Fill in this information to identify the case:

Debtor Tehum Care Services, Inc.

United States Bankruptcy Court for the: Southern District of Texas (State)

Case number 23-90086

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**
   ADA WEST DERMATOLOGY
   Name of the current creditor (the person or entity to be paid for this claim)
   Other names the creditor used with the debtor _____

2. **Has this claim been acquired from someone else?**
   ☑ No
   ☐ Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**
   Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

   Where should notices to the creditor be sent?
   ADA WEST DERMATOLOGY
   1618 S Millennium Way, Suite 100
   Meridian, ID 83642, US

   Contact phone 2088843376
   Contact email adawestdermatology@gmail.com

   Where should payments to the creditor be sent? (if different)
   Contact phone _____
   Contact email _____

   Uniform claim identifier for electronic payments in chapter 13 (if you use one):
   _

4. **Does this claim amend one already filed?**
   ☑ No
   ☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**
   ☑ No
   ☐ Yes. Who made the earlier filing? _____

23900862305040642420000 52

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**

☑ No

☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ___ ___ ___ ___

7. **How much is the claim?** $ 20786 . **Does this amount include interest or other charges?**

☑ No

☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**

Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.

Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

Limit disclosing information that is entitled to privacy, such as health care information.

_____

9. **Is all or part of the claim secured?**

☑ No

☐ Yes. The claim is secured by a lien on property.

Nature or property:

☐ Real estate: If the claim is secured by the debtor's principle residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.

☐ Motor vehicle

☐ Other. Describe: _____

Basis for perfection: _____

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $_____

Amount of the claim that is secured: $_____

Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $_____

Annual Interest Rate (when case was filed)_____%

☐ Fixed

☐ Variable

10. **Is this claim based on a lease?**

☑ No

☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**

☑ No

☐ Yes. Identify the property: _____

23900862305040642420000 52

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check all that apply:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$
☐ Up to $3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$
☐ Wages, salaries, or commissions (up to $15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☑ I am the creditor.

☐ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have reasonable belief that the information is true and correct.

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

Executed on date 08/14/2023
MM / DD / YYYY

/s/Somphane Phimmasone
Signature

Print the name of the person who is completing and signing this claim:

Name: Somphane Phimmasone
First name Middle name Last name

Title: President

Company: Ada West Dermatology
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address

Contact phone _____ Email _____

23900862305040642420000052

KCC ePOC Electronic Claim Filing Summary

For phone assistance: Domestic (866) 967-0491 | International 001-424-236-7244

Debtor:
23-90086 - Tehum Care Services, Inc.
District:
Southern District of Texas, Houston Division

Creditor:
ADA WEST DERMATOLOGY
1618 S Millennium Way, Suite 100
Meridian, ID, 83642
US
Phone:
2088843376
Phone 2:
2088843376
Fax:
Email:
adawestdermatology@gmail.com

Has Supporting Documentation:
Yes, supporting documentation successfully uploaded
Related Document Statement:

Has Related Claim:
No
Related Claim Filed By:

Filing Party:
Creditor

Other Names Used with Debtor:

Amends Claim:
No
Acquired Claim:
No

Basis of Claim:

Last 4 Digits:
No

Uniform Claim Identifier:

Total Amount of Claim:
20786

Includes Interest or Charges:
No

Has Priority Claim:
No

Priority Under:

Has Secured Claim:
No
Based on Lease:
No
Subject to Right of Setoff:
No

Nature of Secured Amount:
Value of Property:
Annual Interest Rate:
Arrearage Amount:
Basis for Perfection:
Amount Unsecured:

Submitted By:
Somphane Phimmasone on 14-Aug-2023 4:08:01 p.m. Eastern Time
Title:
President
Company:
Ada West Dermatology

VN: 01FC017B2520F99B164B3CD98BD20073

Exhibit A

MEDICAL GROUP SERVICES AGREEMENT

between

CORIZON, LLC

and

ADA WEST DERMATOLOGY

This Agreement is made and entered into this 29 day of April, 2015, by and between Corizon, LLC, a Missouri limited liability company with principal offices located at 103 Powell Court Ste-104 Brentwood, TN, 37027, acting for itself or on behalf of any/all/other affiliated companies (hereinafter collectively referred to as "Corizon Health") and **ADA WEST DERMATOLOGY** (hereinafter referred to as "Medical Group"), with principal offices located at 1618 South Millennium Way, Suite 100 Meridian, ID 83642 (hereinafter collectively referred to as the "Parties").

WITNESSETH:

WHEREAS, Corizon Health has a contract to provide or arrange for the provision of Health Care Services to certain inmates and detainees under the control of the Idaho Department of Corrections (hereinafter referred to as "Client"); and

WHEREAS, Medical Group's physicians are licensed in the State of Idaho; and

WHEREAS, Corizon Health desires to engage, and Medical Group desires to provide Dermatology Services to the correctional facility inmates and detainees in the custody of the Client, all on the terms and conditions set forth herein.

NOW THEREFORE, for and in consideration of the mutual covenants and promises as are hereinafter set forth and other good and valuable consideration, the sufficiency of which is hereby acknowledged by the Parties, Corizon Health and Medical Group hereby agree as follows:

SECTION 1
Definitions

1.1 **Affiliated Entity** means any entity who directly or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, Corizon Health.

1.2 **Corizon Health/Client Contract** means the agreement entered into between Corizon Health and the Client whereby Corizon Health has agreed to provide or arrange for the provision of Health Care Services to the inmates and detainees in the custody of the Client.

1.3 Corizon Health's Medical Director means the physician designated as the Corizon Health Medical Director for the correctional facility or facilities served under the Corizon Health/Client Contract.

1.4 Completed Claim means a timely claim submitted on an industry standard claim form (CMS-1500 or UB-04), for reimbursement of Health Care Services which contains at least the following information:

1) Patient (Inmate) name and Department of Correction or Booking Identification number (Inmate Number).
2) Name and Address of Correctional Facility from which the inmate was transported.
3) Patient Date of Birth.
4) Date(s) of Service.
5) Medical Group Name, Address, Phone number, and Tax Identification number.
6) ICD-9 Diagnostic and Surgical Procedure codes and descriptions.
7) Current industry standard procedure coding (UB-04 Revenue Codes, DRG, HCPCS and CPT codes as appropriate) and descriptions.
8) Detailed billing of charges and units.

1.5 Customary Charge means the usual and customary fees charged by Medical Group for the particular service that is performed, which do not exceed the fees Medical Group would charge any other person.

1.6 Eligible Charges mean the amount of Medical Group's Customary Charges from which any reduction is taken for purposes of payment. Eligible Charges do not include amounts that are billed but that are duplicative, incorrectly coded, improperly coded, or that have similar defects, errors, irregularities or mistakes in billing. Eligible Charges also do not include charges for procedures or services that are not Medically Necessary or were unauthorized under this Agreement.

