defendants and Data iSight engaged in conduct violative of NRS 207.400.

115. Since January 2019, the Enterprise worked together to manipulate and artificially lower non-participating provider reimbursement data that coincides and matches the earlier threats made by UHG in an effort to avoid paying the Health Care Providers for the usual and customary fee or rate and/or for the reasonable value of the services provided to Defendants' Members for emergency medicine services. The unilateral reduction in reimbursement rates is not founded on actual statistically sound data, and is not in line with reimbursement rates that can be found through sites such as the FAIR Health database, a recognized source for such reimbursement rates. Each time the Defendants direct payment using manipulated reimbursement rates and issue the Health Care Providers a remittance, the Defendants further their scheme or artifice to defraud Fremont because the Defendants retain the difference between the amount paid based on the artificially reduced reimbursement rate and the amount paid that should be paid based on the usual and customary fee or rate and/or the reasonable value of services provided, to the detriment of the Health Care Providers who have already performed the services being billed. Further, the Health Care Providers' representatives have contacted Data iSight and have been informed that acceptable reimbursement rates are actually influenced and/or determined by Defendants, not Data iSight.

116. As a result of the scheme, Defendants have injured the Health Care Providers in their business or property by a pattern of unlawful activity by reason of their violation of NRS 207.400(1)(a)- (d), (1)(f), (1)(i)-(j). *See* NRS 207.470.

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Defendants' and Data iSight's Activities Constitute Racketeering Activity

117. Defendants and Data iSight committed, and continue to commit, crimes related to racketeering pursuant to NRS 207.360 that have the same or similar pattern, intents, results, accomplices, victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents in violation of NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) such that they have engaged in racketeering activity as defined by NRS 207.400 and which poses a continued threat of unlawful activity such that they constitute a criminal syndicate under NRS 207.370.

118. Defendants and Data iSight have knowingly, wrongfully, and unlawfully reduced payment to the Health Care Providers for the emergency services that the Health Care Providers provided to Defendants' Members, for the financial gain of the Defendants and Data iSight.

119. The racketeering activity has happened on more than two occasions that have happened within five years of each other. In fact, the Defendants have processed and submitted a substantial number of artificially reduced payments to the Health Care Providers since January 2019 in furtherance of Defendants' unlawful conduct.

120. As a direct and proximate result of those activities, the Health Care Providers have suffered millions of dollars in discrete and direct financial loss that stem from the Defendants' knowing retention of payment that is founded on a scheme to manipulate payment rates and payment data to their benefit.

The Enterprise and Scheme

121. The Enterprise is comprised of Defendants and third-party entities, to include Data iSight, that developed software used in reimbursement determinations by Defendants.

122. Defendants and Data iSight agreed to, and do, manipulate reimbursement rates and control allowed payments to the Health Care Providers through acts of the Enterprise.

123. The Defendants and Data iSight conceal their scheme by hiding behind written agreements and/or other arrangements, and false statements.

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124. Since at least January 1, 2019, the Defendants, by virtue of their engagement and use of Data iSight, have falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates.

125. In reality, Data iSight is used as a cover for Defendants to justify paying reimbursement to the Health Care Providers at rates that are far less than the reasonable payment rate that the Health Care Providers have historically received and are entitled to under the law. The reimbursement rates purportedly collected and employed by Data iSight are nothing more than an instrumentality for the Defendants' unilateral decision to stop paying the Health Care Providers the usual and customary fee and/or the reasonable value of the services provided.

126. This scheme is concealed through the use of false statements on Data iSight's website and in Defendants' and Data iSight's communications with providers, including the Health Care Providers' representatives.

127. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between Defendants and Data iSight.

The Enterprise's False Statements: Transparency

128. By the end of June 2019, an increasingly significant amount of non-participating claims submitted to Defendants were being processed for payment by Data iSight.

129. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

130. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

131. This concealment was designed by the Enterprise to, and does, prevent the Health Care Providers from receiving a reasonable payment for the services it provides.

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132. For claims whose reimbursement is determined by Data iSight, non-participating providers receive a Provider Remittance Advice form ("Remittance") from Defendants with "IS" or "1J" in the "Remark/Notes" column.

133. Over the past six months, an ever-increasing number of non-participating claims have been processed by Data iSight with drastically reduced payment amounts.

134. Yet Defendants and Data iSight do not state, on the face of the Remittance, or anywhere else, any reason for the dramatic cut.

135. Instead, the Remittances contain a note to call a toll-free number if there are questions about the claim.

136. In July 2019, a representative of Team Physicians contacted Data iSight via that number to discuss three separate claims with CPT Code 99285 (emergency department visit, problem of highest severity) which had been billed at $1,084.00, but for which Data iSight had allowed two claims at $435.20 (40% of billed charges) and one at $609.28 (56% of billed charges). After Team Physicians' representative spoke with Data iSight's intake representative, a Data iSight representative, Kimberly (Last Name Unknown) ("LNU") ("Kimberly"), called back and she asked if Team Physicians wanted a proposal for one of the inquired-upon claims. Team Physicians' representative indicated that he was interested in learning more and asked what reimbursement rate would be offered. Kimberly stated, "I have to look at a couple of things and decide." Thereafter, Kimberly sent the Team Physicians' representative a proposed Letter of Agreement (prepared July 31, 2019) (ICN: 48218522) offering to increase the allowed amount from $609.28 to $758.80 – increasing the amount to 70% of billed charges instead of 56% – as payment in full and an agreement not to balance bill Defendants' Member or Member's family. All it took was one call and a request for a more reasonable payment and almost immediately Defendant United Healthcare Services increased the amount it would pay, although still not to the level that the Health Care Providers consider to be reasonable.

137. Medical providers that are part of the TeamHealth organization have experienced this same trend across the country with Data iSight. In one instance, in July 2019, a representative of another provider, Emergency Group of Arizona Professional Corporation (the

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"AZ Provider"), contacted Data iSight via that number to discuss a claim with CPT Code 99284 (emergency department visit, problem of high severity) which had been billed at $1,190.00, but for which Data iSight had allowed and paid $295.28, just 24.8% of billed charges.