1.7 Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the Patient in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or such other urgent condition that constitutes an Emergency Medical Condition.

1.8 Emergency Services means those Health Care Services, which are Medically Necessary and provided for the treatment of an Emergency Medical Condition.

1.9 Health Care Services means the hospital, physician, medical and related services and supplies provided to a Patient by Medical Group which are Medically Necessary and are requested by the Corizon Health contracted on-site physician.

1.10 Health Services Administrator (HSA) means the Corizon Health employee responsible for managing the medical program for the correctional facility or facilities served under the Corizon Health/Client Contract.

1.11 Medically Necessary describes those services which are determined to be: (a) appropriate for the treatment of the Patient's medical condition; (b) provided for the diagnosis or care and treatment of the Patient's medical condition; (c) in accordance with the applicable standards of good medical practice; (d) not elective or cosmetic or primarily for the convenience of the Patient, the Medical Group or any medical provider; and (e) the most appropriate and available supplier level of service that can be safely provided to the Patient.

1.12 Patient means those correctional facility inmate patients or detainees in the custody of the Client for whom Corizon Health has contracted to provide or arrange for the provision of Health Care Services pursuant to the Corizon Health/Client Contract.

1.13 Provider-Preventable Condition (PPC) means a condition which reasonably could have been prevented through the application of evidence-based guidelines. For the purposes of this Agreement, PPCs will include, but not be limited to, the most recent list of Medicare Hospital-Acquired Conditions (HACs).

SECTION 2
Medical Group's Rights and Obligations

2.1 General Engagement. Corizon Health hereby engages Medical Group to provide Health Care Services to Patients, and Medical Group hereby accepts such engagement according to the terms and conditions of this Agreement.

2.2 Time and Place of Services. Medical Group agrees to provide and/or make available Health Care Services at Medical Group's office(s) or other usual and customary site(s) for rendering Health Care Services and in accordance with Medical Group's usual and customary schedule for rendering Health Care Services. Medical Group may provide services to patients on-site at the correctional facility as agreed between Corizon Health and Medical Group. Medical Group will comply with applicable site policies, procedures, security measures and security clearance requirements in place at the site.

2.3 Qualifications. Medical Group represents that its physicians possesses a current and unrestricted license to provide Dermatology services in the State of Idaho. Medical Group also represents that Medical Group possesses current and unrestricted controlled substance certification. Medical Group agrees to comply at all times with all applicable federal, state, and local laws, and other regulatory and certification requirements, which govern Medical Group's business. Medical Group further agrees to notify Corizon immediately if Medical Group receives notice of noncompliance with such requirements, conditions and standards, or if Medical Group's qualification status is changed in any respect. Medical Group also agrees to notify Corizon Health immediately in the event that Medical Group's credentialing status or level of privileges is reduced, suspended, terminated, or in any way diminished at any hospital, clinic, or other health

care facility, or within any network, provider group, or other such professional association or society. Medical Group's failure to meet or maintain the required qualifications may result in immediate termination of this Agreement.

2.4 Utilization Review. Medical Group agrees to support and adhere to Corizon Health policies and procedures regarding Credentialing and Utilization Review. Medical Group will ensure that services rendered are reasonable and medically necessary. Medical Group will ensure that inpatient diagnostic procedures, consultations and inpatient surgeries are scheduled following the determination of need. Medical Group will permit Corizon Health to review services rendered and will provide Corizon Health with patient information and documents necessary for utilization management functions. Medical Group will honor Corizon Health's request for medical records. Medical Group acknowledges and understands that payment for unauthorized or inappropriate services may be adjusted or denied by Corizon Health. Disputed claims adjudication may be appealed in accordance with the appeals process set forth in Section 3.4 below.

2.5 Quality Assurance. Medical Group will ensure the application of a quality assurance process that utilizes appropriate quality of care standards. Medical Group will also ensure that appropriate quality assurance review activity, including subsequent action taken by the Medical Group, will occur for quality of care issues referred by Corizon Health. Medical Group shall make available for review and examination by Corizon Health's Medical Director or his or her designee, upon request, specific documentation to evidence Medical Group's adherence to quality of care standards as they may reasonably relate to the Health Care Services rendered to Patients hereunder.

2.6 Compliance with Applicable Law. Medical Group agrees that all Health Care Services provided by or through Medical Group pursuant to this Agreement, and documentation thereof, will be in compliance with applicable law and certification or licensure requirements.

2.7 Security. Medical Group shall cooperate with all necessary security arrangements whether provided by the Client or such other duly qualified security or law enforcement agency.

SECTION 3
Compensation of Medical Group

3.1 Compensation for Services. Medical Group will be compensated for Health Care Services rendered at the lesser of Eligible Charges or as set forth in the Compensation Schedule, attached hereto as Exhibit A. Medical Group agrees to abide by American Medical Association and Medicare billing and coding guidelines.

3.1.1 Claims Review. Completed Claims for professional services are reviewed by a clinical software system during payment processing. This review detects, corrects, and documents improper coding, including unbundling, upcoding, and fragmentation using Medicare National Correct Coding Initiative and/or CPT coding guidelines, and adjusts reimbursement accordingly. Completed Claims questioned by the clinical software may be reviewed by a nurse

analyst and appropriate documentation to substantiate questioned charge(s) may then be requested.

3.2 Claims Submission. To be eligible for compensation under this Agreement, Medical Group must submit a Completed Claim for each episode of Health Care Services provided to a Patient. A Completed Claim must be submitted within sixty (60) days of the service rendered. Completed Claims submitted after sixty (60) days shall be permanently denied. Completed Claims in paper form should be sent to the following address:

Corizon Health
103 Powell Court Ste-104
Brentwood, TN 37027
Attn: Claims Department

Or such other address as Medical Group is notified by Corizon Health.

To inquire about the status of claims submitted, please call Corizon Health Customer Service at 888-865-2910. Customer Service hours are Monday through Friday, 7:30am to 5:30pm (CST) or email us at claimscs@corizonhealth.com.

Corizon Health will also accept the electronic filing of CMS-1500 forms. When submitting CMS-1500 forms via an electronic format, Medical Group should use the Corizon Health payer identification number **43160** and include the Department of Corrections Inmate Number in box 1A of the CMS-1500 form.

In the event Medical Group renders Health Care Services on-site at the correctional facility, Medical Group must bill Place of Service "09" in box 24B of the CMS-1500 form.

3.3 Audit. Corizon Health shall be entitled to audit claims and/or claims payments for up to twelve (12) months following Corizon Health's payment of any Medical Group claim to ensure that services billed to Corizon Health were rendered and paid in accordance with the terms of this Agreement. For any claims found to be overpaid, Medical Group agrees that Corizon Health may recover overpayment made to Medical Group by Corizon Health by offsetting such amounts from later payments to Medical Group, including, without limitation, making retroactive adjustments to payments to Medical Group for errors and omissions relating to data entry errors and incorrectly submitted claims or incorrectly applied discounts.

3.4 Appeal Process. In the event that a dispute arises concerning the resolution of a Completed Claim, Medical Group may appeal by submitting the dispute to Corizon Health in writing, with supporting documentation, within forty five (45) calendar days following Corizon Health's response or denial of the Completed Claim. Corizon Health shall provide a reply and Medical Group shall initiate appropriate action, if any, within forty five (45) days following receipt of Corizon Health's response. If Medical Group fails to dispute in writing Corizon Health's handling of a Completed Claim within forty five (45) calendar days following receipt of

Corizon Health's response, then such claim may be considered waived and Corizon Health shall not be obligated to make any payment or adjustment thereafter.

3.5 Patient Verification. Except for Emergency Services, Medical Group will not provide Health Care Services to any Patient unless the Patient has been referred for care by the Corizon Health contracted on-site physician. Medical Group is responsible for verifying that an individual who presents for services is a Patient and has been referred by the Corizon Health contracted on-site physician to the Medical Group for Health Care Services.

3.6 Right of Recovery. Medical Group will not seek reimbursement from the Patient or from the Client without Corizon Health's written consent.

3.7 Prior Services & Payments. If Medical Group has performed services for Corizon Health Patients prior to the Effective Date of this Agreement, and Corizon Health has compensated Medical Group for these services, Medical Group agrees to accept the amounts previously paid by Corizon Health as full and final reimbursement for services rendered prior to the Effective Date of this Agreement.

3.8 Tax Liability. Medical Group is solely responsible for any tax federal, state or local authorities as a result of this Agreement. Corizon Health shall not withhold any taxes from payments made to Medical Group under this Agreement, nor shall Corizon Health be responsible for providing unemployment insurance coverage for Medical Group.

SECTION 4
Term and Termination

4.1 Term. The term of this Agreement will commence on the Effective Date and will continue in effect for one (1) year ("Initial Term") and shall automatically renew for recurring one (1) year terms thereafter, unless either Party, at least thirty (30) days prior to the expiration date, notifies the other in writing of its desire not to extend or renew this Agreement.

4.2 Termination. This Agreement may be terminated as follows:

4.2.1 Termination without Cause. Either party may terminate this Agreement, without cause, by giving the other party written notice of termination, not less than thirty (30) days prior to the effective date thereof.

4.2.2 Termination for Cause. Corizon Health may terminate this Agreement with Medical Group for cause, including but not limited to the occurrence of any of the following events, which has not been cured within thirty (30) days after written notice from Corizon Health.

4.2.2.1 Medical Group has breached any of the material terms and conditions of this Agreement or the exhibits or attachments hereto; or

4.2.2.2 Any activities or actions of Medical Group that, in the reasonable judgment of Corizon Health, are deemed to be detrimental to Corizon Health.

4.2.3 Immediate Termination. Corizon Health may immediately terminate this Agreement upon the occurrence of any of the following events:

4.2.3.1 Medical Group's failure to maintain required insurance as provided in this Agreement; or

4.2.3.2 Medical Group's inability to meet its obligations pursuant to this Agreement due to financial insolvency, bankruptcy, or lack of capacity to provide Health Care Services; or

4.2.3.3 Medical Group is found guilty of a criminal offense; or

4.2.3.4 Upon termination or expiration of Corizon Health/Client Contract; or

4.2.3.5 Medical Group is found liable for gross misconduct in providing care.

SECTION 5
Insurance and Indemnification

5.1 Medical Group's Insurance. At all times during the term of this Agreement and any renewals hereof, Medical Group shall maintain or cause to be maintained adequate professional liability insurance policies or self-insurance with limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in annual aggregate, and such insurance shall provide occurrence-based coverage, or if it provides claims-made coverage, Medical Group agrees that upon the expiration or termination of this Agreement for any reason, Medical Group will maintain insurance coverage for any liability directly or indirectly resulting from Medical Group's provision of services in connection with this Agreement, or any other acts or omissions of Medical Group occurring in whole or in part during the term of this Agreement (hereinafter, "Continuing Coverage"). Medical Group may procure Continuing Coverage by obtaining subsequent policies which have a retroactive date of coverage equal to the Effective Date of this Agreement, by obtaining an extended reporting endorsement ("tail") applicable to the insurance coverage maintained by Medical Group during the term of this Agreement, or by such other methods as are mutually agreed upon by Medical Group and Corizon Health. In addition, Medical Group agrees to procure and maintain, at its sole expense, such comprehensive general and/or umbrella liability insurance as Medical Group shall reasonably deem necessary to cover its potential general liability risk exposure. Medical Group shall require all health care professionals employed by or under contract with Medical Group to procure or maintain the same limits of professional liability insurance as set forth above, unless such professionals are covered under Medical Group's insurance policy.

The insurance obtained pursuant to this Section, including any Continuing Coverage, will cover all employees, physicians and agents of Medical Group who provide Health Care Services to

Patients, against any and all claims, actions, judgments, liabilities, losses, damages, costs, and obligations (including attorney's fees) which are attributable to or which arise, directly or indirectly, out of any act or omission by Medical Group and/or its employees, physicians, or agents. Without limiting the obligations of Medical Group under this Section, the insurance maintained or caused to be maintained pursuant to this Section will provide coverage against civil actions based on medical treatment brought under 42 U.S.C. § 1983, and as that statute may be amended, modified, recodified, or succeeded in the future. The obligations of this Section concerning Continuing Coverage shall survive termination of this Agreement.

5.2 Corizon Health's Insurance. At all times during the term of this Agreement and any renewals hereof, Corizon Health shall maintain professional liability policies of insurance in amounts and with coverage similar to that required of Medical Group hereunder.

5.3 Certifications. Medical Group shall, within ten (10) days after execution of this Agreement and on an annual basis thereafter, provide to Corizon Health certificates issued by an insurance carrier or its agent or other evidence of insurance as required under this Agreement. Medical Group shall provide Corizon Health with at least thirty (30) days prior written notice of any modification, cancellation, or non-renewal of such policies.

5.4 Hold Harmless and Indemnification. Corizon Health agrees to indemnify and hold harmless Medical Group and its agents and employees from any and all claims, damages and lawsuits of any kind whatsoever based upon the acts and omissions of Corizon Health and any of its staff members, employees or agents.

Medical Group agrees to indemnify and hold harmless Corizon Health and its agents and employees from any and all claims, damages and lawsuits of any kind whatsoever based upon the acts or omissions of Medical Group or any of its staff members, employees or agents.