138. After the AZ Provider's representative spoke with Data iSight's intake representative, a Data iSight representative, Michele Ware ("Ware"), called back and claimed the billed charges were paid based on a percentage of the Medicare fee schedule. The AZ Provider's representative challenged the reasonableness of the $295.28 payment. After learning that the AZ Provider had not yet billed Defendants' Member for the difference, Ware stated "ok – so you're willing negotiate" and offered to pay 80% of billed charges. In response, the AZ Provider's representative asked for payment of 85% of billed charges – $1,011.50 – to which Ware promptly agreed. Immediately thereafter, Ware sent a written agreement for the AZ Provider's representative to review and sign, confirming payment of $1,011.50 as payment in full and an agreement not to balance bill Defendants Services' Member or Member's family.

139. In another instance, when asked to provide the basis for the dramatic cut in payment for the claims, a Data iSight representative by the name of Phina LNU, did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

140. Instead, the representative simply stated that the rates were developed by Data iSight and Defendants. When the Health Care Providers' representative continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations, James LNU responded that "it is just an amount that is recommended and sent over to United [HealthCare]." When James LNU was expressly challenged on Data iSight's false claim that it is transparent with providers, he responded with silence.

141. Further attempts to understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight executives have also been futile.

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142. Data iSight and the Defendants know that the rates that Data iSight have allowed for the Health Care Providers' claims in 2019 are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

143. Defendants know this because when a provider challenges the payment, Data iSight and Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the Health Care Providers persist long enough in the process.

144. This process to contest the unreasonable payment takes weeks to conclude for the Health Care Providers and is impracticable to follow for every claim – a fact that Defendants and Data iSight understand.

145. For example, as evidence of this fraudulent practice, the Health Care Providers' representatives contested the allowed amounts on the claim discussed above in paragraph 136.

146. Eventually, Data iSight, offered to allow payment of at least one claim at 70% of the billed charges.

147. Absent providers taking the time to chase every claim, Data iSight and Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

148. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until the Health Care Providers challenge its determinations continually harms the Health Care Providers, in that, even if they eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens them with excessive administrative time and expense and deprives the Health Care Providers of their right to prompt payment.

The Enterprise's False Statements: Representations that Payment Rates Are "Defensible and Market Tested"

149. The Enterprise's claim to "transparency" is not its only fraudulent representation.

150. The Enterprise, through Data iSight, also falsely represents, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

151. Claims processed by Data iSight contain the following note:

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> MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF-NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835- 4022 OR VISIT DATAISIGHT.COM. THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.

(emphasis added).

152. This note is intended to, and does, mislead the Health Care Providers to believe that the reimbursement calculations are tied to external, objective data.

153. Further, in its provider portal, Data iSight describes its "methodology" for reimbursement determinations as "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

154. Data iSight's parent company, MultiPlan, similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and notes that it has been "[v]alidated by statisticians as effective and fair."

155. These statements are false.

156. Data iSight's rates are not data-driven: they match the rate threatened by Defendants in 2018 and are whatever Defendants want, and direct Data iSight, to allow.

157. For example, the Health Care Providers submitted claims for Members but received reimbursement in very different allowed amounts:

a. Member #14 was treated on May 9, 2019. Fremont billed Defendants $973.00 for procedure code 99284, and Defendants allowed $875.70 through MultiPlan, which is approximately 90% of billed charges – a reasonable rate, in line with the reasonable rate paid by Defendants to Fremont for non-participating provider services.

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b. But, for Member #15, who was treated on May 24, 2019, Defendants, through Data iSight, allowed only $295.28 for billed charges of $1,019.00, which is only 29% of the billed charges.

c. Further, at just one site, Defendants allowed and paid Team Physicians at varying amounts for the same procedure code (99285) (Members ##16a-16e):

i. Date of Service ("DOS"): January 4, 2019; Charge $1084.00; Allowed $609.28 (56% of Charge and reimbursed using Data iSight);

ii. DOS: January 15, 2019; Charge $1084.00; Allowed $294.60 (27% of Charge);

iii. DOS: January 24, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight);

iv. DOS: January 29, 2019; Charge $1084.00; Allowed $328.39 (30% of Charge); and

v. DOS: February 7, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight).

158. This lock-step reduction, consistent with Defendants' 2018 threats to drastically reduce rates even further if the Health Care Providers failed to agree to their proposed contractual rates, spans a significant number of the Health Care Providers' claims for payment for services to Defendants' Members.

159. From the above examples, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable reimbursement rate, as its rates are not consistent, defensible, or reasonable.

160. Rather, Defendants, in complicity with Data iSight, increasingly reimburse the Health Care Providers at entirely unreasonable rates, in retaliation for the Health Care Providers' objections to their reimbursement scheme, and completely contrary to their false assertions designed to mislead the Health Care Providers and similar providers into believing that they will receive payment at reasonable rates.

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

The Enterprise's False Statements: Geographic Adjustment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Enterprise's Predicate Acts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECOND CLAIM FOR RELIEF

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

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

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

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

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

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

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

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

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

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

THIRD CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment)

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

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

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

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

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

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

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

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

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

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

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

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

FOURTH CLAIM FOR RELIEF

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

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

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

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

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

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

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

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

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

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

FIFTH CLAIM FOR RELIEF

(Violations of Nevada Prompt Pay Statutes & Regulations)

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

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

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

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

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

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

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

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

SIXTH CLAIM FOR RELIEF

(Consumer Fraud & Deceptive Trade Practices Acts)

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

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

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

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

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

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

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

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

SEVENTH CLAIM FOR RELIEF

(Declaratory Judgment)

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

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

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

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

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

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

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

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

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

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

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

EIGHTH CLAIM FOR RELIEF

(Violation of NRS 207.350 *et seq.*)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REQUEST FOR RELIEF

WHEREFORE, the Health Care Providers request the following relief:

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

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

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

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

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

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

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

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

I. Reasonable attorneys' fees and court costs;

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

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

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JURY DEMAND

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

DATED this 7th day of January, 2020.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*

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CERTIFICATE OF SERVICE

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

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An employee of McDonald Carano LLP

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EXHIBIT 6

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EXHIBIT 6

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

* * *

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

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

I. Background

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

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

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

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

II. Legal Standard

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

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

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

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

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

III. Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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IV. Conclusion

Accordingly,

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

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

The clerk shall close the case accordingly.