SECTION 6
Relationship of the Parties

6.1 Relationship of the Parties. The relationship of Medical Group to Corizon Health is that of independent contractor. Nothing contained herein shall create an employer-employee, principal-agent, or partnership relationship between Corizon Health and Medical Group or between Corizon Health and any employee, agent, or physicians of Medical Group. Corizon Health shall not exercise control or direction over the manner in which Medical Group or any employee, agent, or physician of Medical Group renders services. Nothing contained herein shall interfere with the provider-patient relationship between Medical Group and any patient, including the Patients under this Agreement, or with Medical Group's legal or ethical obligation to provide the proper standard of care to Patients.

6.2 Confidential Information. Medical Group agrees not to disclose or in any way use, or allow any other person to disclose or use, confidential information of or concerning Corizon Health or the various facilities either during or after the term of this Agreement without Corizon Health's prior express written consent. Confidential information includes, but is not limited to,

legal or claim data, financial data, methods of operation, policies and procedures. Medical Group shall not copy or remove Corizon Health documents for its own use or for the use of others, nor shall Medical Group make use of or allow or assist any other person or company to make use of any Corizon Health procedure or program, including but not limited to those relating to utilization review or quality improvement, except as authorized under this Agreement. Medical Group shall not disclose, or allow others to disclose, the terms of this Agreement, except, as it is necessary to perform this Agreement or to obtain accounting, legal or tax advice from its professional advisors. This Section shall survive termination of this Agreement.

6.3 Non-Exclusivity. This Agreement is a non-exclusive arrangement. Medical Group may participate in other affiliations and render such other Health Care Services as Medical Group determines. Medical Group acknowledges that Corizon Health must contract with other health care providers, including hospitals, for the purpose of fulfilling its obligations pursuant to the Corizon Health/Client Contract.

6.4 Medical Records. Medical Group agrees to prepare comprehensive medical records for each Patient to whom Medical Group provides Health Care Services. Each such medical record shall contain sufficient information to identify the Patient, establish a diagnosis and medical classification, support the diagnosis, identify and justify the treatment, and document the results of such treatment. Medical records prepared by Medical Group during the term of this Agreement will be kept confidential by Medical Group and shall be maintained in accordance with applicable state and federal laws governing confidentiality. Medical Group will allow Corizon Health and its health care professionals access to such medical records without cost to Corizon Health. This Section shall survive termination of this Agreement.

6.5 Non-Solicitation Covenant. Medical Group agrees not to solicit Corizon Health employees for employment by Medical Group, during the term of this Agreement and for a one (1) year period following the termination of this Agreement.

SECTION 7
Construction of Agreement

7.1 **Assignment**. The Parties to this Agreement may not assign, sell or transfer any of their rights or responsibilities under this Agreement without the prior written consent of the other party; provided however, that Corizon Health may assign this Agreement and all its rights and responsibilities hereunder to any Affiliated Entity, as defined above, without Medical Group's prior written consent.

7.2 Amendments. This Agreement may be amended only by written agreement signed by the Parties hereto.

7.3 Section Headings. The headings of sections in this Agreement are for reference only and shall not affect the meaning of this Agreement.

7.4 Entire Agreement. This Agreement, inclusive of any and all amendments, attachments and exhibits incorporated herein by reference, constitutes the entire understanding and agreement between the parties with regard to the subject matter hereof. No other prior or contemporaneous promise, obligation, statement or understanding between the parties, whether written or oral, shall be valid or binding.

7.5 Binding Effect. This Agreement shall be binding upon and inure to the benefit of each party hereto, and their successors and permitted assigns. No party may assign this Agreement, except as specifically provided otherwise herein.

7.6 No Third Party Beneficiary Rights. No patient, nor the Client, nor any other third party shall have any third party beneficiary rights hereunder.

7.7 Non-Waiver. Failure to insist upon strict compliance with any of the terms or conditions of this Agreement shall not be deemed to be a waiver in the event of any future breach of any term or condition hereunder.

7.8 Severability. Should any provision (or part thereof) of this Agreement be held to be invalid and/or unenforceable, the remaining provisions shall remain in full force and effect.

7.9 Notices. Any notice required hereunder (including notice of an amendment of this Agreement) shall be sent by registered or certified mail (return receipt requested), personal delivery, overnight commercial carrier, or other guaranteed delivery. The notice shall be effective as of the date of delivery if the notice is personally delivered, or the date of receipt or refusal to accept delivery if the notice is forwarded by other means. Unless otherwise specified, notices shall be sent to:

Corizon Health
Corizon Health
103 Powell Court Ste-104
Brentwood, TN 37027
Attn: M. Therese Brumfield, Vice President Provider Operations

With a courtesy copy to the Attn: General Counsel

Medical Group
Ada West Dermatology
1618 South Millennium Way, Suite 100
Meridian, ID 83642
Attn: Todd Rodgers, Practice Manager
E-mail: trodgers.awd@gmail.com

7.10 Non-Discrimination. Medical Group shall not discriminate on the basis of race, color, sex, religion, national origin, ethnic group, age or disability.

7.11 Multiple Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute a single instrument.

7.12 Name, Symbol and Service Mark. During the term of this Agreement, Corizon Health shall have the right to use Medical Group's name solely to make public reference to Medical Group as a contracted provider for Client. Medical Group and Corizon Health shall not otherwise use each other's name, symbol or service mark without prior written approval.

7.13 Applicable Law. For conflict of law purposes, the laws of the State of Tennessee shall apply in interpreting the terms of this Agreement.

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of that Commencement Date first above written.

CORIZON, LLC

By: Roland Maldonado

Chief Operations Officer

Date: 4/17/15

By: LaTonya Nicholson

Contract Specialist

Date: 3/26/15

By: M. Therese Brumfield

Vice President, Provider Operations

Date: 4/28/15

ADA WEST DERMATOLOGY

By:

Signature

PRACTICE MANAGER

Title

Print Name: Todd J. Rodgers

Date: 3.20.15

TIN: 203276415

NPI: 1518973338

EXHIBIT A
COMPENSATION SCHEDULE
FOR
ADA WEST DERMATOLOGY

1.1. Procedures billed on CMS-1500. Claims for Health Care Services rendered in the provider's office or other usual and customary site for rendering Health Care Services shall be billed on a standard CMS-1500 form using industry standard procedure coding (i.e. CPT-4/HCPCS Codes).

1.2. Reimbursement. Corizon Health agrees to reimburse for authorized covered services at the lesser of one-hundred percent (100%) of the Medicare Fee Schedule for Idaho, adjusted annually for locality number "00" or Medical Group's Eligible Charges.

When Corizon Health is primary, the payment from Corizon Health shall be accepted by Medical Group as payment in full for all authorized services and Medical Group agrees to make no additional charges to Corizon Health Patient. Notwithstanding, Corizon Health will be considered secondary payor to all other insurance carriers. Verification of available benefits will be documented prior to payment by Corizon Health. Corizon Health will coordinate payment up to 100% with any other insurance carrier, provided, however, that in no case shall Corizon Health be responsible for payments beyond its coverage limits. It is agreed by both parties that Corizon Health is only responsible for payments for services for Patients in the custody of Client's correctional facility.

1.3. Provider-Preventable Conditions. The Parties hereby agree that when a medical condition is not present at the time the Medical Group treats Patient but is reported as a secondary diagnosis associated with Medical Group's care, Corizon Health's payment to Medical Group shall be denied to reflect that the condition could have been prevented by Medical Group. Corizon Health shall not be responsible for reimbursing the Medical Group for the care and services related to PPCs.

Exhibit B

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 58945
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Stevens,	3. PATIENT'S BIRTH DATE MM DD YY: 1944 SEX M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): Po Box 70010	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: Boise STATE: ID	8. RESERVED FOR NUCC USE
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 3869588	
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 [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

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: SOF DATE:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Gregory L Wells MD	17a. 17b. NPI 1871609370
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E): A C4441 B C44519 C D0462 D E F G H I J K L — ICD Ind. 0	

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Stevens,	
7. INSURED'S ADDRESS (No., Street): Po Box 70010	
CITY: Boise STATE: ID	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 3869588	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY: 1944 SEX M [X] F [ ]	
c. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SOF	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES	
22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER: 13D2047540	

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 01 21 21 01 21 21	81		88305		ABC	720 00	4		NPI	1558321323
2 01 21 21 01 21 21	81		88331		A	253 00	1		NPI	1558321323
3 01 21 21 01 21 21	81		88332		A	140 00	1		NPI	1558321323
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 371697222 [X]	26. PATIENT'S ACCOUNT NO.: CB004ZGX4C017	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 1113 00	29. AMOUNT PAID: $ 0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SOF Christine Meesham MD DATE	32. SERVICE FACILITY LOCATION INFORMATION: Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. b.		33. BILLING PROVIDER INFO & PH #: (208) 9915665 Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. 1760730436 b.	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DOD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
						X	95560

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Gunter,	3. PATIENT'S BIRTH DATE MM DD YY / SEX 1970 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Gunter,
5. PATIENT'S ADDRESS (No., Street) 14601 South Pleasant Valley R	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street) 14601 South Pleasant Valley R
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 3312760		ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 3312760
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 X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX 1970 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO X PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, complete items 9, 9a, and 9d.

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 SOF 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.

SIGNED SOF

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 DN Gregory L Wells MD	17a. 17b. NPI 1871609370	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. D0461 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 13D2047540

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 02 08 21	02 08 21	81		88305		A	180 00	1		NPI	1871609370
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 371697222 X	26. PATIENT'S ACCOUNT NO. CB0056J61C017	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 180 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.) SOF Gregory Wells MD SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. b.	33. BILLING PROVIDER INFO & PH # (208) 9915665 Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 95560

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gunter,

3. PATIENT'S BIRTH DATE MM DD YY: 1970 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Gunter,

5. PATIENT'S ADDRESS (No., Street): 14601 South Pleasant Valley R

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 14601 South Pleasant Valley R

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3312760

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3312760

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 [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 1970 SEX M [X] F

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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: SOF DATE:

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

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

SIGNED: SOF

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: DN Gregory L Wells MD

17a.

17b. NPI: 1871609370

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

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. L0461 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

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	02 08 21	02 08 21	81		88312		A	263 00	1		NPI 1871609370
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: 371697222 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: CB0056J78C017

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

28. TOTAL CHARGE: $ 263 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.)

SOF
Gregory Wells MD
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH # (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 116071

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Landon,

3. PATIENT'S BIRTH DATE MM DD YY: 1948 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Landon,

5. PATIENT'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd Co

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd Co

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3869588

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3869588

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 [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 1948 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

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: SOF 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.

SIGNED: SOF

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: DN Gregory L Wells MD

17a.

17b. NPI: 1871609370

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

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. D044 B. L578 C. Z85828 D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

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 02 26 21	02 26 21	81		88305		ABC	360 00	2		NPI	1558321323
2 02 26 21	02 26 21	81		88331		ABC	506 00	2		NPI	1558321323
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 371697222 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO: CB005D549C017

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

28. TOTAL CHARGE: $ 866 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.)

SOF

SIGNED: Christine Meesham MD DATE:

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH # (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ TRICARE (ID#/DOD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK LUNG (ID#) ☒ OTHER (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1) 58945
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Stevens,	3. PATIENT'S BIRTH DATE MM DD YY 1944 SEX M ☒ F ☐		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Stevens,
5. PATIENT'S ADDRESS (No., Street) Po Box 70010	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street) Po Box 70010
CITY Boise	STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83707	TELEPHONE (Include Area Code) (208) 3869588		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 3869588
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 1944 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 Corizon
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 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 SOF 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.

SIGNED SOF

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 DN Gregory L Wells MD	17a. 17b. NPI 1871609370	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
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. C44319 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 13D2047540

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 01 21 03 01 21	81		88305	A	180 00	1		NPI	1871609370
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 371697222 ☒	26. PATIENT'S ACCOUNT NO. CB005D358C017	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 180 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.)

SOF

SIGNED Gregory Wells MD DATE

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457
a. b.

33. BILLING PROVIDER INFO & PH # (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457
a. 1760730436 b.

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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]

1a. INSURED'S I.D. NUMBER: 58945

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Stevens,

3. PATIENT'S BIRTH DATE: 1944 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Stevens,

5. PATIENT'S ADDRESS (No., Street): Po Box 70010

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Po Box 70010

CITY: Boise | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 3869588

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 3869588

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 [X]

a. INSURED'S DATE OF BIRTH: 1944 | SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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: SOF | 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.

SIGNED: SOF

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: DN Gregory L Wells MD

17a.

17b. NPI: 1871609370

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

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. C44319 B. L578 C. Z85828 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

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 21 | 04 22 21	81		88305		ABC	360 00	2		NPI	1558321323
2	04 22 21 | 04 22 21	81		88331		ABC	506 00	2		NPI	1558321323
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 371697222 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CB005ZAW2C017

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

28. TOTAL CHARGE: $ 866 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.)

SOF

SIGNED: Christine Meeshan MD | DATE

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. | b.

33. BILLING PROVIDER INFO & PH # (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	18593
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wolfe,	3. PATIENT'S BIRTH DATE MM DD YY: 1955 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Wolfe,	
5. PATIENT'S ADDRESS (No., Street): 13500 South Pleasant Valley R	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 13500 South Pleasant Valley R	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Kuna STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3869588	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3869588	
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 [X]
a. INSURED'S DATE OF BIRTH MM DD YY: 1955 SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):
b. OTHER CLAIM ID (Designated by NUCC):	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

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: SOF 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.
SIGNED: SOF

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. NPI

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

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. C44629 B. D0461 C. L570 D. D0462
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 13D0895833

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 05 05 21 05 05 21	11		12032	59	A	762 00	1		NPI	1871609370
2 05 05 21 05 05 21	11		11602	59	A	624 00	1		NPI	1871609370
3 05 05 21 05 05 21	11		17262		B	447 00	1		NPI	1871609370
4 05 05 21 05 05 21	11		17004	59	C	399 00	1		NPI	1871609370
5 05 05 21 05 05 21	11		17262	76	D	447 00	1		NPI	1871609370
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
203276415 [ ] [X]	CB005RDR2C017	[X] YES [ ] NO	$ 2679 00	$ 0 00	

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

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatology
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457
a. b.