DATED February 20, 2020.

UNITED STATES DISTRICT JUDGE

EXHIBIT 7

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EXHIBIT 7

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **AMENDED MOTION TO REMAND**

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

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

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

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

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

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

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

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

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

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

LEGAL STANDARD

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

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

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

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

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ARGUMENT

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

ERISA is "one of only a few federal statutes under which two types of preemption may arise: conflict preemption and complete preemption." *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1343 (11th Cir. 2009). These two forms of preemption are doctrinally distinct. Complete preemption occurs where "Congress intended the scope of a federal law to be so broad as to entirely replace any state-law claim." *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 945 (9th Cir. 2009) (internal citation and quotation marks omitted). Complete preemption is a "rare" doctrine, by which a "state-created cause of action can be deemed to arise under federal law[,]" regardless of whether a plaintiff, as "the master of [its] complaint," intentionally "cho[se] not to plead independent federal claims." *ARCO*, 213 F.3d at 1114. As such, complete preemption operates as an exception to the well-pleaded complaint rule. *Marin*, 581 F.3d at 945. "Even if the only claim in a complaint is a state law claim, if that claim is one that is 'completely preempted' by federal law, federal subject matter jurisdiction exists and removal is appropriate." *Toumajian v. Frailey*, 135 F.3d 648, 653 (9th Cir. 1998).

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

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

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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.

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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

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, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation, et al., Defendants.	Case No. 2:19-cv-00832-JAD-VCF Las Vegas, Nevada January 6, 2020 Courtroom 3D 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

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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

EXHIBIT 2

Petition in *Hill Country Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.*

EXHIBIT 2

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., *Plaintiffs*, v. UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc., *Defendants*.	§ § § § § § § § § § § § § § §	IN THE DISTRICT COURT 201ST JUDICIAL DISTRICT TRAVIS COUNTY, TEXAS

PLAINTIFFS' ORIGINAL PETITION

TO THE HONORABLE COURT:

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.

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

9. Defendant UnitedHealthCare Insurance Company is a corporation organized under the laws of the State of Connecticut doing business in Texas. UnitedHealthCare Insurance Company is licensed by the Texas Department of Insurance as a life, health or accident insurance company, and underwrites or administers preferred provider benefit plans and other health insurance products in the State of Texas. It may be served through its agent for service of process, C T Corporation System, 350 North Paul Street, Dallas, TX 75201.

10. Defendant UnitedHealthCare of Texas, Inc. is a corporation organized under the laws of the State of Texas with a principal office in Plano, Texas. UnitedHealthCare of Texas, Inc. is licensed by the Texas Department of Insurance as a basic health maintenance organization ("HMO"). It may be served through its agent for service of process C T Corporation System, 1999 Bryan St., Suite 900, Dallas, TX 75201-3136.

DISCOVERY CONTROL PLAN AND CLAIM FOR RELIEF

11. This case will be governed by Level 3 discovery pursuant to Rule 190.4 of the Texas Rules of Civil Procedure. Plaintiff doctors seek monetary relief in excess of $1,000,000.00.

JURISDICTION & VENUE

12. This Court has subject-matter jurisdiction because this dispute involves an amount in controversy in excess of this Court's minimum jurisdictional requirements.

13. Venue is proper in Travis County, Texas pursuant to Section 15.002(a)(1) of the Texas Civil Practice & Remedies Code because a substantial part of the events or omissions giving rise to Plaintiff Doctors' claims occurred in Travis County, Texas.

14. The Insurance Companies are subject to personal jurisdiction in this state pursuant to Tex. Civ. Prac. & Rem. Code § 17.042(1) because they have entered into contracts to provide insurance to Texas residents and conduct business in this State.

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.

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.

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.

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.

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.

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.

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.

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.

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

53. The foregoing paragraphs are incorporated by reference.

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

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.

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

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.

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

66. The foregoing paragraphs are incorporated by reference.

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

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.

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.

Respectfully submitted,

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

DEFENDANTS' OBJECTION TO PLAINTIFFS' PROPOSED ORDER DENYING DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW

[HEARING NOT REQUESTED]

012707

WEINBERG WHEELER HUDGINS GUNN & DIAL
012707

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Co., Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), by and through their attorneys, object to Plaintiffs' Proposed Order Denying Defendants' Motion for Judgment as a Matter of Law. This Objection is based upon the following Memorandum of Points and Authorities, the pleadings and papers on file herein, and any oral argument this Court may allow on this matter.

MEMORANDUM OF POINTS AND AUTHORITIES

I. PLAINTIFFS' PROPOSED ORDER GOES FAR BEYOND THE COURT'S STATEMENTS AT THE NOVEMBER 18, 2021 HEARING

At the November 18, 2021 hearing on Defendants' Motion for Judgment as a Matter of Law, the Court only made a few brief comments about the Motion after the conclusion of the Parties' oral argument. *See* Nov. 18, 2021 Trial Trans. at 32:23 – 33:5; 33:23 – 34:11. Despite this, Plaintiffs have submitted a one-sided 13-page proposed order that is almost entirely filled with findings the Court never made. *Compare* Plaintiffs' Proposed Order to Nov. 18, 2021 Trial Trans. at 32:23 – 33:5; 33:23 – 34:11. During meet and confer efforts with Plaintiffs, Defendants proposed that the Parties submit an order that simply stated as follows:

> *IT IS HEREBY ORDERED that the Motion is DENIED in full for the reasons stated on the record.*

Plaintiffs rejected this reasonable approach and are instead insisting that the Court adopt their 13-page order. The Court should decline to enter the entirety of Plaintiffs' proposed order as it goes well beyond the findings made at the hearing and instead simply enter an order denying

Defendants' Motion "for the reasons stated on the record." A few examples of Plaintiffs' overreach are set forth below.