33. BILLING PROVIDER INFO & PH # (208) 8843376
Ada West Dermatology Main
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457
a. 1518973338 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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]

1a. INSURED'S I.D. NUMBER: 18593

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wolfe,

3. PATIENT'S BIRTH DATE: 1955 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Wolfe,

5. PATIENT'S ADDRESS (No., Street): 13500 South Pleasant Valley R

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 13500 South Pleasant Valley R

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3869588

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3869588

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 [X]

a. INSURED'S DATE OF BIRTH: 1955 | SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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: SOF | 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.

SIGNED: SOF

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: DN Gregory L Wells MD

17a. | 17b. NPI 1871609370

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

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. D0462 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

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	05 05 21 | 05 05 21	81		88305		A	180 00	1		NPI	1871609370
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 371697222 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CB00632E1C017

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

28. TOTAL CHARGE: $ 180 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.)

SOF

SIGNED: Gregory Wells MD DATE:

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. | b.

33. BILLING PROVIDER INFO & PH #: (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 115729

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Lundquist,	1957 M X / F	Lundquist,

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
15505 South Pleasant Valley R	Self X Spouse Child Other	15505 South Pleasant Valley R

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Kuna	ID		Kuna	ID

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
83634	(208) 3369959	83634	(208) 3369959

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 X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 1957 M X / F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES / NO X / PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES / NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO X If yes, complete items 9, 9a, and 9d.

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 SOF 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.
SIGNED SOF

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. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN Gregory L Wells MD		1871609370	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES / NO X $ CHARGES	22. RESUBMISSION CODE / ORIGINAL REF. NO.

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

A. C44212	B.	C.	D.
E.	F.	G.	H.
I.	J.	K.	L.

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

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 05 27 21	05 27 21	81		88305		A	360 00	2		NPI	1558321323
2 05 27 21	05 27 21	81		88331		A	506 00	2		NPI	1558321323
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
371697222		X	CB006ADW4C017	X YES / NO	$ 866 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (208) 9915665
SOF SIGNED Christine Meeshan MD DATE	Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. b.	Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. 1760730436 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☒ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 78679
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rieser,	3. PATIENT'S BIRTH DATE MM DD YY 1966 SEX M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Rieser,	
5. PATIENT'S ADDRESS (No., Street) 616 Washington St S	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street) 616 Washington St S	
CITY Twin Falls STATE ID	8. RESERVED FOR NUCC USE
CITY Twin Falls STATE ID	
ZIP CODE 83301 TELEPHONE (Include Area Code) (208) 6447900	
ZIP CODE 83301 TELEPHONE (Include Area Code) (208) 6447900	
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 1966 SEX M ☒ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)
c. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ☐ NO ☒
c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon	
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 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 SOF 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.

SIGNED SOF

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 DN Christopher T Scholes MD	17a. 17b. NPI 1760491542
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
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	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. D485 B. C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER 13D2047540

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 12 21 07 12 21	81		88305	TC	A	77 00	1		NPI	1558321323
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER 371697222 SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO. CB006JPA7C017	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐	28. TOTAL CHARGE $ 77 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.)

SOF

SIGNED Christine Measham MD DATE

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH # (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 131043

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Miele,

3. PATIENT'S BIRTH DATE: 1992 SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Miele,

5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Rc

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 14601 S Pleasant Valley Rd

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3890230

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3890230

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 [X]

a. INSURED'S DATE OF BIRTH: SEX

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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: SOF 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.

SIGNED: SOF

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: DN Janet E Mitchell PA-C

17a.

17b. NPI 1194761536

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

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. L700 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 13D0895833

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 21	07 13 21	11		99213		A	191 00	1		NPI	1871609370
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 203276415 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CB006E6F1C01

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

28. TOTAL CHARGE: $ 191 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.)

SOF

Gregory Wells MD

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatology
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH # (208) 9843376
Ada West Dermatology Meth
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457

a. 1518973338 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (ID#/DOD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	48900
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hansen,	3. PATIENT'S BIRTH DATE MM DD YY: 1962 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Hansen,	
5. PATIENT'S ADDRESS (No., Street): 15505 South Pleasant Valley R	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 15505 South Pleasant Valley R	
CITY: Kuna	STATE: ID
8. RESERVED FOR NUCC USE	CITY: Kuna STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3369959	ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3369959
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 [X]
	a. INSURED'S DATE OF BIRTH MM DD YY: 1962 SEX: M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):
	b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
	c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

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: SOF 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.
SIGNED: SOF

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. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. L821 B. C44319 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 15 21 07 15 21	11		99202 25	A	193 00	1		NPI	1871609370
2 07 15 21 07 15 21	11		11644	B	993 00	1		NPI	1871609370
3 07 15 21 07 15 21	11		12054	B	947 00	1		NPI	1871609370
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
203276415 [ ] [X]	CB006E446C017		2133 00	0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SOF Gregory Wells MD SIGNED DATE	Ada West Dermatology 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. b.	Ada West Dermatology Main (208) 8843376 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. 1518973338 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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]

1a. INSURED'S I.D. NUMBER: 48900

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hansen,

3. PATIENT'S BIRTH DATE: 1962 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Hansen,

5. PATIENT'S ADDRESS (No., Street): 15505 South Pleasant Valley R

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 15505 South Pleasant Valley R

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3369959

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 3369959

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 [X]

a. INSURED'S DATE OF BIRTH: 1962 | SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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: SOF 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.

SIGNED: SOF

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: DN Gregory L Wells MD

17a.

17b. NPI: 1871609370

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

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. C44319 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

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 15 21	07 15 21	81		88305		A	180 00	1		NPI	1558321323
2 07 15 21	07 15 21	81		88331		A	253 00	1		NPI	1558321323
3 07 15 21	07 15 21	81		88332		A	140 00	1		NPI	1558321323
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 371697222 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CB006KTL0C017

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

28. TOTAL CHARGE: $ 573 00

29. AMOUNT PAID: $ 0 00

30. Reserved for NUCC Use

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

SOF

SIGNED: Christine Measham MD DATE:

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH #: (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

1 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	66181
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Briggs,	3. PATIENT'S BIRTH DATE MM DD YY: 1978 — SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Briggs,	
5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Road	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 13900 S Pleasant Valley Road	
CITY: Kuna — STATE: ID	8. RESERVED FOR NUCC USE
CITY: Kuna — STATE: ID	
ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 3342731	
ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 3342731	
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 [X]
a. INSURED'S DATE OF BIRTH MM DD YY: 1978 — SEX: M [ ] F [X]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):
b. OTHER CLAIM ID (Designated by NUCC):	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

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: SOF — 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.
SIGNED: SOF

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 — MM DD YY TO
07 19 2006 QUAL. 431		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO
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. D2271	B. D225	C. D2262	D. D2261
E. D2272	F. Z08	G. Z85820	H. D485
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 19 21 — 07 19 21	11		99202	25	ABCD	193 00	1		NPI	1871609370
2	07 19 21 — 07 19 21	11		11306		H	311 00	1		NPI	1871609370
3	07 19 21 — 07 19 21	11		11102	59	H	251 00	1		NPI	1871609370
4	07 19 21 — 07 19 21	11		11103		H	402 00	3		NPI	1871609370
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER / SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
203276415 [ ] [X]	CB006E5A8C017	[X] YES [ ] NO	$ 1157 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (208) 8843376
SOF SIGNED: Gregory Wells MD — DATE: 05/09/2006	Ada West Dermatology 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. — b.	Ada West Dermatology Main 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. 1518973338 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 66181
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Briggs,	3. PATIENT'S BIRTH DATE MM DD YY: 1978 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Briggs,	
5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Road	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 13900 S Pleasant Valley Road	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Kuna STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3342731	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3342731	
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 [X]
a. INSURED'S DATE OF BIRTH MM DD YY: 1978 SEX M [ ] F [X]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

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: SOF 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.
SIGNED: SOF

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: DN Gregory L Wells MD	17a. 17b. NPI 1871609370
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
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	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. D23121 B. D23122 C. D2339 D. D22111 E. D2272 F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER: 13D2047540

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 19 21 07 19 21	81		88305		ABCD	900 00	5		NPI	1871609370
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 371697222 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: CB006MM62C017	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 900 00	29. AMOUNT PAID: $ 0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SOF Gregory Wells MD SIGNED DATE 07/19/21	32. SERVICE FACILITY LOCATION INFORMATION: Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. b.		33. BILLING PROVIDER INFO & PH #: (208) 9915665 Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. 1760730436 b.	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							66181		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Briggs,			1978	M	F X		Briggs,		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
13900 S Pleasant Valley Road			Self X	Spouse	Child	Other	13900 S Pleasant Valley Road		
CITY		STATE	8. RESERVED FOR NUCC USE				CITY		STATE
Kuna		ID					Kuna		ID
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
83634	(208) 3342731						83634	(208) 3342731	
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)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
			YES	NO X			1978	M	F X
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)		
			YES	NO X					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES	NO X			Corizon		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES	NO X	If yes, complete items 9, 9a, and 9d.

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 SOF 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.

SIGNED SOF

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. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
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. D2272	B. Z789	C. D485	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 13 21	08 13 21	11		12041		ABC	636 00	1		NPI	1871609370
2 08 13 21	08 13 21	11		11421		ABC	403 00	1		NPI	1871609370
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
203276415		X	CB006NX84C017	YES X NO	$ 1039 00	$ 0 00	

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

SOF

SIGNED Gregory Wells MD DATE 05/25/2021

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatology
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH # (208) 8843376
Ada West Dermatology Main
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457

a. 1518973338 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 66181
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Briggs,	3. PATIENT'S BIRTH DATE MM DD YY: 1978 — SEX: M ☐ F ☒
5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Road	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
CITY: Kuna — STATE: ID	8. RESERVED FOR NUCC USE
ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 3342731	
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)

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: SOF — DATE:

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 66181	
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Briggs,	
7. INSURED'S ADDRESS (No., Street): 13900 S Pleasant Valley Road	
CITY: Kuna — STATE: ID	
ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 3342731	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY: 1978 — SEX: M ☐ F ☒	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, complete items 9, 9a, and 9d.	

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

SIGNED: SOF

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: DN Gregory L Wells MD	17a. — 17b. NPI 1871609370
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY	
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	22. RESUBMISSION CODE — ORIGINAL REF. NO.
A. D2272 B. C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER: 13D2047540

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 13 21 08 13 21	81		88305		A	180 00	1		NPI	1871609370
2 08 13 21 08 13 21	81		88342		A	265 00	1		NPI	1871609370
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER: 371697222 — SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO.: CB006WHZ4C017	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐	28. TOTAL CHARGE: $ 445 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.) SOF Gregory Wells MD SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. — b.		33. BILLING PROVIDER INFO & PH #: (208) 9915665 Ada West Dermatopathology 1618 S Millennium Way Ste 220 Meridian, ID 83642-6457 a. 1760730436 b.	

PATIENT AND INSURED INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 37236

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Winkler,

3. PATIENT'S BIRTH DATE (MM DD YY): 1952 — SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Winkler,

5. PATIENT'S ADDRESS (No., Street): 13500 Pleasant Valley Rd
CITY: Kuna STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3223555

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 13500 Pleasant Valley Rd
CITY: Kuna STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3223555

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)

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH (MM DD YY): 1952 SEX: M ☒ F ☐
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, complete items 9, 9a, and 9d.

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 SOF 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.
SIGNED SOF

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 FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
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. C44612 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 13D0895833

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES 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	16	21	08	16	21	11		99203		A	273 00	1		NPI	1871609370
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 203276415 SSN ☐ EIN ☒
26. PATIENT'S ACCOUNT NO.: CB006QDH8C017
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐
28. TOTAL CHARGE: $ 273 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.)
SOF
Gregory Wells MD
SIGNED DATE 09/24/2021

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatology
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457
a. b.

33. BILLING PROVIDER INFO & PH # (208) 8843376
Ada West Dermatology Main
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457
a. 1518973338 b.

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA ☐ ☐ PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☒ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 94070
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Fleming,	3. PATIENT'S BIRTH DATE: MM DD YY 1963 SEX: M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Fleming,
5. PATIENT'S ADDRESS (No., Street): 14601 South Pleasant Valley R	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street): 14601 South Pleasant Valley R
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3312760		ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3312760
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 1963 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: Corizon
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 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: SOF 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.
SIGNED: SOF

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. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. C44212 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 09 09 21	09 09 21	11		13151		A	1079 00	1		NPI	1871609370
2 09 09 21	09 09 21	11		11641		A	601 00	1		NPI	1871609370
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 203276415 SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO.: CB0062862C017	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐	28. TOTAL CHARGE: $ 1680 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.) SOF Gregory Wells MD SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Ada West Dermatology 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. b.		33. BILLING PROVIDER INFO & PH #: (208) 8843376 Ada West Dermatology Main 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. 1518973338 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 94070

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Fleming,

3. PATIENT'S BIRTH DATE MM DD YY: 1963 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Fleming,

5. PATIENT'S ADDRESS (No., Street): 14601 South Pleasant Valley R

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 14601 South Pleasant Valley R

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3312760

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3312760

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 [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 1963 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

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: SOF 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.