Paragraphs 10 and 11 of Plaintiffs' proposed order contain nearly a page of discussion and case citations related to Plaintiffs' argument that they should be entitled to recover punitive damages based on their Unjust Enrichment claim. However, the Court only made two statements on the record related to Plaintiffs' Unjust Enrichment claim. The Court stated that (1) "the Plaintiffs have made at least a prima facie case with regard to each element of . . . unjust enrichment, and the punitives" and (2) "I don't think there has been any waiver."[1] Nov. 18 Trial Trans. at 32:24- 33:1; 34:4. Paragraphs 10-11 of Plaintiffs' proposed order go far beyond the Court's statements and findings and are therefore inappropriate.

Paragraph 18(b) of Plaintiffs' Proposed Order contains the following finding: "*Additionally, there is testimony that United violated the Affordable Care Act*." Plaintiffs Proposed Order at 7:3-4. Notably, the Court never even referenced the Affordable Care Act at the November 18 hearing or made any mention whatsoever of a finding that Defendants had violated a federal statute. This finding is therefore inappropriate.

Paragraph 18(d) of Plaintiffs' Proposed Order contains another non-existent finding:

> The Health Care Providers have presented evidence that there are negative consequences if United underpays emergency room providers, including potentially jeopardizing what is defined as the safety net of the community: emergency department doctors, practitioners and clinicians. If they are underpaid, the quality of emergency services is diminished according to the testimony that has been elicited.

This statement is directly from Plaintiffs' counsel's oral argument[2] and not based on any finding of the Court at the hearing. Indeed, the Court never made any statement or finding regarding whether underpayment by the Defendants would result in diminished emergency services in

[1] The Court's reference to waiver presumably referred to a rejection of Defendants' argument that Plaintiffs had waived the right to assert that they should be awarded punitive damages for their Unjust Enrichment claim because Plaintiffs had failed to state that they were seeking punitive damages on their Unjust Enrichment claim in the Joint Pre-Trial Memorandum.

[2] Nov. 18, 2021 Trial Trans. at 25:15-18 (Plaintiffs' counsel's argument that underpayment results in lower quality emergency services and jeopardizes the safety net of the community).

Nevada. Nov. 18, 2021 Trial Trans. at 32:23 – 33:5; 33:23 – 34:11 (consisting of the entirety of the Court's findings). Plaintiffs' attempt to slip such a finding into the proposed order should be rejected.

As another example, Paragraph 18(f) of Plaintiffs' Proposed Order references Plaintiffs' Trial Exhibit 314 in regard to an email from one UMR employee that a Defendant received. Plaintiffs' Proposed Order at 7:18-19. The Court neither referenced this exhibit nor made any finding regarding internal advice the Defendants received.

In Paragraph 19 of Plaintiffs' Proposed Order, Plaintiffs insert a finding that "*The Health Care Providers have introduced evidence that a jury could conclude that United was deliberately placing United's interest over that safety net of [sic] community*." Again, the Court never made any findings regarding the impact of Defendants' alleged underpayments on the safety net of the community. Indeed, no actual evidence was presented at all at trial regarding the impact of Defendants' reimbursement levels, if any, on the medical services provided by Plaintiffs.

Finally, Plaintiffs' proposed order includes over 2 pages of findings and conclusions regarding Plaintiffs' Prompt Pay Statute claim. Plaintiffs' Proposed Order at 9:26 – 11:28. However, the Court never made a single comment about Plaintiffs' Prompt Pay claim at the November 18 hearing.

The above are merely a few examples of the overreach that exists in Plaintiffs' Proposed Order. Therefore, rather than conducting an extensive redline of the Proposed Order, Defendants request that the Court enter an order denying the Motion that simply states as follows: "*IT IS HEREBY ORDERED that the Motion is DENIED in full for the reasons stated on the record*." Defendants proposed order is attached as **Exhibit 1**. Entering Defendants' proposed order will ensure that the order does not go beyond the findings and conclusions the Court made at the November 18 hearing. Further, entering Defendants' proposed order would be consistent with numerous other orders the Court has entered in this case that simply denied a motion "for the reasons stated on the record."[3]

[3] *See e.g.*, November 1, 2021 Order Denying Defendants' Motion in Limine No. 27 to Preclude Evidence of Complaints Regarding Defendants' Out-of-Network Rates or Payments; November 1, 2021 Order

II. CONCLUSION

For the reasons stated herein, Defendants request that this Court not enter Plaintiffs' proposed order denying Defendants' Motion for Judgment as a Matter of Law and instead enter Defendants' proposed order attached hereto as **Exhibit 1**.

Dated this 4th day of January, 2022.

/s/ Colby L. Balkenbush

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Denying Defendants' Motion in Limine No. 2; November 1, 2021 Order Denying Defendants' Motion in Limine No. 4; November 1, 2021 Order Denying Defendants' Motion in Limine No. 10; November 12, 2021 Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 26; November 12, 2021 Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders.

CERTIFICATE OF SERVICE

I hereby certify that on the 4th day of January, 2022, a true and correct copy of the foregoing **DEFENDANTS' OBJECTION TO PLAINTIFFS' PROPOSED ORDER DENYING DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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EXHIBIT 1

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

ORDER DENYING DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

This matter came before the Court on November 18, 2021 on Defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Co., Inc.; and Health Plan of Nevada, Inc.'s (collectively, "Defendants") Motion for Judgment as a Matter of Law (the "Motion"). Pat Lundvall, McDonald Carano LLP; and John Zavitsanos, Joe Ahmad, Jane Robinson, Kevin Leyendecker, Jason McManis, Michael Killingsworth, Ahmad, Zavitsanos, Anaipakos, Alavi & Mensing, P.C., appeared on behalf of 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" and collectively the "Health Care Providers"). D. Lee Roberts, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC; Lee Blalack, Dimitri Portnoi and Jeffrey E. Gordon, O'Melveny & Myers LLP; and Dan Polsenberg, Lewis Roca Rothgerber Christie LLP appeared on behalf of Defendants.

The Court, having considered the Motion, the record, and the argument of counsel at the November 18, 2021 hearing on this matter, and good cause appearing, finds and orders as follows:

IT IS HEREBY ORDERED that the Motion is DENIED in full for the reasons stated on the record.

Submitted by:
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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. 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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation, Defendants	Case No.: A-19-792978-B Dept. No.: XXVII **NOTICE OF ENTRY OF ORDER DENYING DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW**

Please take notice than an Order Denying Defendants' Motion for Judgment as a Matter of Law was entered on January 5, 2022, a copy of which is attached hereto.

DATED this 6th day of January, 2022.

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 6th day of January, 2022, I caused a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER DENYING DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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CLARK COUNTY, NEVADA

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Plaintiffs,

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

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

ORDER DENYING DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW

Hearing Date: November 18, 2021
Hearing Time: 8:30 a.m.

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This matter came before the Court on November 18, 2021 on defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Co., Inc.; and Health Plan of Nevada, Inc.'s (collectively, "Defendants") Motion for Judgment as a Matter of Law (the "Motion"). Pat Lundvall, McDonald Carano LLP; and John Zavitsanos, Joe Ahmad, Jane Robinson, Kevin Leyendecker, Jason McManis, Michael Killingsworth, Ahmad, Zavitsanos, Anaipakos, Alavi & Mensing, P.C., appeared on behalf of 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" and collectively the "Health Care Providers"). D. Lee Roberts, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC; Lee Blalack, Dimitri Portnoi and Jeffrey E. Gordon, O'Melveny & Myers LLP; and Dan Polsenberg, Lewis Roca Rothgerber Christie LLP appeared on behalf of defendants United Healthcare Insurance Company; United Health Care Services Inc., dba UnitedHealthcare; UMR, Inc., dba United Medical Resources; Sierra Health And Life Insurance Company, Inc. and Health Plan Of Nevada, Inc. (collectively "Defendants" or "United").

The Court, having considered the Motion, the Health Care Providers' oral opposition, the Health Care Providers' Trial Briefs Regarding (1) Punitive Damages for Unjust Enrichment Claim, (2) Nevada Unfair Settlement Practices Applicability, (3) Elements of Unfair Insurance Practices Act, (4) Price as Material Term (collectively, the "Trial Briefs"), the record, and the argument of counsel at the hearing on this matter, and good cause appearing, finds and orders as follows:

1. The central issue in this case is whether United allowed the Health Care Providers a reasonable out-of-network reimbursement rate for approximately 11,500 health insurance claims. This case is not about right to payment, but rather the rate of payment.

2. The Health Care Providers assert that United is obligated to them under four causes of action and are liable for punitive damages based on United's malicious, oppressive and fraudulent conduct.

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3. On November 17, 2021, United filed a Motion pursuant to NRCP 50(a), contending that:

a. There Is No Evidence to Support Any of TeamHealth Plaintiffs' Claims Against SHL, HPN, or UMR;

b. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Cause of Action Under the Nevada Unfair Insurance Practices Act;

c. There Is No Evidence That Supports an Award of Punitive Damages;

d. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Claim for Breach of Implied-in-Fact Contract;

e. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Prompt Pay Act Claim; and

f. TeamHealth Plaintiffs' Causes of Action Are Preempted by ERISA Motion at Section II(A)-(F), respectively.

4. NRCP Rule 50(a) provides:

> (a) **Judgment as a Matter of Law**.
>
> (1) **In General**. If a party has been fully heard on an issue during a jury trial and the court finds that a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue, the court may:
>
> > (A) resolve the issue against the party; and
> > (B) grant a motion for judgment as a matter of law against the party on a claim or defense that, under the controlling law, can be maintained or defeated only with a favorable finding on that issue.

5. A Rule 50(a) motion does not test the legal sufficiency of the claims, but whether there is a sufficient evidentiary basis to find for the Health Care Providers.

6. Sections IIB(1), B(2), C(1), C(2), E(1), E(2), and (F) of United's Motion contain purely legal arguments which are inappropriate basis for a Rule 50(a) motion.

Unfair Claims Settlement Practices, NRS 686A.310

7. The definition of who is liable under NRS 686A.020 and .310 is broad in that provides:

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> ***A person shall not engage*** in this state in any practice which is defined in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

NRS 686A.020.

8. Neither *Gunny v. Allstate Ins. Co*., 108 Nev. 344, 830 P.2d 1335 (1992) nor *Fulbrook v. Allstate Ins. Co*., No. 61567, 2015 WL 439598 (Nev. Jan. 30, 2015) stand for the proposition that Nevada's Unfair Insurance Practices Act does not create a private right of action against insurers in favor of third party claimants like the Health Care Providers.

9. Nor is a contractual relationship required to establish standing to assert a claim for violation of the Unfair Insurance Practices Act. *Gunny* provides that the proper inquiry is not whether a contractual relationship exists, but instead whether the plaintiff has suffered a legally redressable harm.

10. Further, United already raised this standing argument to this Court in its prior motion to dismiss. Not only did this Court reject United's argument as to each United Defendant, the Nevada Supreme Court affirmed this Court's decision in response to United's Petition for Writ of Prohibition, or, Alternatively, Mandamus, challenging this Court's order denying a motion to dismiss wherein the Court rejected United's argument regarding the applicability of *Gunny v. Allstate Ins. Co*., 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992) and determined that United's argument that Nevada's Unfair Insurance Practices Act "does not create a private right of action against insurers in favor of third party claimants like Fremont" lacked merit. *Id*. at COL ¶ 68.

11. The Health Care Providers have elicited testimony about policy setting from United executives representing each defendant: Mr. Haben on behalf of UnitedHealthcare Insurance Company and UnitedHealthcare Services; Mr. Ziemer, UMR's Vice President of customer solutions and reimbursement strategies; and Ms. Hare on behalf of Sierra and HPN.

12. The Health Care Providers have elicited oral testimony and introduced documentary evidence that each United defendant recognizes the Health Care Providers are

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entitled to a reasonable reimbursement rate and evidence supporting the Health Care Providers' claim that defendants' failed to pay a reasonable reimbursement rate.

13. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Briefs on this issue.

14. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Punitive Damages

15. Under NRS 42.005(1), "[e]xcept as otherwise provided in NRS 42.007, in an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud or malice, express or implied, the plaintiff, in addition to the compensatory damages, may recover damages for the sake of example and by way of punishing the defendant."

16. Although the Nevada Supreme Court has held that punitive damages are not available for *breach of contract* claims, no such restriction exists for a claim of unjust enrichment, which, by its terms and United's own arguments throughout the course of this litigation, is not based on a contract. *See Ins. Co. of the West v. Gibson Title Co., Inc.,* 122 Nev. 455, 464, 134 P.3d 698, 703 (2006) ("[T]he award of punitive damages cannot be based upon a cause of action sounding **solely** in contract.") (emphasis added); *see also Peri & Sons Farms, Inc. v. Jain Irr., Inc.,* 933 F. Supp. 2d 1279, 1294 (D. Nev. 2013) ("Punitive damages are not available under Nevada law for contract-based causes of action); *Leasepartners Corp. v. Robert L. Brooks Tr. Dated Nov. 12, 1975*, 113 Nev. 747, 755–56, 942 P.2d 182, 187 (1997) ("[a]n action based on a theory of unjust enrichment is not available when there is an express, written contract, because no agreement can be implied when there is an express agreement."). Federal court decisions are in accord. *See e.g. Hester v. Vision Airlines, Inc.*, 687 F.3d 1162 (9th Cir. 2012); *Bavelis v. Doukas*, No. 2:17-CV-00327, 2021 WL 1979078, at *3 (S.D. Ohio May 18, 2021) (affirming punitive damages award based on a theory of unjust enrichment).

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17. Unjust enrichment "is grounded in the theory of restitution, not in contract theory." *Schirmer v. Souza*, 126 Conn. App. 759, 765, 12 A.3d 1048 (2011).

18. Similarly, for the reasons already expressed herein, the cause of action under the Unfair Claims Practices Act does not sound in contract and punitive damages are available under that claim as well, and the claim is applicable to all defendants.

19. NRS 42.001(1) defines "Conscious disregard" as "the knowledge of the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences."

20. NRS 42.001(2) defines "fraud" as "an intentional misrepresentation, deception or concealment of a material fact known to the person with the intent to deprive another person of his or her rights or property or to otherwise injure another person."

21. NRS 42.001(3) defines "malice, express or implied" as "conduct which is intended to injure a person or despicable conduct which is engaged in with a conscious disregard of the rights or safety of others."

22. NRS 42.001(4) defines "oppression" as "despicable conduct that subjects a person to cruel and unjust hardship with conscious disregard of the rights of the person."

23. *Countrywide Home Loans, Inc. v. Thitchener*, 124 Nev. 725, 192 P.3d 243 (2008) provides the framework for punitive damages conduct.

24. The Health Care Providers have introduced evidence that a jury could deem to constitute malice, oppression and/or fraud, express or implied, including but not limited to:

a. United's representatives testified that United has a duty to pay a reasonable reimbursement amount and the origin of the duty, that is found in the legal claims that he Health Care Providers have asserted.

b. The United representatives testified that United has not paid a reasonable value in accord with the Affordable Care Act because the Affordable Care Act sets the minimum, and that Affordable Care Act has language concerning usual and customary rates. And each and every one of the Defendants have identified, expressly by Ms. Hare, Mr.

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Ziemer, Mr. Haben and Ms. Paradise, that, in fact, they did not include usual and customary in the analysis determining reimbursement rates under United's various out-of-network programs; and Ms. Hare testified that defendants Sierra Health and Life and Health Plan of Nevada did not have out-of-network reimbursement programs, but that they too did not use usual and customary as a foundation for determining reasonable value. Additionally, there is testimony that United has violated the Affordable Care Act. A jury could determine that this testimony identifies conduct that is oppressive and fraudulent

c. United's representatives testified, expressly or inferentially, that the motivation for reducing out-of-network reimbursement rates was to underscore and to increase the amount of profits that United was enjoying or to try to save money allegedly for their administrative services clients and keep it in the context of third party administrator fees from a shared savings program.

d. The Health Care Providers have presented evidence that there are negative consequences if United underpays emergency room providers, including potentially jeopardizing what is defined as the safety net of our community: emergency department doctors, practitioners and clinicians. If they are underpaid, the quality of emergency services is diminished according to the testimony that has been elicited.

e. Further, written documentary evidence presented to the jury states that United has an obligation to pay billed charges.

f. United received advice from their internal regulatory and compliance department. PX 314. Ms. Hare testified that SHL and HPN received provider services. Mr. Ziemer identified that UMR also received support from United's provider services. In that email, United identified the obligation under the Affordable Care Act and how the law provides a minimum floor, yet United representatives' testimony demonstrates United did something different than what the law required.

25. The Health Care Providers have introduced evidence that a jury could conclude that United was deliberately placing United's interest over that safety net of community. Based

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on the testimony and other evidence, the Court concludes that there are sufficient facts such that the jury could find United engaged in oppressive, fraudulent and/or malicious conduct.

26. The Court also does not find that the Health Care Providers have waived their claim for punitive damages under either an unjust enrichment or Nevada state law statutory basis.

27. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Brief on this issue.

28. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Implied-in-Fact Contact

29. "[T]o find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract and promises were exchanged, the general obligations for which must be sufficiently clear. It is at that point that a party may invoke quantum meruit as a gap-filler to supply the absent term." *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. at 379–80, 283 P.3d 250, 256 (2012).

30. Although "[a] valid contract cannot exist when material terms are lacking or are insufficiently certain and definite[,] [a] contract can be formed, however, when the parties have agreed to the material terms, even though the contract's exact language is not finalized until later." *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005); *see also Brinkerhoff v. Foote*, 132 Nev. 950, 387 P.3d 880 (2016). "Which terms are essential 'depends on the agreement and its context and also on the subsequent conduct of the parties, including the dispute which arises and the remedy sought." *Id.* (quoting RESTATEMENT (SECOND) OF CONTRACTS § 131, cmt. g (1981)); *see also Aliya Medcare Fin., LLC v. Nickell*, No. CV1407806MMMSHX, 2015 WL 11089594, at *9 (C.D. Cal. May 28, 2015) (interpreting Nevada law).

31. The Nevada Supreme Court explicitly acknowledged that "quantum meruit [for an implied in fact contract] fills price term when it is appropriate to imply the parties agreed to a reasonable price" and "[w]here such a contract exists, then, quantum meruit ensures the

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laborer receives the reasonable value, usually market price, for his services." *Certified Fire Prot.*, 128 Nev. at 379–80, 283 P.3d 250, 256 (2012), citing 1 Dan B. Dobbs, *Dobbs Law of Remedies* § 4.2(3) (2d ed. 1993)).

32. The Health Care Providers have presented evidence that they are obligated to treat United's members under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410; that they will submit claims the way United has asked for claims to be submitted and they agreed not to balance bill United's members. This part of the agreement is also evidenced by both parties' spreadsheets identifying the at-issue claims and indications that United acknowledged its obligation to pay for the identified members and did indeed pay.

33. The Court concludes that the Health Care Providers have made a *prima facie* case on their implied contract claim as to all Defendants because the conduct was to submit a claim to United, the claim was adjudicated and then paid. The Health Care Providers are obligated under law to provide the services and United's representatives admitted on the stand that they have a duty to pay a reasonable amount for out-of-network emergency services. The Healthcare Providers performed medical services for United's insureds and submitted claims to them for payment on their platform. The Healthcare Providers also agreed not to balance bill their insureds. The Healthcare Providers submit that was an offer in the form of conduct. United adjudicated those claims accepting responsibility of payment for its insureds, including an acknowledgement that the insured was covered for the work performed, and paid something. It is that conduct the Healthcare Providers submit forms an implied contract. The parties dispute the value of the services performed. The price term is what remains at issue in this case for the jury to decide.

34. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Brief on this issue.

35. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Nevada Prompt Pay Statutes

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36. The Health Care Providers' fourth claim for relief is premised on United's alleged violation of the NV Healthcare Prompt Pay Statutes set forth in NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), and NRS 695C.185 (HMO). Each statute provides as follows:

> NRS 683A.0879 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]
>
> 1. Except as otherwise provided in subsection 2, an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the claim. If the claim is approved, the administrator shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the administrator shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.
>
> ***
>
> 4. An administrator shall not pay only part of a claim that has been approved and is fully payable.
>
> 5. ***A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section***.

Subsections 4 and 5 appear in each NV Healthcare Prompt Pay Statute.[1]

[1] **NRS 689A.410 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]**

***

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section

NRS 689B.255 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

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37. United relies on an inapplicable prompt pay statute, NRS 690B.012 (the "Casualty Prompt Pay Statute"), only applicable to casualty insurance that does not provide for a private right of action. United's reliance on *Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 571, 170 P.3d 989, 993 (2007) in an effort to support its Motion is misplaced because *Allstate's* ruling is limited to NRS 690B.012 and is wholly inapplicable to the Health Care Providers' claims.

38. The Casualty Prompt Pay Statute is categorically different than the NV Health Care Prompt Pay Statutes which provide: "***A court*** shall award costs and reasonable attorney's fees to the prevailing party ***in an action brought pursuant to this section.***"[2]

---

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

NRS 689C.485 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

***

4. A carrier shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

NRS 695C.185 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

***

4. A health maintenance organization shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

[2] *Arora v. Eldorado Resorts Corp.*, No. 2:15-cv-00751-RFB-PAL, 2016 WL 5867415, at *8 (D. Nev. Oct. 5, 2016) ("the provision within the [wage] statute for the payment of 'attorney fee[s]' further supports an implied private right of action. There would be no need for such allowance within the language of the statute if a private right of action were not implied."); *see Neville v. Eighth Judicial District Court*, 133 Nev. 777, 783 (2017) (stating it would be absurd to think that the Legislature intended a private cause of action to obtain attorney fees for an unpaid wages suit but no private cause of action to bring the suit itself);

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39. The Court concludes that the Health Care Providers were not required to exhaust administrative remedies, if any, prior to commencement of this action.

40. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

41. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Briefs on this issue.

ERISA

42. As this Court has stated in its prior Orders, this is a rate of payment case, not a right of payment case.

43. The Court has previously considered and rejected United's ERISA conflict preemption argument, as has the Nevada Supreme Court in connection with United's writ petition.

44. For the reasons previously expressed by the Court and incorporated herein, the Court does not find merit in the United's argument and the Court concludes that none of the Health Care Providers' claims are preempted.

45. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Accordingly,

ORDER

IT IS HEREBY ORDERED that the Motion is DENIED in full for the reasons stated herein, on the record at the November 18, 2021 hearing and contained in the Health Care Providers' Trial Briefs.

January 5, 2022

Dated this 5th day of January, 2022

Nancy L Allf

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District Court Judge

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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 DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order Denying Motion was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

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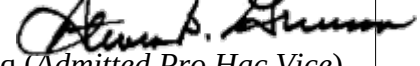

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

MOTION TO SEAL DEFENDANTS' REPLY IN SUPPORT OF MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS

[CHAMBERS HEARING REQUESTED]

012739

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Co., Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), by and through their attorneys, hereby move to seal, pursuant to Rule 3(1) of the Nevada Supreme Court Rules Governing Sealing and Redacting of Court Records ("SRCR"), Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits.

This Motion is made and based upon the papers and pleadings on file herein, the Declaration of Brittany M. Llewellyn, and the following memorandum of points and authorities.

Dated this 10th day of January, 2022.

/s/ Brittany M. Llewellyn

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DECLARATION OF BRITTANY M. LLEWELLYN IN SUPPORT OF MOTION TO SEAL DEFENDANTS' REPLY IN SUPPORT OF MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS

1. I am an attorney licensed to practice law in the State of Nevada, a partner at Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, counsel for Defendants in the above-captioned matter.

2. This Declaration is submitted in support of the instant Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits.

3. I have personal knowledge of the matters set forth herein and, unless otherwise stated, am competent to testify to the same if called upon to do so.

4. Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits contains clips and summaries of documents that have been designated as "Confidential" or "Attorneys' Eyes Only" under the Stipulated Confidentiality and Protective Order ("Protective Order") entered in this matter.

5. The Protective Order sets forth that documents designated as "Confidential" or "Attorneys' Eyes Only" must be filed under seal.

6. Defendants file the instant Motion to Seal in accordance with SRCR 3(1), as there are sufficient grounds to seal the Confidential Material under SRCR 3(4).

7. I declare that the foregoing is true and correct under the penalty of perjury under the laws of the state of Nevada.

DATED: January 10, 2022.

/s/ Brittany M. Llewellyn
Brittany M. Llewellyn

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Defendants move this Court to allow the filing of their Reply in Support of Motion to Seal Certain Confidential Trial Exhibits under seal, pursuant to Rule 3(1) of the Nevada Supreme Court Rules Governing Sealing and Redacting of Court Records ("SRCR"). The Reply in Support of Defendants' Motion to Seal Certain Confidential Trial Exhibits contains clips and summaries of exhibits that have been designated as "Confidential" or "Attorneys' Eyes Only" under the parties' Stipulated Confidentiality and Protective Order ("Protective Order").

There will be no prejudice to Plaintiffs because the parties' Protective Order mandates that documents designated as "Confidential" or "Attorneys' Eyes Only" must be filed under seal, and Plaintiffs' counsel has full access to Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits and any Confidential Material therein. Defendants respectfully request that the Court permit the filing of the Confidential Material under seal.

II. LEGAL ARGUMENT

Pursuant to SRCR 3(1), "[a]ny person may request that the court seal or redact court records for a case that is subject to these rules by filing a written motion . . . ." A court may order that the records be redacted or sealed provided that "the court makes and enters written findings that the specific sealing or redaction is justified by identified compelling privacy or safety interest that outweigh the public interest in access to the court records," which includes a finding that "[t]he sealing or redaction furthers. . . a protective order entered under NRCP 26(c)" or "[t]he sealing or redaction is justified or required by another identified compelling circumstance." SRCR 3(4)(b), (h).

On June 24, 2020, pursuant to a stipulation by and between the parties, this Court entered the Protective Order. The Protective Order provides that a party may designate a document as "Confidential" if it "reasonably and in good faith believes [the document] contains or reflects: (a) proprietary, business sensitive, or confidential information; (b) information that should otherwise be subject to confidential treatment pursuant to applicable federal and/or state law; or (c) Protected Health Information, Patient Identifying Information, or other HIPAA-governed

information." Prot. Ord. at §2(a). The Protective Order also provides that a party may designate a document as "Attorneys' Eyes Only" if any portion of it contains material, testimony, or information that the party "reasonably and in good faith believes contains trade secrets or is such highly competitive or commercially sensitive proprietary and non-public information that would significantly harm business advantages of [the Party]…and that disclosure of such information could reasonably be expected to be detrimental to the [Party's] interests." *Id.* at §2(b).

The Protective Order further provides that the parties will file a motion to have confidential / sensitive discovery material filed under seal, including any portion of a court paper that discloses confidential / sensitive discovery material. *Id.* at 20. Consistent with the parties' agreement contained in the Protective Order, Defendants move to file their Reply in Support of their Motion to Seal Certain Confidential Trial Exhibits under seal. The Reply contains clips and detailed summaries of documents which have been designated as "Confidential" or "Attorneys' Eyes Only" under the Protective Order.

Based on the Protective Order and the confidential nature of these documents, SRCR 3(4) provides a sufficient basis to order sealing Defendants' Reply in Support of their Motion to Seal Certain Confidential Trial Exhibits. The Reply has thus been filed temporarily under seal and should remain under seal until such time as this Court has had an opportunity to rule on the instant Motion, and in perpetuity unless this Court finds otherwise.

III. RELIEF REQUESTED

For the foregoing reasons, Defendants respectfully request that the Court enter an Order sealing Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits. Defendants further request that the Confidential Material remain under seal until such time as this Court has had an opportunity to rule on the instant Motion, and in perpetuity unless this Court finds otherwise.

Dated this 10th day of January, 2022.

/s/ Brittany M. Llewellyn

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CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of January, 2022, a true and correct copy of the foregoing **MOTION TO SEAL DEFENDANTS' REPLY IN SUPPORT OF MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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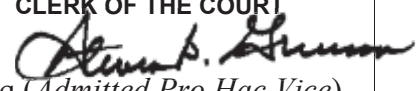

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

MOTION TO SEAL DEFENDANTS' SECOND SUPPLEMENTAL APPENDIX OF EXHIBITS TO MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS

[CHAMBERS HEARING REQUESTED]

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Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Co., Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), by and through their attorneys, hereby move to seal, pursuant to Rule 3(1) of the Nevada Supreme Court Rules Governing Sealing and Redacting of Court Records ("SRCR"), Defendants' Second Supplemental Appendix of Exhibits to Motion To Seal Certain Confidential Trial Exhibits.

This Motion is made and based upon the papers and pleadings on file herein, the Declaration of Brittany M. Llewellyn, and the following memorandum of points and authorities.

Dated this 10th day of January, 2022.

/s/ Brittany M. Llewellyn

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