SIGNED: SOF

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: DN Gregory L Wells MD

17a.

17b. NPI: 1871609370

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

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. C44212 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	09 09 21	09 09 21	81		88305		A	180 00	1		NPI	1558321323
2	09 09 21	09 09 21	81		88331		A	253 00	1		NPI	1558321323
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 371697222

26. PATIENT'S ACCOUNT NO.: CB00740W4C017

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

28. TOTAL CHARGE: $ 433 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.)

SOF

SIGNED: Christine Meashem MD DATE:

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH # (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457

a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 19452

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE (MM DD YY) / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Bishop,	10 10 1964 M X / F	Bishop,

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 South Pleasant Valley R	Self X / Spouse / Child / Other	13900 South Pleasant Valley R

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Kuna	ID		Kuna	ID

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
83634	(208) 3330037	83634	(208) 3330037

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. EMPLOYMENT? (Current or Previous) YES / X NO	a. INSURED'S DATE OF BIRTH (MM DD YY) / SEX: 1964 M X / F
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? YES / X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
b. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon
c. RESERVED FOR NUCC USE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO If yes, complete items 9, 9a, and 9d.

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 SOF 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.

SIGNED SOF

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. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. C44519 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 09 24 21	09 24 21	11		12032		A	762 00	1		NPI	1871609370
2 09 24 21	09 24 21	11		11603		A	712 00	1		NPI	1871609370
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
203276415	/ X	CB0075D98C017	X YES / NO	$ 1474 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (208) 8843376
SOF Gregory Wells MD	Ada West Dermatology 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457	Ada West Dermatology Main 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457
SIGNED DATE	a. / b.	a. 1518973338 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (FECA ID#) [X] (ID#)	19452
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bishop,	3. PATIENT'S BIRTH DATE: 1964 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Bishop,	
5. PATIENT'S ADDRESS (No., Street): 13900 South Pleasant Valley R	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 13900 South Pleasant Valley R	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Kuna STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3330037	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3330037	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. RESERVED FOR NUCC USE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH: 1964 SEX: M [X] F [ ]	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

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 SOF 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.
SIGNED SOF

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: DN Gregory L Wells MD
17a.
17b. NPI 1871609370

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

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. C44519 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 13D2047540

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 24 21	09 24 21	81		88305		A	180 00	1		NPI	1871609370
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
371697222		[X]	CB007AGB4C017	YES [X] NO [ ]	$ 180 00	$ 0 00	

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

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457
a. b.

33. BILLING PROVIDER INFO & PH # (208) 9915665
Ada West Dermatopathology
1618 S Millennium Way Ste 220
Meridian, ID 83642-6457
a. 1760730436 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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]	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							37236		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Winkler,	3. PATIENT'S BIRTH DATE MM DD YY / SEX 1952 M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Winkler,
5. PATIENT'S ADDRESS (No., Street) 13500 Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) 13500 Pleasant Valley Rd
CITY Kuna	STATE ID	8. RESERVED FOR NUCC USE	CITY Kuna	STATE ID
ZIP CODE 83634	TELEPHONE (Include Area Code) (208) 3312760		ZIP CODE 83634	TELEPHONE (Include Area Code) (208) 3312760
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 [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX 1952 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.

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 SOF 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.

SIGNED SOF

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. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. C44612 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 15 21	10 15 21	11		99213		A	191 00	1		NPI	1871609370
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 203276415 [ ] [X]	26. PATIENT'S ACCOUNT NO. CB00TC335C01T	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE $ 191 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.) SOF Gregory Wells MD SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION Ada West Dermatology 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. b.		33. BILLING PROVIDER INFO & PH # (208) 8843376 Ada West Dermatology Main 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. 1518973338 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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			

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 26692

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE (MM DD YY)	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Danca,	1945	M X / F	Danca,

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self X Spouse Child Other	13500 S Pleasant Valley Rd

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
Kuna	ID		Kuna	ID

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
83634	(208) 3360740	83634	(208) 3360740

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 X NO	a. INSURED'S DATE OF BIRTH (MM DD YY) 1945 SEX M X / F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.

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 SOF 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.
SIGNED SOF

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
03 07 2020 QUAL 431		

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN William Rogers		1881056448	

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	22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. L2089 B. C. D. E. F. G. H. I. J. K. L.	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 07 22 03 07 22	11		99203		A	273 00	1		NPI	1871609370
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
203276415 X	CB008V961C017	X YES NO	$ 273 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (208) 8843376
SOF Gregory Wells MD SIGNED DATE	Ada West Dermatology 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. b.	Ada West Dermatology Main 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. 1518973338 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 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#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 37236

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Winkler,

3. PATIENT'S BIRTH DATE: MM DD YY: 1952 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Winkler,

5. PATIENT'S ADDRESS (No., Street): 13500 Pleasant Valley Rd

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 13500 Pleasant Valley Rd

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3312760

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 3312760

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 [X]

a. INSURED'S DATE OF BIRTH: MM DD YY: 1952 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

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

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Corizon

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

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: SOF 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.

SIGNED: SOF

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. NPI

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

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. D225 B. D2262 C. D2261 D. Z08
E. Z85828 F. C44612 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	11	22	03	11	22	11		99213	25	ABCD	191 00	1		NPI	1871609370
2	03	11	22	03	11	22	11		14021		F	2192 00	1		NPI	1871609370
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 203276415 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CB008X8F9C017

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

28. TOTAL CHARGE: $ 2383 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.)

SOF

SIGNED: Gregory Wells MD DATE: 03/13/2012

32. SERVICE FACILITY LOCATION INFORMATION
Ada West Dermatology
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457

a. b.

33. BILLING PROVIDER INFO & PH # (208) 8843376
Ada West Dermatology Main
1618 S Millennium Way Ste 100
Meridian, ID 83642-6457

a. 1518973338 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639

El Paso, TX 79998

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA ☐ ☐ PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 18593

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Wolfe,	1955 M ☒ F ☐	Wolfe,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 South Pleasant Valley R	Self ☒ Spouse ☐ Child ☐ Other ☐	13500 South Pleasant Valley R
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 3869588		ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 3869588
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: 1955 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: Corizon
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 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: SOF 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.
SIGNED: SOF

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: DN Selah Worley FNP-C	17a. / 17b. NPI 1033752498	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
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. D692	B. D1722	C. R208	D. Z08
E. Z85828	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 04 22 04 04 22	11		99213		ABCD	191 00	1		NPI	1871609370
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
203276415 ☐ ☒	CB0094AQ7C017	☒ YES ☐ NO	$ 191 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SOF Gregory Wells MD SIGNED DATE 04/04/22	Ada West Dermatology 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. b.	Ada West Dermatology Main (208) 8843376 1618 S Millennium Way Ste 100 Meridian, ID 83642-6457 a. 1518973338 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION