Fill in this information to identify the case:

Debtor 1 Tehum Care Services, Inc.

Debtor 2 (Spouse, if filing) _____

United States Bankruptcy Court for the: Southern District of Texas

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 of 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 County Paramedics
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor County of Ada

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?

Ammon C. Taylor
Name

200 W. Front St., Room 3191
Number Street

Boise ID 83702
City State ZIP Code

Contact phone 208-287-7700

Contact email _____

Where should payments to the creditor be sent? (if different)

Ada County Paramedics
Name

370 N. Benjamin Lane
Number Street

Boise ID 83704
City State ZIP Code

Contact phone 208-287-2950

Contact email _____

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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? _____

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?** $ 84,225.61. **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.
   Ambulance Services

9. **Is all or part of the claim secured?**
   - ☑ No
   - ☐ Yes. The claim is secured by a lien on property.

   Nature of property:
   - ☐ Real estate. If the claim is secured by the debtor's principal 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 amounts 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

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AUG 1 0 2023
KURTZMAN CARSON CONSULTANTS

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: _____

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 one:*

	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 acknowledgment 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 a 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 8/4/2023
MM / DD / YYYY

Signature

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

Name: Rod Beck
First name Middle name Last name

Title: Chairman, Board of Ada County Emergency Medical Services District

Company: Ada County Paramedics
Identify the corporate servicer as the company if the authorized agent is a servicer.

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AUG 10 2023
KURTZMAN CARSON CONSULTANTS

Address: 370 N. Benjamin Lane
Number Street

Boise ID 83704
City State ZIP Code

Contact phone 208-287-2950 Email

Print | Save As... | Add Attachment | Reset

ADA COUNTY PROSECUTING ATTORNEY
JAN M. BENNETTS

Criminal Division
200 W. Front Street, Rm 3191
Boise, Idaho 83702

Phone (208) 287-7700
Fax (208) 287-7709

Civil Division
200 W. Front Street, Rm 3191
Boise, Idaho 83702

Phone (208) 287-7700
Fax (208) 287-7719

Juvenile Division
6300 Denton Street
Boise, Idaho 83704

Phone (208) 577-4900
Fax (208) 577-4909

August 4, 2023

VIA U.S. MAIL

Tehum Care Services, Inc. Claims Processing Center
c/o KCC
222 N. Pacific Coast Hwy., Ste. 300
El Segundo, CA 90245

RE: Chapter 11 Case No. 23-90086
U.S. Bankruptcy Court – Southern District of Texas (Houston Division)

Dear Claims Agent:

I am enclosing an original Proof of Claim, to be filed in the above referenced Chapter 11 bankruptcy.

Please add the Ada County Paramedics to the Mailing Matrix for this case. The mailing address is Ada County Paramedics c/o Ammon C. Taylor, 200 W. Front Street, Rm. 3191, Boise, ID 83702.

If you need any additional information, feel free to contact me at (208) 287-7700.

Sincerely,

JAN M. BENNETTS
Ada County Prosecuting Attorney

Ammon C. Taylor
Deputy Prosecuting Attorney

JMB:ACT:sr

Encl.

cc: Gray Reed & McGraw LLP, Debtor's Counsel
Berger Singerman LLP, Debtor's Counsel
O'Connor Kimball LLP, Debtor's Counsel

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA

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): [redacted]85ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Dunlap Timothy A

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1968 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): IMSI Max Security

5. PATIENT'S ADDRESS (No., Street): 13400 S Pleasant Valley Rd

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

7. INSURED'S ADDRESS (No., Street): ATTEN DIANNA

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 338-1635

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 389-0230

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 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 SIGNATURE ON FILE DATE 07 12 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 12 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. R079 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634-2716

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 07122021	07122021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 07122021	07122021	41	Y	MILEAGE A0425	EH	A	186 16	13.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN EIN X

26. PATIENT'S ACCOUNT NO.: [redacted]955A

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

28. TOTAL CHARGE: $ 1326 63

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.)

ADA County Paramedics

05 10 2023

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FROM: 13400 S Pleasant Valley Rd
Kuna, ID 83634-2716
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950

ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498

a. [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]68ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1949 | SEX M [x] F [ ]

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

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

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Boise | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83705 | TELEPHONE (Include Area Code): (208)331-1195

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-1195

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: [redacted]1607

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: [redacted]1967 | 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 SIGNATURE ON FILE DATE 07 12 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 12 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]

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

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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				AMBULANCE SERVICE - ALS1						NPI	
07122021	07122021	41	Y	A0427	EH	A	1205 18	1		NPI	
2				MILEAGE						NPI	
07122021	07122021	41	Y	A0425	EH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [ ] [x]

26. PATIENT'S ACCOUNT NO.: [redacted]975A

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

28. TOTAL CHARGE: $ 1401 36

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.)
ADA County Paramedics
05 10 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]07ID

PATIENT AND INSURED INFORMATION

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)
ROBERTS MICHAEL D	[redacted] 1989 M X F	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self Sppuse Child Other X	ATTEN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 629-8783		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-2760
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 M 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 SIGNATURE ON FILE DATE 07 14 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 14 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. LR4182 B. C. D.		23. PRIOR AUTHORIZATION NUMBER: 83634
E. F. G. H.		
I. J. K. L.		

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 07142021 07142021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 07142021 07142021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		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
[redacted]0277 X	[redacted]204A	YES NO X	$ 1167 17	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 10 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	a [redacted]9987 b

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]4429

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Maki Tawny L

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1991 | SEX: M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PRISON DOC WOMENS

5. PATIENT'S ADDRESS (No., Street): 733 W Ramsbrook St

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN LARRY HEINZ

CITY: Boise | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83702 | TELEPHONE (Include Area Code): ( )

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Maki Tawny L

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]8961

a. EMPLOYMENT? (Current or Previous): YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY | 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: IDHW

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: SIGNATURE ON FILE | DATE: 08 08 2021

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 08 2021 QUAL. 431

15. OTHER DATE QUAL. | MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]

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. R000 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83712

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	08082021 08082021	41	Y	AMBULANCE SERVICE - ALS2 A0433	SH	A	1105 45	1		NPI	
2	08082021 08082021	41	Y	MILEAGE A0425	SH	A	27 21	1.9		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 ( ) (X)

26. PATIENT'S ACCOUNT NO.: [redacted]986A

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

28. TOTAL CHARGE: $ 1132 66

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.)
ADA County Paramedics
05 10 2023
SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 2366 E Old Penitentiary Rd
Boise, ID 83712
TO: 190 E Bannock Street
Boise, ID 83702-6241
a. b.

33. BILLING PROVIDER INFO & PH.# (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]84ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Ferguson Robert R	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1964 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760
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 M [ ] 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 SIGNATURE ON FILE DATE 05 31 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 31 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NU[redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 83634

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 05312021	05312021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1042 86	1		NPI	
2 05312021	05312021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN EIN [X]	26. PATIENT'S ACCOUNT NO.: [redacted]602A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE: $ 1231 88	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.) ADA County Paramedics 04 21 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]86ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): TAYLOR TYLER N

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1986 | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

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

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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 M [ ] 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 SIGNATURE ON FILE DATE 06 02 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 02 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R55 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06022021	06022021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 06022021	06022021	41	Y	MILEAGE A0425	SH	A	189 02 13.2			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.: [redacted]844A

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

28. TOTAL CHARGE: $ 1329 49

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.)
ADA County Paramedics
04 21 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]91ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Shakespeare Justin A

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1982 | SEX M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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 M ( ) 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ 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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 02 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06022021	06022021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 06022021	06022021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]881A

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

28. TOTAL CHARGE: $ 1329 49

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.)

ADA County Paramedics
04 21 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950

ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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) [redacted]70ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOFTHOUSE TRAVIS C	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1996 SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) LOFTHOUSE TRAVIS C
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ☒ 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) 270-9694		ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 270-9694
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) LOFTHOUSE TRAVIS C	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER [redacted]8813	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY [redacted] 1996 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 Select Health	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 SIGNATURE ON FILE DATE 06 03 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 03 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. Z889 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

PATIENT AND INSURED INFORMATION

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 06032021	06032021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1003 62	1		NPI	
2 06032021	06032021	41	Y	MILEAGE A0425	EH	A	187 59	13.1		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
[redacted]0277	☐ ☒	[redacted]932A	☐ YES ☒ NO	$ 1191 21	$ 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) 287 2950
ADA County Paramedics 04 21 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]64ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1996 | SEX M (X) F ( )

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

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

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

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: [redacted]1996 | 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 06 05 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 05 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. R079 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06052021	06052021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 06052021	06052021	41	Y	MILEAGE A0425	SH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]341A

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

28. TOTAL CHARGE: $ 1336 65

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.)
ADA County Paramedics
04 21 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 15505 S. Pleasant Valley R
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]34ID

PATIENT AND INSURED INFORMATION

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)
Nava Christopher I	[redacted]1974 M X F	Alt Placement Correctional
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
15505 S Pleasant Valley Rd	Self Spouse Child Other X	15505 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)459-7179		ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )
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 M 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 SIGNATURE ON FILE DATE 06 07 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
06 07 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R109 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 83634

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 06072021 06072021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1148 96	1		NPI	
2 06072021 06072021	41	Y	MILEAGE A0425	SH	A	196 18	13.7		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
[redacted]0277 X	[redacted]545A	YES X NO	$ 1345 14	$ 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)287 2950
ADA County Paramedics 04 21 2023 SIGNED DATE	FROM: 15505 S. Pleasant Valley R Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]42ID

PATIENT AND INSURED INFORMATION

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)
Anderson Drew	[redacted] 1992 M X F	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14195 Pleasant Valley Road	Self Spouse Child Other X	ATTEN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-2760
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
		[redacted]1607
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 M 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 SIGNATURE ON FILE DATE 06 07 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
06 07 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R55 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06072021	06072021	41	Y	ALS Non-Transport A0998		A	408 45	1		NPI	
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
[redacted]0277 X	[redacted]605A	YES NO X	$ 408 45	$ 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) 287 2950
ADA County Paramedics 04 21 2023	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED DATE	a. / b.	[redacted]9987 / b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]74ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Osborn David A	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1948 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) ( )		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-1195
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER [redacted]74	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY [redacted]1967 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 Centurion of ID IDOC	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 SIGNATURE ON FILE DATE 06 08 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 08 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. R0602 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 06082021 06082021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1042 86	1		NPI	
2 06082021 06082021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 [ ] [X]	26. PATIENT'S ACCOUNT NO. [redacted]766A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE $ 1239 04	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.) ADA County Paramedics 04 21 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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): [redacted]05ID

PATIENT AND INSURED INFORMATION

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)
Harrvey Richard	[redacted]1975 M ☒ F ☐	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd		ATTEN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-2760
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: 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 SIGNATURE ON FILE DATE 06 11 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
06 11 2021 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 NUC[redacted]		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. I10 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06112021	06112021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 06112021	06112021	41	Y	MILEAGE A0425	SH	A	189 02 13.2			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	☒	[redacted]155A	☐ YES ☒ NO	$ 1167 17	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
04 21 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]27ID

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RIVAS JUSTIN	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1994 SEX: M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial): RIVAS JUSTIN
5. PATIENT'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )		ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )
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: [redacted] 1994 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 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

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 08 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]		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. R55 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04082021	04082021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 04082021	04082021	41	Y	MILEAGE A0425	EH	A	194 75	13.6		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
[redacted]0277		X	[redacted]306A	YES NO X	$ 855 69	$ 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) 287 2950
ADA County Paramedics 04 19 2023	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.
SIGNED DATE		

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]65ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1957 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

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

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208)331-2760

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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 M 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 SIGNATURE ON FILE DATE 04 09 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 09 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. M79605 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04092021	04092021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 04092021	04092021	41	Y	MILEAGE A0425	SH	A	189 02 13.2			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 X

26. PATIENT'S ACCOUNT NO.: [redacted]467A

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

28. TOTAL CHARGE: $ 1329 49

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.)
ADA County Paramedics
04 19 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

CARRIER

Corizon
PO Box 981639
El Paso, TX 79998

PICA | 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) [redacted]05ID

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith Randolph O	3. PATIENT'S BIRTH DATE MM DD YY / SEX [redacted]1959 M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Road	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other X	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 375-0201		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195
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 [redacted]1967 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 SIGNATURE ON FILE DATE 05 25 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 25 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 05252021	05252021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	986 64	1		NPI	
2 05252021	05252021	41	Y	MILEAGE A0425	EH	A	196 18 13 7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER [redacted]0277	SSN EIN X	26. PATIENT'S ACCOUNT NO. [redacted]802A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 1182 82	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.) ADA County Paramedics 04 19 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987		

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]73ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hassan Mohammed A	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1964 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 395-0459		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-1195
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 [redacted] 1967 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 SIGNATURE ON FILE DATE 07 03 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 07 03 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. I639 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 07032021	07032021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 07032021	07032021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 [X]	26. PATIENT'S ACCOUNT NO. [redacted]563A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO	28. TOTAL CHARGE $ 1336 65	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.) ADA County Paramedics 04 19 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]32ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Taylor Anita M

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1962 | SEX: M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Taylor Anita M

5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Rd

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): 13900 S Pleasant Valley Rd

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

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

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

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: [redacted] 1962 | 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: SIGNATURE ON FILE | DATE: 09 24 2021

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 24 2021 | QUAL: 431

15. OTHER DATE QUAL: | MM DD YY:

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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	09242021 09242021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2	09242021 09242021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]337A

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

28. TOTAL CHARGE: $ 1336 65

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.)
ADA County Paramedics
04 19 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13900 S Pleasant Valley Rd
Kuna, ID 83634-0000
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted] 9987

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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 [redacted]14ID	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Knibbe Jordan J	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1998 SEX M (X) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial) IMSI Max Security
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ( ) Spouse ( ) Child ( ) Other (X)	7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA
CITY Kuna	STATE ID	8. RESERVED FOR NUCC USE	CITY Boise	STATE ID
ZIP CODE 83634	TELEPHONE (Include Area Code) ( )		ZIP CODE 83707	TELEPHONE (Include Area Code) (208) 389-0230
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 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 SIGNATURE ON FILE DATE 04 10 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 10 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. T1491XA B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-2716

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 04102021 04102021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 04102021 04102021	41	Y	MILEAGE A0425	EH	A	186 16	13.0		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 (X)	26. PATIENT'S ACCOUNT NO. [redacted]602A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES (X) NO	28. TOTAL CHARGE $ 1164 31	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]12ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Weaver Tyler A

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1988 | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

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

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208)587-5180

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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 M [ ] 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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 10 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. G8911 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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	AMBULANCE SERVICE - ALS1										
04102021	04102021	41	Y	A0427	SH	A	1216 85	1		NPI	
2	MILEAGE										
04102021	04102021	41	Y	A0425	SH	A	190 46	13.3		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]39AA

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

28. TOTAL CHARGE: $ 1407 31

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]93ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Shelly Carl D

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1979 SEX M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 376-4597

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760

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 M ( ) 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 SIGNATURE ON FILE DATE 04 12 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 12 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]

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. M549 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04122021	04122021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	983 45	1		NPI	
2 04122021	04122021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]829A

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

28. TOTAL CHARGE: $ 1172 47

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]5ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mocaby Michael L			3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1953	SEX: M ☒ F ☐			4. INSURED'S NAME (Last Name, First Name, Middle Initial): Mocaby Michael L
5. PATIENT'S ADDRESS (No., Street): 4802 Layton Ave			6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐				7. INSURED'S ADDRESS (No., Street): 4802 Layton Ave
CITY: Caldwell	STATE: ID		8. RESERVED FOR NUCC USE				CITY: Caldwell STATE: ID
ZIP CODE: 83607	TELEPHONE (Include Area Code): (208) 899-0230						ZIP CODE: 83607 TELEPHONE (Include Area Code): (208) 899-0230
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: [redacted]1953 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 SIGNATURE ON FILE DATE 04 13 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 13 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. M25511 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 83634

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 04132021	04132021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1042 86	1		NPI	
2 04132021	04132021	41	Y	MILEAGE A0425	SH	A	187 59	13.1		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
[redacted]0277 ☒	[redacted]998A	YES ☐ NO ☒	$ 1230 45	$ 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) 287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]75ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): RODGERS DANIEL E

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1949 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): RODGERS DANIEL E

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

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): ( )

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): RODGERS DANIEL E

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]75

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

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 1949 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: Centurion of ID IDOC

10d. CLAIM CODES (Designated by NUCC)

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 04 15 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 15 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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

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

A. R509 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04152021	04152021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 04152021	04152021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.: [redacted]258A

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

28. TOTAL CHARGE: $ 1167 17

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 190 E Bannock Street
Boise, ID 83712-6241

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]60ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): OLSON TONY W

3. PATIENT'S BIRTH DATE (MM DD YY): [redacted] 1960 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): OLSON TONY W

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

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

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

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

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

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

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): [redacted] 1960 | 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ 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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY): 04 15 2021 QUAL. 431

15. OTHER DATE QUAL. (MM DD YY)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. I499 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04152021	04152021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1225 35	1		NPI	
2 04152021	04152021	41	Y	MILEAGE A0425	SH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]267A

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

28. TOTAL CHARGE: $ 1421 53

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 15505 S. Pleasant Valley R
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]21ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patrick Richard W	3. PATIENT'S BIRTH DATE MM DD YY / SEX [redacted] 1939 M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634-1350 TELEPHONE (Include Area Code): (208) 386-9588		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195
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 [redacted] 1967 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 SIGNATURE ON FILE DATE 04 16 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 16 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 04162021	04162021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 04162021	04162021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		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
[redacted]0277 [ ] [X]	[redacted]422A	YES [ ] NO [X]	$ 1174 33	$ 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) 287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]75ID

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)
SAUNDER CLIFFORD D	[redacted] 1973 M X F	SAUNDER CLIFFORD D

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self X Spouse Child Other	14601 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	( )		83634	( )

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 / SEX: [redacted] 1973 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 04 19 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
04 19 2021 QUAL. 431		

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]	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. R569 B. C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER 83634

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 04192021 04192021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1054 53	1		NPI	
2 04192021 04192021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]773A	YES X NO	$ 1243 55	$ 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)287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
04 20 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	a [redacted]9987 b

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]32 ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Lockhart Michael V

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Lockhart Michael V

5. PATIENT'S ADDRESS (No., Street): PO Box 51

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): PO Box 51

CITY: Boise STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 233-6909

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 233-6909

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Lockhart Michael V

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]5141

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

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 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: CIGNA HEALTH CARE

10d. CLAIM CODES (Designated by NUCC)

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 04 19 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 19 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R079 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04192021	04192021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 04192021	04192021	41	Y	MILEAGE A0425	SH	A	187 59 13 1			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]796A

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

28. TOTAL CHARGE: $ 1328 06

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]57ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Narvaiz Monica L

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1984 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Narvaiz Monica L

5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Rd

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

7. INSURED'S ADDRESS (No., Street): 13900 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)219-3911

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 219-3911

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: [redacted]1984 | 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 SIGNATURE ON FILE | DATE 04 19 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 19 2021 QUAL. 431

15. OTHER DATE QUAL. | MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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	04192021 04192021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2	04192021 04192021	41	Y	MILEAGE A0425	EH	A	194 75	13.6		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]858A

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

28. TOTAL CHARGE: $ 855 69

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.)
ADA County Paramedics
SIGNED | 04 20 2023 DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13900 S Pleasant Valley Rc
Kuna, ID 83634-0000
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]10ID

PATIENT AND INSURED INFORMATION

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)
SIMON BRENT	[redacted] 1950 M X F	SIMON BRENT
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self X Spouse Child Other	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): ( )		ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )
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: [redacted] 1950 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 SIGNATURE ON FILE DATE 04 19 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
04 19 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		20. OUTSIDE LAB? YES NO $ CHARGES

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

A. R0602 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04192021	04192021	41	Y	A0427 AMBULANCE SERVICE - ALS1	EH	A	1205 18	1		NPI	
2 04192021	04192021	41	Y	A0425 MILEAGE	EH	A	189 02	13.2		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
[redacted]0277 X	[redacted]862A	YES NO X	$ 1394 20	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
04 20 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	a. Boise, ID 83704-1309	a. [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]42ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Dade Dana J	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1963 SEX M (X) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ( ) Spouse ( ) Child ( ) Other (X)	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) ( )		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-1195
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 [redacted]1967 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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 20 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R000 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO: 23. PRIOR AUTHORIZATION NUMBER 83634

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 04202021 04202021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1042 86	1		NPI	
2 04202021 04202021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		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
[redacted]0277 ( ) (X)	[redacted]927A	YES ( ) NO (X)	$ 1239 04	$ 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) 287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309 a. b.	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]57ID

PATIENT AND INSURED INFORMATION

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)
Narvaiz Monica L	[redacted] 1984 M F X	Narvaiz Monica L
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 S Pleasant Valley Rd	Self X Spouse Child Other	13900 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) 219-3911		ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 219-3911
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: [redacted] 1984 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 SIGNATURE ON FILE DATE 04 20 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
04 20 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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 04202021	04202021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 04202021	04202021	41	Y	MILEAGE A0425	EH	A	194 75	13.6		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
[redacted]0277		X	[redacted]998A	YES NO X	$ 855 69	$ 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) 287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
04 20 2023	Kuna, ID 83634-0000	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	a. [redacted]9987 b.

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]78ID

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)
BRONCHO MONNIE	[redacted] 1970 M [ ] F [X]	BRONCHO MONNIE
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 S Pleasant Valley Rd	Self [X] Spouse [ ] Child [ ] Other [ ]	13900 S Pleasant Valley Rd
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )

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: [redacted] 1970 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 _____ 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 _____

PATIENT AND INSURED INFORMATION

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
04 21 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. T50904A B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634-0000

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 04212021 04212021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1205 18	1		NPI	
2 04212021 04212021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [ ] [X]	[redacted]141A	YES [ ] NO [X]	$ 1401 36	$ 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) 287 2950
ADA County Paramedics 04 20 2023	FROM: 13900 S Pleasant Valley Rc Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED DATE	a. [redacted]9987	b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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)		
							[redacted]49ID		
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)		
KELLY KEVIN H			[redacted] 1964		M ☒	F ☐	KELLY KEVIN H		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
13500 S Pleasant Valley Rd			Self ☒	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	( )						83634	( )	
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			[redacted] 1964	M ☒	F ☐
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?		PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)		
			☐ YES	☒ NO					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			☐ YES	☒ NO			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 _____ DATE _____

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SIGNED _____

PATIENT AND INSURED INFORMATION

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
04 21 2021 QUAL. 431	QUAL.	FROM TO
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 NUC [redacted]		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 R109 B C D		23. PRIOR AUTHORIZATION NUMBER
E F G H		83634
I J K L		

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 04212021	04212021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 04212021	04212021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277		☒	[redacted]152A	☐ YES ☒ NO	$ 1336 65	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
04 20 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]82ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PACK THOMAS	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1969 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SICI
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Road	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTEN VAUGHN
CITY Boise STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83705 TELEPHONE (Include Area Code) ( )		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 333-0037
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 [redacted]1607
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 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 SIGNATURE ON FILE DATE 04 21 2021

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 21 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. K2970 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-2716

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 04212021 04212021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 04212021 04212021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 [ ] [X]	26. PATIENT'S ACCOUNT NO. [redacted]178A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO	28. TOTAL CHARGE $ 1167 17	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13400 S Pleasant Valley Rc Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208)287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]28ID

PATIENT AND INSURED INFORMATION

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)
Hunsaker Richard	[redacted] 1965 M [X] F [ ]	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self [ ] Spouse [ ] Child [ ] Other [X]	ATTN MEDICAL
CITY: Kuna — STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise — STATE: ID
ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 331-1195		ZIP CODE: 83707 — TELEPHONE (Include Area Code): (208) 331-1195

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: [redacted] 1967 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 SIGNATURE ON FILE DATE 04 22 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
04 22 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

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

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 04222021 04222021	41	Y	AMBULANCE SERVICE - ALS1 A0427 EH	A	1119 24	1		NPI	
2 04222021 04222021	41	Y	MILEAGE A0425 EH	A	196 18 13 7			NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [ ] [X]	[redacted]229A	YES [ ] NO [X]	$ 1315 42	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
04 20 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]95ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) WILLIAMS KILBY D	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1984 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) WILLIAMS KILBY D
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) 13500 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) 680-2873		ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 680-2873
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 [redacted] 1984 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 SIGNATURE ON FILE DATE 04 23 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 23 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. G8911 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23 PRIOR AUTHORIZATION NUMBER 83634

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 04232021	04232021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1054 53	1		NPI	
2 04232021	04232021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 [ ] [X]	26. PATIENT'S ACCOUNT NO. [redacted]362A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO	28. TOTAL CHARGE $ 1250 71	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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) [redacted]81ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Ridgley Lee A	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1954 SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☒	7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 331-1195		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ☐ NO ☒	c. INSURANCE PLAN NAME OR PROGRAM NAME 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 SIGNATURE ON FILE DATE 04 24 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 24 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

A. R0602 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 83634

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 04242021 04242021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 04242021 04242021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 ☐ ☒	[redacted]517A	YES ☐ NO ☒	$ 1329 49	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 04 20 2023 DATE	a.	a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]58ID

PATIENT AND INSURED INFORMATION

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)
Shields Keith L	[redacted] 1974 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634-0000 / TELEPHONE (Include Area Code): (208) 861-7718		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-1195
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
Shields Keith L		[redacted]1607
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]6000	YES X NO	[redacted] 1967 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
PacificSource Medicare		X 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 SIGNATURE ON FILE DATE 12 19 2013

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
04 25 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R0603 B. C. D. / E. F. G. H. / I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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				AMBULANCE SERVICE - ALS1							
04252021	04252021	41	Y	A0427	EH	A	1209 72	1		NPI	
2				MILEAGE							
04252021	04252021	41	Y	A0425	EH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]652A	YES X NO	$ 1398 74	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
04 20 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]42ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhodes Billy G	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1973 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) (208)331-2760		ZIP CODE 83707 TELEPHONE (Include Area Code) ( )(208) 331-1195
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 [redacted]1967 SEX M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER [redacted] (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 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
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 26 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [redacted]	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. R509 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

PATIENT AND INSURED INFORMATION

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 04262021 04262021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1042 86	1		NPI	
2 04262021 04262021	41	Y	MILEAGE A0425	EH	A	194 75	13.6		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
[redacted]0277 [X]	[redacted]723A	YES [ ] NO [X]	$ 1237 61	$ 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)287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]8845
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flores Ramirez Juan M	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1977 SEX M (X) F ( )
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter	
5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Road	6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)
7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 375-7052	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760	
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: [redacted]1607	
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 M ( ) 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 SIGNATURE ON FILE DATE 04 29 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 29 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]	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. H538 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: 83634

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 04292021	04292021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 04292021	04292021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN ( ) EIN (X)	26. PATIENT'S ACCOUNT NO.: [redacted]128A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO (X)	28. TOTAL CHARGE: $ 849 96	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]04ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MOORE BENNIE J	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1974 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) MOORE BENNIE J
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd	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) ( )		ZIP CODE 83634 TELEPHONE (Include Area Code) ( )
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 [redacted]1974 SEX M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]	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 SIGNATURE ON FILE DATE 05 05 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 05 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. R531 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 05052021 05052021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1205 18	1		NPI	
2 05052021 05052021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		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
[redacted]0277 [X]	[redacted]947A	YES [ ] NO [X]	$ 1394 20	$ 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) 287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]32 ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1963 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V
5. PATIENT'S ADDRESS (No., Street) PO Box 51	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) PO Box 51
CITY Boise STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83707 TELEPHONE (Include Area Code) (208)233-6909		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 233-6909
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Lockhart Michael V	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER [redacted]5141	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY [redacted] 1963 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 CIGNA HEALTH CARE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 SIGNATURE ON FILE DATE 05 09 2021

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 09 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 05092021	05092021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 05092021	05092021	41	Y	MILEAGE A0425	SH	A	187 59	13.1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER [redacted]0277	SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO. [redacted]477A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO	28. TOTAL CHARGE $ 1328 06	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	33. BILLING PROVIDER INFO & PH # (208)287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]53ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Snider Mack L	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1961 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SICI .
5. PATIENT'S ADDRESS (No., Street): 13950 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street): ATTEN VAUGHN
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208)336-1260		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 333-0037
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 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.

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SIGNED SIGNATURE ON FILE DATE 05 10 2021

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 10 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): [redacted]		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. I4891 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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 05102021	05102021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 05102021	05102021	41	Y	MILEAGE A0425	EH	A	196 18 13 7			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
[redacted]0277 [X]	[redacted]618A	YES [ ] NO [X]	$ 1336 65	$ 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)287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 13900 S Pleasant Valley Rc Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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)	
	[redacted]12ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Boman John W	3. PATIENT'S BIRTH DATE MM DD YY / SEX [redacted]1993 M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Alt Placement Correctional
5. PATIENT'S ADDRESS (No., Street) 1050 N Clover Dr	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) 15505 S Pleasent Valley Rd
CITY Boise STATE ID	8. RESERVED FOR NUCC USE	CITY Kuna STATE ID
ZIP CODE 83703 TELEPHONE (Include Area Code) (208)985-5522		ZIP CODE 83634 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Boman John W	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER [redacted]0029	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO	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 IDHW	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 SIGNATURE ON FILE DATE 05 10 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 10 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R112 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 05102021	05102021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	983 45	1		NPI	
2 05102021	05102021	41	Y	MILEAGE A0425	SH	A	193 32	13.5		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 [ ] [X]	26. PATIENT'S ACCOUNT NO. [redacted]645A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO	28. TOTAL CHARGE $ 1176 77	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley I Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208)287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]20ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ANDERSON RIO J	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1997 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ANDERSON RIO J
5. PATIENT'S ADDRESS (No., Street) 2366 E Old Penitentiary Rd	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) 2366 E Old Penitentiary Rd
CITY Boise STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83712 TELEPHONE (Include Area Code) (208)900-8629		ZIP CODE 83712 TELEPHONE (Include Area Code) ((208) 900-8629
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 [redacted] 1997 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 SIGNATURE ON FILE DATE 05 11 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 11 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R55 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83712

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 05112021	05112021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 05112021	05112021	41	Y	MILEAGE A0425	SH	A	25 78	1.8		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
[redacted]0277 [ ] [X]	[redacted]875A	YES [ ] NO [X]	$ 1166 25	$ 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)287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 2366 E Old Penitentiary Rc Boise, ID 83712 TO: 190 E Bannock Street Boise, ID 83712-6241 a. b.	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]42ID

PATIENT AND INSURED INFORMATION

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)
Pena Jose A	[redacted] 1986 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 386-9588		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-1195
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
		[redacted]1607
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 / SEX: [redacted] 1967 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 SIGNATURE ON FILE DATE 05 12 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
05 12 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R002 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 83634

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 05122021 05122021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 05122021 05122021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		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
[redacted]0277 X	[redacted]954A	YES / X NO	$ 1329 49	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 04 20 2023 DATE		[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]41ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BEVERLY JON L

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1987 SEX M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): BEVERLY JON L

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

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna STATE: ID

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

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

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: [redacted] 1987 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 SIGNATURE ON FILE DATE 05 13 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 13 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]

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. M79605 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 05132021	05132021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 05132021	05132021	41	Y	MILEAGE A0425	SH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]053A

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

28. TOTAL CHARGE: $ 857 12

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 15505 S. Pleasant Valley I
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]68ID

PATIENT AND INSURED INFORMATION

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)
Storey Gregory S	[redacted]1949 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Boise / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83705 / TELEPHONE (Include Area Code): (208)331-1195		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-1195
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
		[redacted]1607
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: [redacted]1967 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 SIGNATURE ON FILE DATE 05 13 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
05 13 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. I499 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 05132021 05132021	41	Y	AMBULANCE SERVICE - ALS2 A0433	EH	A	1177 60	1		NPI	
2 05132021 05132021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			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
[redacted]0277 X	[redacted]142A	YES X NO	$ 1373 78	$ 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)287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
04 20 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

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HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]67ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1991 SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PRISON DOC WOMENS

5. PATIENT'S ADDRESS (No., Street): 13200 S Pleasant Valley Rd

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN LARRY HEINZ

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208)681-5500

ZIP CODE: 83707 TELEPHONE (Include Area Code): ( )

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 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 05 14 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 14 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

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

A. R509 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634-2720

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 05142021	05142021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 05142021	05142021	41	Y	MILEAGE A0425	EH	A	177 57	12.4		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]271A

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

28. TOTAL CHARGE: $ 1155 72

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13200 S Pleasant Valley Rc
Kuna, ID 83634-2720
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

CARRIER

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)
[redacted]42ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Rhodes Bill G

3. PATIENT'S BIRTH DATE MM DD YY
[redacted] 973
SEX M [X] F [ ]

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

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

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

7. INSURED'S ADDRESS (No., Street)
ATTN MEDICAL

CITY
Kuna

STATE
ID

8. RESERVED FOR NUCC USE

CITY
Boise

STATE

ZIP CODE
83634

TELEPHONE (Include Area Code)
(208)331-2760

ZIP CODE
83707

TELEPHONE (Include Area Code)
((208) 331-1195

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
[redacted] 1967
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 SIGNATURE ON FILE 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 F

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
05 15 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC
[redacted]

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

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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	05152	21	05152	21	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1205	18	1		NPI	
2	05152	21	05152	21	41	Y	MILEAGE A0425	EH	A	196	18	13.7		NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
[redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.
[redacted]356A

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

28. TOTAL CHARGE
$ 1401 36

29. AMOUNT PAID
$ 0 0

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI ADA COUNTY PARAMEDICS
Kuna, ID 83634
Boise, ID 837 4-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
370 N. Benjamin Lane
7 4- 4
[redacted]2987 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: [redacted]52ID

(For Program in Item 1)

PICA

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

3. PATIENT'S BIRTH DATE: MM [redacted] DD 986 YY SEX: M [ ] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 13200 S Pleasant Valle Rd

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

7. INSURED'S ADDRESS (No., Street): ATTEN LARRY HEINZ

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208)969-1469

ZIP CODE: 83707 TELEPHONE (Include Area Code): ( )

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 SEX M [ ] F [X]

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 SIGNATURE ON FILE 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 SI

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 05 DD 16 YY 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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

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

A. R0789 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER: 83634-2720

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 05162 21	05162021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	725 65	1			NPI
2 05162 21	05162021	41	Y	MILEAGE A0425	EH	A	177 57 12.4				NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]534A

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

28. TOTAL CHARGE: $ 903 22

29. AMOUNT PAID: $ 0 0

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.)

ADA County Paramedics

04 20 2023

SIGNED DATE

32. SERVICE FACILITY LOCATIO INFORMATION

FROM: 13200 S Pleasant Valley Rc
Kuna, ID 83634-2720
T · 1 is Road
Boise, ID 837 4-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950

ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Bois ID 7 4-
[redacted]9987 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

HEALTH INSURANCE CLAIM FORM

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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: [redacted]26ID

(For Program in Item 1)

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

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

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

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

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

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

CITY
Kuna

STATE

8. RESERVED FOR NUCC USE

CITY
Kun

STATE

ZIP CODE
83634

TELEPHONE (Include Area Code)
( )

ZIP CODE
83634

TELEPHONE (Include Area Code)
( )

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: [redacted] 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
05 17 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. I469 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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	17	21	05	17	21	41	Y	AMBULANC SERVICE - ALS2 A0433	EH					NPI
2	05	17	21	05	17	21	41	Y	MILEAGE A0425	EH	A	193 32 13.5			NPI
3															NP
4															NP
5															N
6															NP

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]594A

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

28. TOTAL CHARGE: $ 1508 83

29. AMOUNT PAID: $ 0 0

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI ADA COUNTY PARAMEDICS
Kuna, ID 83634
Boise, ID 837 4-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
370 N. Benjamin Lane
b. [redacted]9987

HEALTH INSURANCE CLAIM FORM

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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' I.D. NUMBER (For Program in Item 1)
[redacted]82ID

PICA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
HOLLAND TRAVIS E

3. PATIENT'S BIRTH DATE MM DD YY [redacted] 978 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
HOLLAND TRAVIS E

5. PATIENT'S ADDRESS (No., Street)
14601 S Pleasant Valle Rd

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

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

CITY
Kuna

STATE
ID

8. RESERVED FOR NUCC USE

CITY
Kuna

STATE
ID

ZIP CODE
83634

TELEPHONE (Include Area Code)
( )

ZIP CODE
83634

TELEPHONE (Include Area Code)
( )

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 [redacted] 1978 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

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

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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE

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

SIGNED SI

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
05 17 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R50 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 05172 21	05172 21	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1042	6	1	NPI	
2 05172 21	05172 21	41	Y	MILEAGE A0425	EH	A	189	02	13.2	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
[redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.
[redacted]512A

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

28. TOTAL CHARGE
$ 1231 88

29. AMOUNT PAID
$ 0 0

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
Boise, ID 837 4-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
[redacted]9987

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: [redacted]39ID

(For Program in Item 1)

PICA

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

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

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

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

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

7. INSURED'S ADDRESS (No., Street)
ATTN MEDICAL

CITY
Kuna

STATE
ID

8. RESERVED FOR NUCC USE

CITY
B i

STATE
ID

ZIP CODE
83634

TELEPHONE (Include Area Code)
(208)344-4030

ZIP CODE
83707

TELEPHONE (Include Area Code)
((208) 331-1195

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
[redacted]

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

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1967 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
Centurion of ID IDOC

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 SIGNATURE ON FILE DATE 05 18 2021

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 18 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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

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

A. R0602 B. M6281 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

24. A. DATE(S) OF SERVICE From MM	DD	YY	M	To DD	YY	B. PLACE OF SERVICE	C. EMG	D. 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	18	21	05	18	21	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	AB				NPI
2	05	18	21	05	18	21	41	Y	MILEAGE A0425	EH	AB	196	18	13.7	NPI
3															NP
4															NP
5															N
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.: [redacted]727A

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

28. TOTAL CHARGE: $ 1405 90

29. AMOUNT PAID: $ 0 0

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI ADA COUNTY PARAMEDICS
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 837 4-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
370 N. Benjamin Lane
Boise ID 704-84
a [redacted]9987 b.

NUCC Instruction Manua 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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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 [redacted]39ID (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Marks Frank

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M ( ) F ( )

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

5. PATIENT'S ADDRESS (No., Street)
14601 S Pleasant Valle Rd

6. PATIENT RELATIONSHIP TO INSURED
Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY

STATE

8. RESERVED FOR NUCC USE

CITY

STATE

ZIP CODE
83634

TELEPHONE (Include Area Code)
( )

ZIP CODE
83634

TELEPHONE (Include Area Code)
( )

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 [redacted] 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)

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED GNATURE ON FILE 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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 18 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]

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. R079 B. C. D.
E. F. G. H.
I J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 5 1	05182 21	41	Y	AMBULANC SERVICE - ALS1 A0427	H					NPI	
2 05182021	05182 21	41	Y	MILEAGE A0425	SH	A	242 01 16.9			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO. [redacted]809A

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

28. TOTAL CHARGE $ 1284 87

29. AMOUNT PAID $ 0 0

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
Boise ID 837 2-6241

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
[redacted]9987 b.

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 [redacted]14ID

(For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM [redacted] DD YY SEX M [ ] F [ ]

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

5. PATIENT'S ADDRESS (No., Street)
13400 S Pleasant Valle Rd

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

7. INSURED'S ADDRESS (No., Street)
DI

CITY

STATE

8. RESERVED FOR NUCC USE

CITY

STATE

ZIP CODE
83634

TELEPHONE (Include Area Code)
( )

ZIP CODE
83707

TELEPHONE (Include Area Code)
(208) 389-0230

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 M [X] F [ ]

b. RESERVED FOR NUCC USE

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

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 E

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
05 21 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. T1491XA B. C. D.
E. F. G. H.
I. J. K. L.

23. PRIOR AUTHORIZATIO NUMBER
83634

24. A. DATE(S) OF SERVICE From MM	DD	YY	M	To DD	YY	B. PLACE OF SERVICE	C. EM	D. PROCEDURES, SERVICES, O (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								AMBULANC SERVICE - ALS1							NPI
2	05212021			05212021		41	Y	MILEAGE A0425	SH		7 59 13.1				NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN
[redacted]0277 [X]

26. PATIENT'S ACCOUNT NO.
[redacted]242A

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

28. TOTAL CHARGE
$ 11

29. AMOUNT PAID
$ 0

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI ADA COUNTY PARAMEDICS
Kuna, ID 83634
Boise ID 837 4-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
370 N. Benjamin Lane
a. [redacted]9987 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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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)
[redacted]32ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
H r h

3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M [ ] F [ ]

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

5. PATIENT'S ADDRESS (No., Street)
1249 W Grand Ave 308

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

7. INSURED'S ADDRESS (No., Street)
ATTN MEDICAL

CITY
Boise

STATE
ID

8. RESERVED FOR NUCC USE

CITY
Boise

STATE

ZIP CODE
83702

TELEPHONE (Include Area Code)
(208)602-3374

ZIP CODE
83707

TELEPHONE (Include Area Code)
((208) 331-1195

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
[redacted] 1967 SEX M [X] F [ ]

b. RESERVED FOR NUCC US

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

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
05 22 2021 QUAL. 431

15. OTHER DATE QUAL. M 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 NUC[redacted]

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. T83028A B. C. D.
E. F. G. H.
I. J. K. L.

23. PRIOR AUTHORIZATIO NUMBER
83634

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								AMBULANC SERVICE - ALS1							NPI
2								MILEAGE							NPI
2	05	22	21	05	22	21	41	Y A0425	EH	A	196	18	13.7		NPI
3															NPI
4															NPI
5															NPI
6															NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
[redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.
[redacted]335A

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

28. TOTAL CHARGE
$ 1174 33

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
Boise ID 837 4-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
[redacted]9987 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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]84ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Ferguson Robert R

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1964 | SEX: M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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: M ( ) 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 SIGNATURE ON FILE DATE 05 26 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 26 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. R079 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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. EF/SDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05262021 | 05262021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1042 86	1		NPI	
2	05262021 | 05262021	41	Y	MILEAGE A0425	SH	A	187 59	13.1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]845A

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

28. TOTAL CHARGE: $ 1230 45

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]63ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CASTORENA CHRISTOPHER G	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1992 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) CASTORENA CHRISTOPHER G
5. PATIENT'S ADDRESS (No., Street) 15501 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) 15501 S Pleasant Valley Rd
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )		ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )
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 [redacted] 1992 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 SIGNATURE ON FILE DATE 05 27 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 27 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. S0990XA B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 05272021	05272021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 05272021	05272021	41	Y	MILEAGE A0425	SH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER [redacted]0277 SSN EIN [ ] [X]	26. PATIENT'S ACCOUNT NO. [redacted]964A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO	28. TOTAL CHARGE $ 857 12	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley I Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]36ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Passantino Eric B

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1962 SEX M [X] F [ ]

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

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

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 377-1062

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Passantino Eric B

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]5906

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

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 1967 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: BLUE CROSS

10d. CLAIM CODES (Designated by NUCC)

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 05 27 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 27 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. R52 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 05272021	05272021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	725 65	1		NPI	
2 05272021	05272021	41	Y	MILEAGE A0425	EH	A	186 16	13.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [X]

26. PATIENT'S ACCOUNT NO.: [redacted]083A

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

28. TOTAL CHARGE: $ 911 81

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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) [redacted]28ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Isaak Augustus J	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1971 SEX M (X) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial) IMSI Max Security
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ( ) Spouse ( ) Child ( ) Other (X)	7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) (208)389-0233		ZIP CODE 83707 TELEPHONE (Include Area Code) ((208) 389-0230
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 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 SIGNATURE ON FILE DATE 05 28 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 28 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]		20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. R531 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-2716

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 05282021	05282021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 05282021	05282021	41	Y	MILEAGE A0425	EH	A	187 59	13.1		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
[redacted]0277		(X)	[redacted]175A	YES ( ) NO (X)	$ 1165 74	$ 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)287 2950
ADA County Paramedics 04 20 2023 SIGNED DATE	FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]36ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Passantino Eric B

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1962 SEX M [X] F [ ]

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

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

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 377-1062

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Passantino Eric B

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]5906

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

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1967 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: BLUE CROSS

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 SIGNATURE ON FILE DATE 05 29 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 28 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted])

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. Z889 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 05282021	05282021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1145 77	1		NPI	
2 05282021	05282021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [X]

26. PATIENT'S ACCOUNT NO.: [redacted]247A

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

28. TOTAL CHARGE: $ 1341 95

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]64ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1996 SEX M (X) F ( )

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna STATE: ID

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

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

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: [redacted]1996 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 05 29 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 29 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]

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. R079 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 05292021	05292021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 05292021	05292021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 ( ) (X)

26. PATIENT'S ACCOUNT NO.: [redacted]315A

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

28. TOTAL CHARGE: $ 1174 33

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]07ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Dalton Jacob C	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1984 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 409-9839		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-1195
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 [redacted]1967 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 SIGNATURE ON FILE DATE 05 30 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 30 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. M545 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 05302021	05302021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	725 65	1		NPI	
2 05302021	05302021	41	Y	MILEAGE A0425	SH	A	233 42	16.3		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 [ ] [X]	26. PATIENT'S ACCOUNT NO. [redacted]404A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE $ 959 07	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.) ADA County Paramedics 04 20 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13950 S Pleasant Valley Rd Kuna, ID 83634 TO: 190 E Bannock Street Boise, ID 83712-6241		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]42ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1992 | SEX: M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

5. PATIENT'S ADDRESS (No., Street): 14195 Pleasant Valley Road

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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: [redacted]1607

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: M ( ) 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 SIGNATURE ON FILE | DATE 05 31 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 05 31 2021 QUAL. 431

15. OTHER DATE QUAL. | MM DD YY

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R55 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83704

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	05312021 05312021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1205 18	1		NPI	
2	05312021 05312021	41	Y	MILEAGE A0425	SH	A	40 10	2.8		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]542A

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

28. TOTAL CHARGE: $ 1245 28

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.)
ADA County Paramedics
04 20 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 303 N Kimball Pl
Boise, ID 83704
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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) [redacted]25ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ASH TERRY L	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1957 SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ASH TERRY L
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd	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) 389-0229		ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 389-0229
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 [redacted]1957 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 SIGNATURE ON FILE DATE 06 12 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 12 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R4020 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 06122021	06122021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1258 23	1		NPI	
2 06122021	06122021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER [redacted]0277	SSN EIN X	26. PATIENT'S ACCOUNT NO. [redacted]276A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO X	28. TOTAL CHARGE $ 1447 25	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.) ADA County Paramedics 05 09 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]20ID

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)
ANDERSON RIO J	[redacted] 1997 M [ ] F [X]	ANDERSON RIO J

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
2366 E Old Penitentiary Rd	Self [X] Spouse [ ] Child [ ] Other [ ]	2366 E Old Penitentiary Rd

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

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
83712	(208) 900-8629		83712	(208) 900-8629

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: [redacted] 1997 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 SIGNATURE ON FILE DATE 06 13 2021

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06 13 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R112 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83712

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 06132021	06132021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 06132021	06132021	41	Y	MILEAGE A0425	SH	A	27 21	1.9		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
[redacted]0277	[ ] [X]	[redacted]377A	YES [ ] NO [X]	$ 1005 36	$ 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) 287 2950
ADA County Paramedics	FROM: 2366 E Old Penitentiary Rd	ADA COUNTY PARAMEDICS
05 09 2023	Boise, ID 83712	370 N. Benjamin Lane
SIGNED DATE	TO: 190 E Bannock Street	Boise ID 83704-8498
	Boise, ID 83712-6241	[redacted]9987 b.

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]84ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Nosalskiy Walter I	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1993 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ISCI IDAHO	
5. PATIENT'S ADDRESS (No., Street): 617 S Roosevelt Street	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL	
CITY: Boise STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83705 TELEPHONE (Include Area Code): (208) 284-0668	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Nosalskiy Walter I	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]0303	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1967 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: Division of Medicaid	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, complete items 9, 9a, and 9d.	

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06 13 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06 13 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R45851 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 06132021 06132021	41.	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 06132021 06132021	41	Y	MILEAGE A0425	EH	A	191 89	13.4		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [ ] [X]	[redacted]485A	[ ] YES [X] NO	$ 1170 04	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE		[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]08ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1985 | SEX M (X) F ( )

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

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

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

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

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

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: [redacted]1985 | 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 06 14 2020

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 14 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. K922 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06142021	06142021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 06142021	06142021	41	Y	MILEAGE A0425	SH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]568A

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

28. TOTAL CHARGE: $ 1174 33

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 15505 S. Pleasant Valley F
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309
a. b.

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]73ID

PATIENT AND INSURED INFORMATION

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)
WATRING SHERRI L	[redacted] 1966 M F X	WATRING SHERRI L
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 S Pleasant Valley Rd	Self X Spouse Child Other	13900 S Pleasant Valley Rd
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )
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: [redacted] 1966 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 _____ 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 _____

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
06 14 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R52 B. C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634-0000
I. J. K. L.		

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 06142021	06142021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	737	32	1	NPI	
2 06142021	06142021	41	Y	MILEAGE A0425	EH	A	187	59	13.1	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]579A	YES X NO	$ 924 91	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13900 S Pleasant Valley Rc Kuna, ID 83634-0000 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a [redacted]9987 b

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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) [redacted]40ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hites Maynard L	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1946 SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☒	7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) ( )		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760
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 [redacted]1607
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME 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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 14 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. I6789 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 06142021 06142021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 06142021 06142021	41	Y	MILEAGE A0425	SH	A	161 82	11.3		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
[redacted]0277 ☒	[redacted]655A	☐ YES ☒ NO	$ 1139 97	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]31ID

PATIENT AND INSURED INFORMATION

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)
MITCHELL CHRISTOPHER	[redacted] 1995 M X F	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN MEDICAL
CITY: Kuna	STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise	STATE: ID
ZIP CODE: 83634	TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707	TELEPHONE (Include Area Code): (208) 331-2760

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 / SEX M 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 SIGNATURE ON FILE DATE 06 17 2021

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

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06 17 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D. / E. F. G. H. / I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 83634

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 06172021 06172021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 06172021 06172021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		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
[redacted]0277 X	[redacted]102A	YES / X NO	$ 1329 49	$ 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) 287 2950
ADA County Paramedics 05 09 2023	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.
SIGNED DATE		

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]64ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Joyce Jourdan	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1996 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Joyce Jourdan	
5. PATIENT'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Kuna STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
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: [redacted] 1996 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 SIGNATURE ON FILE DATE 06 23 2021

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 23 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]	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. R079 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 83634

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 06232021	06232021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2 06232021	06232021	41	Y	MILEAGE A0425	SH	A	194 75	13.6		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: [redacted]932A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE: $ 1335 22	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.) ADA County Paramedics 05 09 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley I Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.		

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]50ID

PATIENT AND INSURED INFORMATION

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)
Murdoch Keisha D	[redacted] 1994 M F X	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 / ( )		83707 / (208) 331-1195
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: [redacted] 1967 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 SIGNATURE ON FILE DATE 06 23 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06 23 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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 06232021	06232021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 06232021	06232021	41	Y	MILEAGE A0425	EH	A	197 62 13.8			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	X	[redacted]936A	YES NO X	$ 1338 09	$ 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) 287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-0000	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]94ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Payne Erik J

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1968 SEX M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

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

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760

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 M ( ) 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 06 23 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 23 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. S0990XA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06232021	06232021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 06232021	06232021	41	Y	MILEAGE A0425	SH	A	189 02 13.2			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]073A

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

28. TOTAL CHARGE: $ 1167 17

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]11ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bronstad Randy M

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: [redacted]1607

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]11

a. EMPLOYMENT? (Current or Previous): YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ( ) 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: Centurion of ID IDOC

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 SIGNATURE ON FILE | DATE 06 24 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 24 2021 QUAL 431

15. OTHER DATE QUAL | MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a:

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. R109 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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	06242021	06242021	41	Y	AMBULANCE SERVICE - BLS A0429 EH	A	660 94	1		NPI	
2	06242021	06242021	41	Y	MILEAGE A0425 EH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]094A

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

28. TOTAL CHARGE: $ 849 96

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA

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#)	[redacted]76ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): McClain Steven	3. PATIENT'S BIRTH DATE (MM DD YY): [redacted]1954 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ISCI IDAHO	
5. PATIENT'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195	
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): [redacted]1967 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 SIGNATURE ON FILE DATE 06 24 2021

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06 24 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634
I. J. K. L.		

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				AMBULANCE SERVICE - ALS1							
06242021	06242021	41	Y	A0427	EH	A	1205 18	1		NPI	
2				MILEAGE							
06242021	06242021	41	Y	A0425	EH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE $ 1401 36	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC Use
[redacted]0277 [ ] [X]	[redacted]185A				

31. SIGNATURE OF PHYSICIAN 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987
SIGNED 05 09 2023 DATE	a. b.	a. b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]66ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1987 | SEX: M (X) F ( )

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 886-9588

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-1195

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]66

a. EMPLOYMENT? (Current or Previous): YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 1967 | 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: Centurion of ID IDOC

10d. CLAIM CODES (Designated by NUCC)

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

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 06 25 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 25 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NU[redacted]

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. R079 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 06252021	06252021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 06252021	06252021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]251A

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

28. TOTAL CHARGE: $ 1336 65

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309
a. b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[redacted]07ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Dalton Jacob C

3. PATIENT'S BIRTH DATE MM DD YY | SEX
[redacted]1984 | M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ISCI IDAHO

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

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

7. INSURED'S ADDRESS (No., Street)
ATTN MEDICAL

CITY
Kuna

STATE
ID

8. RESERVED FOR NUCC USE

CITY
Boise

STATE
ID

ZIP CODE
83634

TELEPHONE (Include Area Code)
(208)409-9839

ZIP CODE
83707

TELEPHONE (Include Area Code)
(208) 331-1195

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 | SEX
[redacted]967 | M [X] F [ ]

b. RESERVED FOR NUCC USE

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

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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 07 01 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
07 01 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
[redacted]

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

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 07012021	07012021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1205 18	1		NPI	
2 07012021	07012021	41	Y	MILEAGE A0425	EH	A	197 62 13.8			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
[redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.
[redacted]233A

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

28. TOTAL CHARGE
$ 1402 80

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]83ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1993 | SEX M [X] F [ ]

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

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

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): ( )

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

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: [redacted]1993 | 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 SIGNATURE ON FILE DATE 07 01 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 01 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. S51811A B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: B3634

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 07012021	07012021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 07012021	07012021	41	Y	MILEAGE A0425	EH	A	190 46	13.3		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]39A

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

28. TOTAL CHARGE: $ 1168 61

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.)
ADA County Paramedics
SIGNED 05 09 2023 DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]48ID

PATIENT AND INSURED INFORMATION

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)
Navejar Pete	[redacted] 1959 M X F	Navejar Pete
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
575 S 13th St	Self X Spouse Child Other	575 S 13th St
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Boise / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83702 / (208) 286-6738		83702 / (208) 286-6738
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
Navejar Pete		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]4847	YES NO X	[redacted] 1959 M X F
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?
IDHW		X 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 SIGNATURE ON FILE DATE 07 02 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
07 02 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		20. OUTSIDE LAB? YES NO / $ CHARGES

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

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

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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) GPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07022021	07022021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 07022021	07022021	41	Y	MILEAGE A0425	EH	A	143 20	10.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]398A	YES X NO	$ 804 14	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	TO: 1055 N Curtis Road Boise, ID 83704-1309	[redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]26ID

PATIENT AND INSURED INFORMATION

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)
Russell Donald B	[redacted]1938 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208)336-0740		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-1195
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 / SEX: [redacted]1967 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 SIGNATURE ON FILE DATE 07 02 2021

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14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
07 02 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. M79605 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07022021	07022021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 07022021	07022021	41	Y	MILEAGE A0425	EH	A	157 52	11.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	X	[redacted]496A	YES / X NO	$ 1297 99	$ 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)287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]93ID

PATIENT AND INSURED INFORMATION

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 William F	[redacted] 1955 M X F	Wolfe William F
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: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )
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
		[redacted]1607
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: [redacted] 1955 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 SIGNATURE ON FILE DATE 07 04 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 04 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R0602 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 07042021	07042021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1276 26	1		NPI	
2 07042021	07042021	41	Y	MILEAGE A0425	EH	A	197 62	13 8		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	X	[redacted]687A	YES NO X	$ 1473 88	$ 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 #
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS (208)287 2950 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	a. Boise, ID 83704-1309 b.	a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]34ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Clausen James D	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1965 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter	
5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Clausen James D	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]1188	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] 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: IDHW	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 SIGNATURE ON FILE DATE 07 06 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 06 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER B3634

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 07062021 07062021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1148 96	1		NPI	
2 07062021 07062021	41	Y	MILEAGE A0425	SH	A	134 61	9.4		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [ ] [X]	[redacted]045A	YES [ ] NO [X]	$ 1283 57	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 a

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]21ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FISHER DALE	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1977 SEX M (X) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial) IMSI Max Security
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ( ) Spouse ( ) Child ( ) Other (X)	7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 389-0230
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 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 SIGNATURE ON FILE DATE 07 07 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 07 07 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NU[redacted]		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. R109 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-2716

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 07072021	07072021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 07072021	07072021	41	Y	MILEAGE A0425	EH	A	187 59	13.1		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
[redacted]0277	EIN (X)	[redacted]228A	YES ( ) NO (X)	$ 848 53	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13400 S Pleasant Valley Rc Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]8875

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1969 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 13200 S Pleasant Valley Rd

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

7. INSURED'S ADDRESS (No., Street): 13200 S Pleasant Valley Rd

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna STATE: ID

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

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

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: [redacted] 1969 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 SIGNATURE ON FILE DATE 07 07 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 07 2021 QUAL 431

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a:

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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

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

A. R0602 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634-2720

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 07072021	07072021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1205 18	1		NPI	
2 07072021	07072021	41	Y	MILEAGE A0425	EH	A	179 00	12.5		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]266A

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

28. TOTAL CHARGE: $ 1384 18

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13200 S Pleasant Valley Rc
Kuna, ID 83634-2720
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]51ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Shiffer Timothy P	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1954 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): IMSI Max Security	
5. PATIENT'S ADDRESS (No., Street): PO Box 70010	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN DIANNA	
CITY: Boise STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 972-2519	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 389-0230	
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: 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 SIGNATURE ON FILE DATE 07 08 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 08 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. E162 B. C. D.		23. PRIOR AUTHORIZATION NUMBER 83634
E. F. G. H.		
I. J. K. L.		

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 07082021 07082021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 07082021 07082021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		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
[redacted]0277 [X]	[redacted]295A	YES [X] NO [ ]	$ 849 96	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	TO: 1055 N Curtis Road a. Boise, ID 83704-1309 b.	a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]42ID

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pena Jose A

3. PATIENT'S BIRTH DATE (MM DD YY) SEX: [redacted]1986 M X F

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

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

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 386-9588

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-1195

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 | X NO

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

c. OTHER ACCIDENT? YES | X NO

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER: [redacted]1607

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX: [redacted]1967 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 | 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 SIGNATURE ON FILE DATE 07 08 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY): 07 08 2021 QUAL 431

15. OTHER DATE QUAL (MM DD YY)

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO:

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07082021	07082021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 07082021	07082021	41	Y	MILEAGE A0425	EH	A	171 84	12.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN | EIN X

26. PATIENT'S ACCOUNT NO.: [redacted]350A

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

28. TOTAL CHARGE: $ 1312 31

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a [redacted]9987 b

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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)	
	[redacted]8875	
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)
Williford Christian M	[redacted] 1999 M [X] F [ ]	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self [ ] Spouse [ ] Child [ ] Other [X]	ATTEN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 / ( )		83707 / (208) 331-2760
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 M [ ] 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 SIGNATURE ON FILE DATE 07 08 2021

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

PATIENT AND INSURED INFORMATION

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
07 08 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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 G8911 B C D		23. PRIOR AUTHORIZATION NUMBER
E F G H		83634
I J K L		

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 07082021	07082021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	669 43	1		NPI	
2 07082021	07082021	41	Y	MILEAGE A0425	EH	A	180 43	12.6		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [X]	[redacted]363A	YES [ ] NO [X]	$ 849 86	$ 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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309
a. b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]37ID

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)
OGDEN LAURIE A	[redacted] 1967 M F X	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 223-3050		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195
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
OGDEN LAURIE A		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]6464	YES X NO	[redacted] 1967 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
IDHW		X 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 SIGNATURE ON FILE DATE 07 09 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
07 09 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 07092021	07092021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1042 86	1		NPI	
2 07092021	07092021	41	Y	MILEAGE A0425	EH	A	170 41 11.9			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
[redacted]0277 X	[redacted]459A	YES X NO	$ 1213 27	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]64ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WILLIAMSON PAULA M	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1969 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): PRISON DOC WOMENS	
5. PATIENT'S ADDRESS (No., Street): 13200 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN LARRY HEINZ	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): ( )	
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 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 SIGNATURE ON FILE DATE 07 09 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 09 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. T71162A B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634-2720

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 07092021 07092021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1216 85	1		NPI	
2 07092021 07092021	41	Y	MILEAGE A0425	EH	A	177 57	12.4		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE $ 1394 42	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC Use
[redacted]0277 [ ] [X]	[redacted]548A				

31. SIGNATURE OF PHYSICIAN 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 #
ADA County Paramedics	FROM: 13200 S Pleasant Valley Rc Kuna, ID 83634-2720	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	TO: 1055 N Curtis Road Boise, ID 83704-1309	(208) 287 2950 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]07ID

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1967 | SEX: M (X) F ( )

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-1195

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: [redacted]07

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: [redacted] 1967 | 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 SIGNATURE ON FILE | DATE 07 11 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 11 2021 QUAL 431

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07112021	07112021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 07112021	07112021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN ( ) EIN (X)

26. PATIENT'S ACCOUNT NO.: [redacted]855A

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

28. TOTAL CHARGE: $ 1336 65

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309
a. b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[redacted]72ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Tilford Alan P

3. PATIENT'S BIRTH DATE MM DD YY | SEX
[redacted] 1959 | M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
IMSI Max Security

5. PATIENT'S ADDRESS (No., Street)
13400 S Pleasant Valley Rd

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

7. INSURED'S ADDRESS (No., Street)
ATTEN DIANNA

CITY | STATE
Kuna | ID

8. RESERVED FOR NUCC USE

CITY | STATE
Boise | ID

ZIP CODE | TELEPHONE (Include Area Code)
83634 | ( )

ZIP CODE | TELEPHONE (Include Area Code)
83707 | (208) 389-0230

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 | SEX
M [X] F [ ]

b. RESERVED FOR NUCC USE

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

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 SIGNATURE ON FILE DATE 07 12 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
07 12 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. R4182 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634-2716

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 07122021	07122021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 07122021	07122021	41	Y	MILEAGE A0425	EH	A	197 62	13.8		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
[redacted]0277 [ ] [X]

26. PATIENT'S ACCOUNT NO.
[redacted]916A

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

28. TOTAL CHARGE
$ 1175 77

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13400 S Pleasant Valley Rc
Kuna, ID 83634-2716
TO: 1055 N Curtis Road
Boise, ID 83704-1309
a. b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]22ID

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)
Neal Antonio T	[redacted]1974 M [X] F [ ]	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self [ ] Spouse [ ] Child [ ] Other [X]	ATTEN MEDICAL
CITY: Kuna — STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise — STATE: ID
ZIP CODE: 83634 — TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 — TELEPHONE (Include Area Code): (208) 331-2760

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 / SEX M [ ] 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 SIGNATURE ON FILE DATE 07 14 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
07 14 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R52 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 83634

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 07142021	07142021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 07142021	07142021	41	Y	MILEAGE A0425	SH	A	187 59	13.1		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
[redacted]0277 [X]	[redacted]258A	[ ] YES [X] NO	$ 848 53	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]22ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Neal Antonio T

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1974 | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

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

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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 M [ ] 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE | DATE 07 15 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 15 2021 QUAL 431

15. OTHER DATE QUAL: | MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted])

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. T50902A B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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	07152021 | 07152021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1140 47	1		NPI	
2	07152021 | 07152021	41	Y	MILEAGE A0425	SH	A	446 78	31.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [X]

26. PATIENT'S ACCOUNT NO.: [redacted]386A

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

28. TOTAL CHARGE: $ 1587 25

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
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El Paso, TX 79998

CARRIER

PICA | 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): [redacted]63ID

PATIENT AND INSURED INFORMATION

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)
MILLER GARRY R	[redacted] 1963 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna ID		Boise ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 ( )		83707 (208) 331-1195
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: [redacted] 1967 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.

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SIGNED SIGNATURE ON FILE DATE 07 18 2021

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SIGNED SIGNATURE ON FILE

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07 18 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 83634

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 07182021	07182021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 07182021	07182021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			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
[redacted]0277 X	[redacted]815A	YES NO X	$ 1336 65	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

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CARRIER

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						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]32 ID

PATIENT AND INSURED INFORMATION

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)
Lockhart Michael V	[redacted] 1963 M X F	Lockhart Michael V
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
PO Box 51	Self X Spouse Child Other	PO Box 51
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Boise / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83707 / (208)233-6909		83707 / (208) 233-6909
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
Lockhart Michael V		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]5141	YES NO X	[redacted] 1963 M X F
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?
CIGNA HEALTH CARE		X YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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07 19 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634
I. J. K. L.		

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 07192021 07192021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 07192021 07192021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]934A	YES NO X	$ 1329 49	$ 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)287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road Boise, ID 83704-1309	Boise ID 83704-8498
SIGNED DATE		[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]89ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Boman Mark C

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1964 | SEX: M X | F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): TMSI Max Security

5. PATIENT'S ADDRESS (No., Street): 13400 S Pleasant Valley Rd

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

7. INSURED'S ADDRESS (No., Street): ATTEN DIANNA

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

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

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 389-0230

PATIENT AND INSURED INFORMATION

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 X

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

c. OTHER ACCIDENT? YES | NO X

10d. CLAIM CODES (Designated by NUCC):

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. INSURED'S DATE OF BIRTH MM DD YY: | 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 SIGNATURE ON FILE DATE 07 21 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 21 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. K920 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634-2716

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 07212021	07212021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 07212021	07212021	41	Y	MILEAGE A0425	EH	A	186 16	13.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 | EIN X

26. PATIENT'S ACCOUNT NO.: [redacted]320A

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

28. TOTAL CHARGE: $ 847 10

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13400 S Pleasant Valley Rc
Kuna, ID 83634-2716
TO: 1055 N Curtis Road
Boise, ID 83704-1309
a b

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]91ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): O'NEILL ALEXANDER	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1991 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): O'NEILL ALEXANDER	
5. PATIENT'S ADDRESS (No., Street): 15505 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 15505 S Pleasant Valley Rd	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Kuna STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
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: [redacted] 1991 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 SIGNATURE ON FILE DATE 07 22 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 22 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. T50901A B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER 83634

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 07222021	07222021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 07222021	07222021	41	Y	MILEAGE A0425	SH	A	196 18	13.7		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
[redacted]0277 [X]	[redacted]454A	YES [X] NO	$ 1174 33	$ 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)287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 15505 S. Pleasant Valley R Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]91ID

PATIENT AND INSURED INFORMATION

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)
Bennett Steven J	[redacted]1970 M X F	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 Pleasant Valley Road	Self Spouse Child Other X	ATTEN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (325)614-1303		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-2760
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
Bennett Steven J		
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]0716	a. EMPLOYMENT? (Current or Previous) YES NO X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M 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: Veterans Office of Community Care	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X 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 SIGNATURE ON FILE DATE 07 23 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 23 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07232021	07232021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1205 18	1		NPI	
2 07232021	07232021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]7540A	X YES NO	$ 1401 36	$ 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)287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA

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): [redacted]48ID

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)
Navejar Pete	[redacted] 1959 M X F	Navejar Pete

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
575 S 13th St	Self X Spouse Child Other	575 S 13th St

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

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
83702	(208) 286-6738		83702	(208) 286-6738

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
Navejar Pete		
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]4847	a. EMPLOYMENT? (Current or Previous) YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: [redacted] 1959 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: IDHW	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X 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 SIGNATURE ON FILE DATE 07 23 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 23 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NU[redacted]		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. R531 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 07232021	07232021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 07232021	07232021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			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
[redacted]0277	X	[redacted]542A	YES X NO	$ 857 12	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	a.	[redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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)	
	[redacted]93ID	
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)
SAVEDRA EDDIE	[redacted] 1995 M [X] F [ ]	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self [ ] Spouse [ ] Child [ ] Other [X]	ATTN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 / ( )		83707 / (208) 331-1195
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 / SEX
		[redacted] 1967 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 SIGNATURE ON FILE DATE 07 24 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / 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
07 24 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. S0990XA B. C. D. / E. F. G. H. / I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 07242021 07242021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1054 53	1		NPI	
2 07242021 07242021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			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
[redacted]0277 [X]	[redacted]730A	[ ] YES [X] NO	$ 1250 71	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
	Kuna, ID 83634	370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	[redacted]9987 a.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]81ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Ridgley Lee A

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1954 | SEX: M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter

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

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83634 | TELEPHONE (Include Area Code): (208) 331-1195

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-2760

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 M ( ) 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 07 24 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 24 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

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

A. R0602 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07242021	07242021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 07242021	07242021	41	Y	MILEAGE A0425	SH	A	187 59	13.1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]749A

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

28. TOTAL CHARGE: $ 1165 74

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 14601 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309
a. b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 a. b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]52ID

PATIENT AND INSURED INFORMATION

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)
NEEP DANNY H	[redacted] 1956 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 336-1260		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-1195
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: [redacted] 1967 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 SIGNATURE ON FILE DATE 07 25 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 25 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07252021	07252021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1247 62	1		NPI	
2 07252021	07252021	41	Y	MILEAGE A0425	EH	A	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]819A	YES X NO	$ 1443 80	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]10ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mygrant Charlotte A	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1956 SEX: M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): SICI
5. PATIENT'S ADDRESS (No., Street): 13900 Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street): ATTEN VAUGHN
CITY: Boise STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83709 TELEPHONE (Include Area Code): (208) 334-2731		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 333-0037
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 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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 07 27 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 27 2021 QUAL: 431	15. OTHER DATE QUAL: MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R7989 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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 07272021	07272021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 07272021	07272021	41	Y	MILEAGE A0425	EH	A	194 75	13.6		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: [redacted]097A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE: $ 855 69	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.) ADA County Paramedics 05 09 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000 TO: 1055 N Curtis Road a. Boise, ID 83704-1309 b.	33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.			

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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)
							[redacted]32 ID

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)
Lockhart Michael V	[redacted] 1963 M [X] F [ ]	Lockhart Michael V
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
PO Box 51	Self [X] Spouse [ ] Child [ ] Other [ ]	PO Box 51
CITY: Boise / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 233-6909		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 233-6909
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
Lockhart Michael V		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]5141	YES [ ] NO [X]	[redacted] 1963 M [X] F [ ]
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?
CIGNA HEALTH CARE		YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 07 19 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 27 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]		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. R079 B. C. D.	
E. F. G. H.	23. PRIOR AUTHORIZATION NUMBER
I. J. K. L.	83634

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 07272021 07272021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1218 97	1		NPI	
2 07272021 07272021	41	Y	MILEAGE A0425	SH	A	186 16	13.0		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [X]	[redacted]L71A	YES [ ] NO [X]	$ 1405 13	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	TO: 1055 N Curtis Road Boise, ID 83704-1309	[redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]9829	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MORLEY JAMIE L	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1977 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) PRISON DOC WOMENS
5. PATIENT'S ADDRESS (No., Street) 13200 S Pleasant Valley Rd 2	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTEN LARRY HEINZ
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (385) 224-1269		ZIP CODE: 83707 TELEPHONE (Include Area Code): ( )
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 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 SIGNATURE ON FILE DATE 07 29 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 07 29 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. R0602 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634-2720

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 07292021 07292021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1377 05	1		NPI	
2 07292021 07292021	41	Y	MILEAGE A0425	EH	A	177 57	12.4		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
[redacted]0277 [X]	[redacted]374A	YES [ ] NO [X]	$ 1554 62	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13200 S Pleasant Valley Rc Kuna, ID 83634-2720 TO: 1055 N Curtis Road Boise, ID 83704-1309 a. b.	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]9230

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CHAVEZ REYMUNDO A

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1977 SEX: M X F

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

5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Rd

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

7. INSURED'S ADDRESS (No., Street): ATTEN VAUGHN

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

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

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 333-0037

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: [redacted]1607

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: 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 SIGNATURE ON FILE DATE 07 29 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 29 2021 QUAL 431

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. M79605 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07292021	07292021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 07292021	07292021	41	Y	MILEAGE A0425	SH	A	171 84	12.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 X

26. PATIENT'S ACCOUNT NO.: [redacted]410A

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

28. TOTAL CHARGE: $ 1149 99

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13900 S Pleasant Valley Rc
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]42ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Dade Dana J

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

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

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

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

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

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195

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: [redacted] 1967 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 SIGNATURE ON FILE DATE 07 29 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 29 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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

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

A. R0602 B. I959 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 07292021	07292021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	AB	1297 48	1		NPI	
2 07292021	07292021	41	Y	MILEAGE A0425	EH	AB	196 18 13.7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]439A

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

28. TOTAL CHARGE: $ 1493 66

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987

PATIENT AND INSURED INFORMATION

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]23ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BALLARD WESTON L	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1982 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): IMSI Max Security	
5. PATIENT'S ADDRESS (No., Street): 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN DIANNA	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 389-0230	
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: 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 SIGNATURE ON FILE DATE 07 30 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 30 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. IG8911 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634-2716

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 07302021 07302021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	737 32	1		NPI	
2 07302021 07302021	41	Y	MILEAGE A0425	EH	A	186 16	13.0		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
[redacted]0277 [ ] [X]	[redacted]544A	YES [ ] NO [X]	$ 923 48	$ 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) 287 2950
ADA County Paramedics	FROM: 13400 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-2716	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA

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): [redacted]23ID

PATIENT AND INSURED INFORMATION

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)
Delgado Eluith S	[redacted] 1963 M X F	Delgado Eluith S
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self X Spouse Child Other	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): ( )		ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )
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: [redacted] 1963 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 SIGNATURE ON FILE DATE 07 31 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
07 31 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. I639 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 07312021	07312021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 07312021	07312021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		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
[redacted]0277	X	[redacted]713A	YES NO X	$ 849 96	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	a. Boise, ID 83704-1309 b.	a. [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]52ID

PATIENT AND INSURED INFORMATION

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)
Williams Eric L	[redacted] 1996 M X F	IMSI Max Security
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13400 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN DIANNA
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna ID		Boise ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 ( )		83707 (208) 389-0230

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 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 _____ 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 _____

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
08 04 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R609 B. C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634-2716
I. J. K. L.		

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 08042021	08042021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 08042021	08042021	41	Y	MILEAGE A0425	EH	A	186 16	13.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	X	[redacted]465A	X YES NO	$ 847 10	$ 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) 287 2950
ADA County Paramedics	FROM: 13400 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-2716	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]52ID

PATIENT AND INSURED INFORMATION

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)
NEEP DANNY H	[redacted] 1956 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Kuna — STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise — STATE: ID
ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 336-1260		ZIP CODE: 83707 — TELEPHONE (Include Area Code): (208) 331-1195
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 / SEX: [redacted] 1967 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 SIGNATURE ON FILE DATE 08 05 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 05 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08052021	08052021	41	Y	A0427	EH	A	1205 18	1		NPI	
2 08052021	08052021	41	Y	A0425 MILEAGE	EH	A	194 75	13.6		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
[redacted]0277	X	[redacted]567A	YES / X NO	$ 1399 93	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	a. b. Boise, ID 83704-1309	a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]14ID

PATIENT AND INSURED INFORMATION

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)
Knibbe Jordan J	[redacted] 1998 M X F	IMSI Max Security
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13400 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN DIANNA
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 389-0230
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 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 SIGNATURE ON FILE DATE 05 21 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 06 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R58 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08062021 08062021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	978 15	1		NPI	
2 08062021 08062021	41	Y	MILEAGE A0425	SH	A	187 59	13.1		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) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
[redacted]0277 X	[redacted]726A	X	$ 1165 74	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

CARRIER

Corizon
PO Box 981639
El Paso, TX 79998

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): [redacted]06ID

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)
SALINAS PABLO	[redacted] 1966 M ☒ F ☐	SALINAS PABLO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13400 S Pleasant Valley Rd	Self ☒ Spouse ☐ Child ☐ Other ☐	13400 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) 250-2323		ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 250-2323
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: [redacted] 1966 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 SIGNATURE ON FILE DATE 08 06 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
08 06 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

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

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

22. RESUBMISSION CODE	ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08062021	08062021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1147 90	1		NPI	
2 08062021	08062021	41	Y	MILEAGE A0425	SH	A	196 18	13.7		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
[redacted]0277	☐ ☒	[redacted]734A	☐ YES ☒ NO	$ 1344 08	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	TO: 1055 N Curtis Road Boise, ID 83704-1309	[redacted]9987 b

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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 [redacted]32ID	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Richman Rodney	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1968 SEX M (X) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Richman Rodney
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd	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) 515-0373		ZIP CODE 83634 TELEPHONE (Include Area Code) (208) 515-0373
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 SEX [redacted]1968 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 SIGNATURE ON FILE DATE 08 07 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 08 07 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NU[redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 08072021	08072021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1148 96	1		NPI	
2 08072021	08072021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		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
[redacted]0277	( ) (X)	[redacted]894A	( ) YES (X) NO	$ 1337 98	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]50ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Murdoch Keisha D	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1994 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ISCI IDAHO	
5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195	
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: [redacted]1967 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 SIGNATURE ON FILE DATE 08 09 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 09 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634-0000

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 08092021 08092021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 08092021 08092021	41	Y	MILEAGE A0425	EH	A	194 75	13.6		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
[redacted]0277 [ ] [X]	[redacted]237A	YES [ ] NO [X]	$ 1335 22	$ 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) 287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634-0000	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	TO: 1055 N Curtis Road Boise, ID 83704-1309	[redacted]9987 b

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]67ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Blake Cody R	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1988 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Blake Cody R	
5. PATIENT'S ADDRESS (No., Street): 8886 W Overland Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 8886 W Overland Rd	
CITY: Boise STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83709 TELEPHONE (Include Area Code): (208) 488-8056	
ZIP CODE: 83709 TELEPHONE (Include Area Code): (208) 488-8056	
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: [redacted] 1988 SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): ID
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 SIGNATURE ON FILE DATE 08 10 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
08 10 2021 QUAL. 431	QUAL. 439 08 10 2021	FROM TO
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 NUC[redacted]		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. G8911 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83714

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 08102021	08102021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1063 02	1		NPI	
2 08102021	08102021	41	Y	MILEAGE A0425	SH	A	42 96	3.0		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	[ ] [X]	[redacted]306A	YES [ ] NO [X]	$ 1105 98	$ 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.)
ADA County Paramedics
SIGNED 05 09 2023 DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: N Glenwood St / W Lorimer
Garden City, ID 83714
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]39ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hart Denver J

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1969 SEX: M X F

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

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

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

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

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]39

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME: Centurion of ID IDOC

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES | X NO

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

c. OTHER ACCIDENT? YES | X NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted]1967 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? X 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 SIGNATURE ON FILE DATE 08 10 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 10 2021 QUAL 431

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]

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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08102021	08102021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1056 65	1		NPI	
2 08102021	08102021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 EIN X

26. PATIENT'S ACCOUNT NO.: [redacted]347A

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

28. TOTAL CHARGE: $ 1252 83

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]06ID

PATIENT AND INSURED INFORMATION

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)
Kohoutek Johnathan	[redacted] 1956 M X F	Alt Placement Correctional
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
15505 S Pleasant Valley Rd	Self Spouse Child Other X	15505 S Pleasent Valley Rd
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Kuna / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Kohoutek Johnathan	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]6233	a. EMPLOYMENT? (Current or Previous) YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M 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: Humana	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X 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 SIGNATURE ON FILE DATE 08 13 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 13 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. M79605 B. M25512 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08132021	08132021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	AB	1063	02	1	NPI	
2 08132021	08132021	41	Y	MILEAGE A0425	SH	AB	194	75	13.6	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]866A	YES X NO	$ 1257 77	$ 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) 287 2950
ADA County Paramedics	FROM: 15505 S. Pleasant Valley R	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]30ID

PATIENT AND INSURED INFORMATION

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)
HASS GREGORY	[redacted] 1964 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna ID		Boise ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 ( )		83707 (208) 331-1195
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 [redacted] 1967 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 SIGNATURE ON FILE DATE 08 15 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 15 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. IR109 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08152021 08152021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 08152021 08152021	41	Y	MILEAGE A0425	EH	A	197 62	13.8		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]044A	YES X NO	$ 1175 77	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.
SIGNED 05 09 2023 DATE		

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]65ID

PATIENT AND INSURED INFORMATION

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)
Rogstad Jesse R	[redacted]1980 M X F	IMSI Max Security
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13400 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN DIANNA
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 / ( )		83707 / (208) 389-0230
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 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 SIGNATURE ON FILE DATE 08 16 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
08 16 2021 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 NUC [redacted]		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. E876 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08162021 08162021	41	Y	AMBULANCE SERVICE - BLS A0429 SH	A	660 94	1		NPI	
2 08162021 08162021	41	Y	MILEAGE A0425 SH	A	186 16	13.0		NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]224A	YES X NO	$ 847 10	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
SIGNED 05 09 2023 DATE	Boise, ID 83704-1309	a. [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]1494

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

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1994 | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Alt Placement Correctional

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

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

7. INSURED'S ADDRESS (No., Street): 15505 S Pleasent Valley Rd

CITY: Kuna | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Kuna | STATE: ID

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]9790

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

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] 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: IDHW

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 SIGNATURE ON FILE DATE 08 16 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 16 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]

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. R6884 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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	08162021	08162021	41	Y	AMBULANCE SERVICE - BLS A0429 SH	A	660 94	1		NPI	
2	08162021	08162021	41	Y	MILEAGE A0425 SH	A	194 75	13.6		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]249A

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

28. TOTAL CHARGE: $ 855 69

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 15505 S. Pleasant Valley F
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]60ID

PATIENT AND INSURED INFORMATION

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)
Aguilera Raechal M	[redacted] 1988 M F X	SICI,
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN VAUGHN
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (208) 414-2121		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 333-0037

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 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 SIGNATURE ON FILE DATE 08 16 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 16 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R531 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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 08162021	08162021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 08162021	08162021	41	Y	MILEAGE A0425	EH	A	194 75	13.6		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
[redacted]0277 X	[redacted]272A	YES X NO	$ 1335 22	$ 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) 287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-0000	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	a. Boise, ID 83704-1309 b.	a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]35ID

PATIENT AND INSURED INFORMATION

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)
Hardt Fredrick F	[redacted] 1973 M X F	Hardt Fredrick F
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
2758 N Reno Way	Self X Spouse Child Other	2758 N Reno Way
CITY: Boise / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83704 / TELEPHONE (Include Area Code): (208) 724-1948		ZIP CODE: 83704 / TELEPHONE (Include Area Code): (208) 724-1948
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
Hardt Fredrick F		
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]8247	a. EMPLOYMENT? (Current or Previous) YES NO X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: [redacted] 1973 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: IDHW	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 SIGNATURE ON FILE DATE 08 17 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 17 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. I10 B. C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634
I. J. K. L.		

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 08172021 08172021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 08172021 08172021	41	Y	MILEAGE A0425	EH	A	187 59	13.1		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]347A	YES NO X	$ 848 53	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
05 09 2023	TO: 1055 N Curtis Road Boise, ID 83704-1309	[redacted]9987
SIGNED DATE	a. b.	a. b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]11ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hunter Kristofer W

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1990 | SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 575 E 13th St

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Boise | STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise | STATE: ID

ZIP CODE: 83702 | TELEPHONE (Include Area Code): (986) 837-1623

ZIP CODE: 83707 | TELEPHONE (Include Area Code): (208) 331-1195

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Hunter Kristofer W

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]8194

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

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 1967 | 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: Division of Medicaid

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 SIGNATURE ON FILE | DATE 08 17 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 17 2021 QUAL 431

15. OTHER DATE QUAL | MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]

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. R079 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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	08172021	08172021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI
2	08172021	08172021	41	Y	MILEAGE A0425	EH	A	171 84 12.0			NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: [redacted]0277 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: [redacted]447A

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

28. TOTAL CHARGE: $ 1312 31

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.)
ADA County Paramedics
SIGNED | DATE 05 09 2023

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]65ID

PATIENT AND INSURED INFORMATION

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)
Rogstad Jesse R	[redacted] 1980 M X F	IMSI Max Security
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13400 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN DIANNA
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 389-0230
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 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 SIGNATURE ON FILE DATE 08-18-2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
08 18 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. M25551 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08182021	08182021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 08182021	08182021	41	Y	MILEAGE A0425	SH	A	186 16 13.0			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]503A	YES NO X	$ 847 10	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	a. [redacted]9987 b.

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

	X	[redacted]14ID
Knibbe Jordan J	[redacted] 1998 X	IMSI Max Security
13400 S Pleasant Valley Rd	X	ATTEN DIANNA
Kuna ID		Boise ID
83634		83707 (208) 389-0230
	X	X
	X NO	
	X	Corizon
		X
SIGNATURE ON FILE	08 19 2021	SIGNATURE ON FILE
08 19 2021 431		
[redacted]	[redacted]	
R52	0	N
		83634-2716

				AMBULANCE SERVICE - ALS1							
08192021	08192021	41	Y	A0427	EH		A	1071	51	1	
				MILEAGE							
08192021	08192021	41	Y	A0425	EH		A	186	16	13.0	NPI
											NPI
											NPI

[redacted]0277	X	[redacted]655A	X	1257 67	0 00
					208 287 2950
ADA County Paramedics	FROM: 13400 S Pleasant Valley Rd Kuna, ID 83634-2716			ADA COUNTY PARAMEDICS	
05 09 2023	TO: 1055 N Curtis Road Boise, ID 83704-1309			370 N. Benjamin Lane Boise ID 83704-8498	
				[redacted]9987	

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA ☐ | PICA ☐

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

PATIENT AND INSURED INFORMATION

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
[redacted]99ID	

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)
CLEMENTS, TYSON D	[redacted] 1995 M ☒ F ☐	ISCI IDAHO

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

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

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
83634	(208) 519-9996	83707	(208) 331-1195

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 [redacted] 1967 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 SIGNATURE ON FILE DATE 08 19 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 19 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. S0990XA B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08192021	08192021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1068 32	1		NPI	
2 08192021	08192021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		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
[redacted]0277 ☐ ☒	[redacted]678A	☐ YES ☒ NO	$ 1264 50	$ 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 #
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	a. Boise, ID 83704-1309 b.	[redacted]9987 (208) 287 2950

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[redacted]99ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Mora Peter T

3. PATIENT'S BIRTH DATE MM DD YY [redacted]1968 SEX M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
ICC ID CorrecCenter

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

6. PATIENT RELATIONSHIP TO INSURED
Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street)
ATTEN MEDICAL

CITY | STATE
Kuna | ID

8. RESERVED FOR NUCC USE

CITY | STATE
Boise | ID

ZIP CODE | TELEPHONE (Include Area Code)
83634 | (208) 386-9588

ZIP CODE | TELEPHONE (Include Area Code)
83707 | (208) 331-2760

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
[redacted]1607

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 M ( ) F ( )

b. RESERVED FOR NUCC USE

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

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 SIGNATURE ON FILE DATE 08 19 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
08 19 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
[redacted]

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. K922 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER
83634

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 08192021	08192021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 08192021	08192021	41	Y	MILEAGE A0425	EH	A	199 05 13 9			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
[redacted]0277 ( ) (X)

26. PATIENT'S ACCOUNT NO.
[redacted]727A

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

28. TOTAL CHARGE $ 859 99

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 190 E Bannock Street
a. Boise, ID 83712-6241 b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]60ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Aguilera Raechal M

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1988 SEX: M ( ) F (X)

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

5. PATIENT'S ADDRESS (No., Street): 13900 S Pleasant Valley Rd

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other (X)

7. INSURED'S ADDRESS (No., Street): ATTEN VAUGHN

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 414-2121

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 333-0037

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: 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 SIGNATURE ON FILE DATE 08 20 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 20 2021 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

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

A. R569 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634-0000

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 08202021	08202021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1222 16	1		NPI	
2 08202021	08202021	41	Y	MILEAGE A0425	EH	A	196 18 13 7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 (X)

26. PATIENT'S ACCOUNT NO.: [redacted]893A

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

28. TOTAL CHARGE: $ 1418 34

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.)
ADA County Paramedics
05 09 2023
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13900 S Pleasant Valley Rc
Kuna, ID 83634-0000
TO: 1055 N Curtis Road
Boise ID 83704-1309
a. b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639
El Paso, TX 79998

	[redacted] 09ID
PIERCE ROBERT W	[redacted] 1970 X
14601 S Pleasant Valley Rd	X
Kuna ID	
83634-2709	
	X
	X
	X
SIGNATURE ON FILE 02-22-2021	

	ICC ID CorrecCenter
	ATTEN MEDICAL
	Boise ID
	83707 (208) 331-2760
	[redacted] 1607
	Corizon
	X
	SIGNATURE ON FILE

08 21 2021 431

[redacted]

A R0603 B 0
E F
J

83634

				AMBULANCE SERVICE - BLS							
08212021	08212021	41	Y	A0429	EH		A	660	94	1	
				MILEAGE							NPI
08212021	08212021	41	Y	A0425	EH		A	189	02	13.2	NPI
											NPI

[redacted] 0277 X [redacted] 1956A X 849 96 0 00

208 287 2950

ADA County Paramedics
05 09 2023

FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted] 9987

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]13ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Campbell Jerry W	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1945 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Campbell Jerry W	
5. PATIENT'S ADDRESS (No., Street): 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 13400 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) 338-1635	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 338-1635	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): ISCI IDAHO	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]13	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX: [redacted] 1945 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: Centurion of ID IDOC	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, complete items 9, 9a, and 9d.	

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 08 22 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 22 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R109 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 08222021 08222021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1281 56	1		NPI	
2 08222021 08222021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		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
[redacted]0277 [ ] [X]	[redacted]162A	[ ] YES [X] NO	$ 1477 74	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	a. [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA

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#)	[redacted]52ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): AMLIN CHAMBRAY R	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1991 SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SICI	
5. PATIENT'S ADDRESS (No., Street): 2621 Sparrow	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN VAUGHN	
CITY: Caldwell STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83605 TELEPHONE (Include Area Code): (208) 453-1380	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 333-0037	
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: 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 SIGNATURE ON FILE DATE 08-24-2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 24 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		23 PRIOR AUTHORIZATION NUMBER 83634-0000

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 08242021 08242021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 08242021 08242021	41	Y	MILEAGE A0425	EH	A	206 21	14.4		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
[redacted]0277 [ ] [X]	[redacted]502A	YES [ ] NO [X]	$ 1346 68	$ 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) 287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-0000	370 N. Benjamin Lane
SIGNED DATE	TO: 190 E Bannock Street	Boise ID 83704-8498
	Boise, ID 83712-6241	a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]58ID
WISE CHAD L	[redacted] 1969 X	Alt Placement Correctional
15505 S Pleasant Valley Rd	X	15505 S Pleasent Valley Rd
Kuna ID		Kuna ID
83634		83634
WISE CHAD L		
[redacted]58	X	
	X	
	X	Corizon
Centurion of ID IDOC		X
SIGNATURE ON FILE	08 25 2021	SIGNATURE ON FILE

08 25 2021 431												D	
[redacted]							[redacted]						
R079										0			
												83634	
				AMBULANCE SERVICE - ALS1									
08252021	08252021	41	Y	A0427	SH			A		1145	77	1	
				MILEAGE									
08252021	08252021	41	Y	A0425	SH			A		194	75	13.6	NPI
													NPI
[redacted]0277			X	[redacted]649A				X		1340	52	0 00	
													208 287 2950

ADA County Paramedics
05 09 2023

FROM: 15505 S. Pleasant Valley I
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA

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): [redacted]96ID

PATIENT AND INSURED INFORMATION

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)
Litzenberg Marklin W	[redacted]1984 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna ID		Boise ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 (208) 336-0740		83707 (208) 331-1195
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
Litzenberg Marklin W		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]8739	YES X NO	[redacted]1967 M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
UNITED HEALTH CARE		X 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 SIGNATURE ON FILE DATE 08 26 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 26 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]		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. R531 B. C. D.		
E. F. G. H.		23. PRIOR AUTHORIZATION NUMBER
I. J. K. L.		83634

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 08262021 08262021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1		NPI	
2 08262021 08262021	41	Y	MILEAGE A0425	EH	A	196 18	13.7		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]826A	YES X NO	$ 1174 33	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]93ID

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)
Shelly Carl D	[redacted] 1979 M X F	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN MEDICAL
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise STATE: ID
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 376-4597		ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760
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 M 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 SIGNATURE ON FILE DATE 08 27 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 27 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. M25572 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 08272021 08272021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 08272021 08272021	41	Y	MILEAGE A0425	SH	A	189 02	13.2		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
[redacted]0277 X	[redacted]945A	X YES NO	$ 849 96	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	a. Boise, ID 83704-1309	a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]55ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Wildman Thomas	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1981 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) (541) 316-3616		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-2760
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 M [ ] 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 SIGNATURE ON FILE DATE 02-28-2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 08 27 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. M79604 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

PATIENT AND INSURED INFORMATION

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 08272021	08272021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 08272021	08272021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER [redacted]0277 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO. [redacted]982A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE $ 849 96	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.) ADA County Paramedics SIGNED 05 09 2023 DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309 a. b.		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.		

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]20ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Johnson Crystal M	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1990 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13900 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY Kuna	STATE ID	8. RESERVED FOR NUCC USE	CITY Boise	STATE ID
ZIP CODE 83634	TELEPHONE (Include Area Code) (208) 360-2894		ZIP CODE 83707	TELEPHONE (Include Area Code) (208) 331-1195
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 [redacted] 1967 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 SIGNATURE ON FILE DATE 08-27-2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 27 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R1030 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 08272021 08272021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	986 64	1		NPI	
2 08272021 08272021	41	Y	MILEAGE A0425	SH	A	194 75	13.6		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) YES [ ] NO [X]	28. TOTAL CHARGE $ 1181 39	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC Use
[redacted]0277 [ ] [X]	[redacted]990A				

31. SIGNATURE OF PHYSICIAN 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13900 S Pleasant Valley Rd Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309 a. b.	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]87ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Beckett David W	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1961 SEX M (X) F ( ) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Beckett David W
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self (X) Spouse ( ) Child ( ) Other ( ) 7. INSURED'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE CITY Kuna STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) ( )	ZIP CODE 83634 TELEPHONE (Include Area Code) ( )
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 [redacted] 1961 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 SIGNATURE ON FILE DATE 08 30 2021

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

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

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
08 30 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted] 117		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. R52 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 08302021 08302021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 08302021 08302021	41	Y	MILEAGE A0425	EH	A	197 62	13.8		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
[redacted]0277 ( ) (X)	[redacted]395A	( ) YES (X) NO	$ 1338 09	$ 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 #
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise ID 83704-1309 a. b.	(208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]65ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MARKS RICKIE L	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1957 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): MARKS RICKIE L	
5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Rd	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): ( )	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
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: [redacted] 1957 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 SIGNATURE ON FILE DATE 08 30 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
08 30 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. I.R58 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 08302021 08302021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 08302021 08302021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		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
[redacted]0277 [ ] [X]	[redacted]467A	YES [ ] NO [X]	$ 849 96	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	[redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]52ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Williams Eric L	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1996 SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) IMSI Max Security
5. PATIENT'S ADDRESS (No., Street) 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) ATTEN DIANNA
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Boise STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) ( )		ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 389-0230
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 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 SIGNATURE ON FILE DATE 08 31 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 08 31 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. R55 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 08312021 08312021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	1145 77	1		NPI	
2 08312021 08312021	41	Y	MILEAGE A0425	SH	A	186 16	13 0		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted]0277 [ ] [X]	26. PATIENT'S ACCOUNT NO. [redacted]598A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 1331 93	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.) ADA County Paramedics 05 09 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309		33. BILLING PROVIDER INFO & PH # (208) 287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]2987 b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]40ID
NICHOLS TYLER	[redacted]1985 X ☐	IMSI Max Security
13400 S Pleasant Valley Rd	X	ATTEN DIANNA
Kuna ID		Boise ID
83634		83707 (208) 389-0230
	X	X
	X NO ___	
	X	Corizon
		X
SIGNATURE ON FILE	09 02 2021	SIGNATURE ON FILE
09 02 2021 431		D
[redacted]	[redacted]	
R0602	0	83634

				AMBULANCE SERVICE - ALS1						
09022021	09022021	41	Y	A0427	SH		A	1205 18 1		
				MILEAGE						
09022021	09022021	41	Y	A0425	SH		A	187 59 13.1	NPI	
									NPI	
									NPI	

[redacted]0277	X	[redacted]850A	X	1392 77	0 00		
						208 287 2950	
ADA County Paramedics		FROM: 14601 S PLEASANT VALLEY RI		ADA COUNTY PARAMEDICS			
05 09 2023		Kuna, ID 83634		370 N. Benjamin Lane			
		TO: 1055 N Curtis Road		Boise ID 83704-8498			
		Boise, ID 83704-1309		[redacted]9987			

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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#)	[redacted]99ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Mora Peter T	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1968 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial) ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street) 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street) ATTEN MEDICAL
CITY: Kuna — STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise — STATE: ID
ZIP CODE: 83634 — TELEPHONE (Include Area Code): (208) 386-9588	
ZIP CODE: 83707 — TELEPHONE (Include Area Code): (208) 331-2760
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 [redacted]1607
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 SEX M [ ] 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 SIGNATURE ON FILE DATE 09 02 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 02 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [ ] 17b. NPI [ ]	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]		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. I R06.02 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 09022021	09022021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 09022021	09022021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		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
[redacted]0277	[ ] [X]	[redacted]867A	[ ] YES [X] NO	$ 1329 49	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise, ID 83704-8498 a. [redacted]9987 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]4429
Maki Tawny L	[redacted] 1991 ☐ X	PRISON DOC WOMENS
733 W Ramsbrook St	X	ATTEN LARRY HEINZ
Boise ID		Boise ID
83702		83707
Maki Tawny L		
[redacted]8961	X	X
	X	
	X	Corizon
IDHW		X
SIGNATURE ON FILE	09 02 2021	SIGNATURE ON FILE

09 02 2021	431		M					
[redacted]			[redacted]					
A R102	B					0		
E	F							
I	J						83634-0000	
09022021	09022021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978 15	1
09022021	09022021	41	Y	MILEAGE A0425	EH	A	196 18	13.7
[redacted]0277	X			[redacted]932A	X		1174 33	0 00

208 287 2950

ADA County Paramedics
05 09 2023

FROM: 13900 S Pleasant Valley Rd
Kuna, ID 83634-0000
TO: 1055 N Curtis Road
Boise, ID 83704-1309

ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]4429

PATIENT AND INSURED INFORMATION

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)
Maki Tawny L	[redacted] 1991 M F X	PRISON DOC WOMENS
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
733 W Ramsbrook St	Self Spouse Child Other X	ATTEN LARRY HEINZ
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Boise / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83702 / ( )		83707 / ( )
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
Maki Tawny L		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]8961	YES X NO	M F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES X NO	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	Corizon
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
IDHW		X 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 SIGNATURE ON FILE DATE 09 03 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
09 03 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. LI959 B. C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634-0000
I. J. K. L.		

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 09032021 09032021	41	Y	AMBULANCE SERVICE - ALS1 A0427 EH	A	978 15	1		NPI	
2 09032021 09032021	41	Y	MILEAGE A0425 EH	A	194 75	13.6		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
[redacted]0277 X	[redacted]007A	YES X NO	$ 1172 90	$ 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) 287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-0000	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

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

	X	[redacted]73ID
LARSON JUSTIN T	[redacted] 1991 X	ICC ID CorrecCenter
14601 S Pleasant Valley Rd	X	ATTEN MEDICAL
Kuna ID		Boise ID
83634		83707 (208) 331-2760
	X	
	X NO	
	X	Corizon
		X
SIGNATURE ON FILE 09 03 2021		SIGNATURE ON FILE
09 03 2021 431		
[redacted]		
R55	0	83634

AMBULANCE SERVICE - BLS											
09032021	09032021	41	Y	A0429	EH		A	725	65	1	
MILEAGE											
09032021	09032021	41	Y	A0425	EH		A	189	02	13.2	NPI
											NPI
											NPI

[redacted]0277	X	[redacted]035A	X	914 67	0 00
					208 287 2950
ADA County Paramedics 05 09 2023	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309			ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498	[redacted]9987

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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)
						X	[redacted]66ID

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)
Gunn Michael J	[redacted] 1965 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1201 Garfield St	Self Spouse Child Other X	ATTN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Boise / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83706-0000 (626)626-3603		83707 (208) 331-1195
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
Gunn Michael J		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
[redacted]2687	YES NO X	[redacted] 1967 M X F
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?
Veterans Office of Community Care		X 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 SIGNATURE ON FILE DATE 09 05 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
09 05 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		20. OUTSIDE LAB? YES NO / $ CHARGES

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

A. R4182 B. Z8616 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
83634

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 09052021	09052021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	AB	1377 05	1		NPI	
2 09052021	09052021	41	Y	MILEAGE A0425	EH	AB	191 89	13.4		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
[redacted]0277 X	[redacted]303A	YES X NO	$ 1568 94	$ 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 #
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS (208)287 2950
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]78ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Escamilla Teddy G.	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1959 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ISCI IDAHO	
5. PATIENT'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195	
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: [redacted]1967 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 SIGNATURE ON FILE DATE 09 05 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 05 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY
	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]	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. G8911 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER 83634

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 09052021	09052021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	978	15	1	NPI	
2 09052021	09052021	41	Y	MILEAGE A0425	EH	A	191	89	13.4	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
[redacted]0277 [X]	[redacted]316A	YES [ ] NO [X]	$ 1170 04	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 a. [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

CARRIER

Corizon
PO Box 981639
El Paso, TX 79998

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) [redacted]96ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) STEWART AARON R			3. PATIENT'S BIRTH DATE MM DD YY [redacted]1988	SEX M ☒ F ☐			4. INSURED'S NAME (Last Name, First Name, Middle Initial) ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street) 13500 S Pleasant Valley Rd			6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☒				7. INSURED'S ADDRESS (No., Street) ATTN MEDICAL
CITY Kuna	STATE ID		8. RESERVED FOR NUCC USE				CITY Boise STATE ID
ZIP CODE 83634	TELEPHONE (Include Area Code) ( )						ZIP CODE 83707 TELEPHONE (Include Area Code) (208) 331-1195
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 [redacted]1967 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 SIGNATURE ON FILE DATE 09 07 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 07 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. U071 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 09072021	09072021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1216 85	1		NPI	
2 09072021	09072021	41	Y	MILEAGE A0425	EH	A	196 18 13 7			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
[redacted]0277	☐ ☒	[redacted]627A	YES ☐ NO ☒	$ 1413 03	$ 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 #
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309 a. b.	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 (208)287 2950 [redacted]9987 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

Corizon
PO Box 981639
El Paso, TX 79998

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#)	[redacted]73ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LARSON JUSTIN T	3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1991 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter	
5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760	
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 M [ ] 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 SIGNATURE ON FILE DATE 09 08 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
09 08 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. U071 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 09082021 09082021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	725 65	1		NPI	
2 09082021 09082021	41	Y	MILEAGE A0425	EH	A	189 02	13.2		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
[redacted]0277 [ ] [X]	[redacted]751A	YES [ ] NO [X]	$ 914 67	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.
SIGNED 05 09 2023 DATE		

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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) [redacted]52ID	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MORTON FRED	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1973 SEX M (X) F ( )	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Alt Placement Correctional
5. PATIENT'S ADDRESS (No., Street) 15501 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED Self ( ) Spouse ( ) Child ( ) Other (X)	7. INSURED'S ADDRESS (No., Street) 15505 S Pleasant Valley Rd
CITY Kuna STATE ID	8. RESERVED FOR NUCC USE	CITY Kuna STATE ID
ZIP CODE 83634 TELEPHONE (Include Area Code) ( )		ZIP CODE 83634 TELEPHONE (Include Area Code) ( )
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 M ( ) 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 SIGNATURE ON FILE DATE 09 08 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 08 2021 QUAL 431	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 09082021	09082021	41	Y	AMBULANCE SERVICE - BLS A0429	SH	A	660 94	1		NPI	
2 09082021	09082021	41	Y	MILEAGE A0425	SH	A	196 18 13 7			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER [redacted]0277 SSN EIN (X)	26. PATIENT'S ACCOUNT NO. [redacted]780A	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO (X)	28. TOTAL CHARGE $ 857 12	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.) ADA County Paramedics 05 09 2023 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: 15505 S. Pleasant Valley I Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309 a. b.		33. BILLING PROVIDER INFO & PH # (208)287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 a. b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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): [redacted]09ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Borowiak Clifford	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1981 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Borowiak Clifford	
5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Rd	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): ( )	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]09	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX: [redacted] 1981 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: Centurion of ID IDOC	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 _____ 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 _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 10 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]	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. R52 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23 PRIOR AUTHORIZATION NUMBER: 83634

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 09102021 09102021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	A	660 94	1		NPI	
2 09102021 09102021	41	Y	MILEAGE A0425	EH	A	187 59	13.1		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
[redacted]0277 [X]	[redacted]999A	YES [X] NO [ ]	$ 848 53	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

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): [redacted]57ID

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hibbard Randy L

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1984 SEX: M ☒ F ☐

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

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

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

7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL

CITY: Kuna STATE: ID

8. RESERVED FOR NUCC USE

CITY: Boise STATE: ID

ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 616-6144

ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195

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: [redacted] 1967 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 SIGNATURE ON FILE DATE 03 05 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 10 2021 QUAL: 431

15. OTHER DATE QUAL: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

A. R0602 B. Z8616 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 09102021	09102021	41	Y	AMBULANCE SERVICE - BLS A0429	EH	AB	725 65	1		NPI	
2 09102021	09102021	41	Y	MILEAGE A0425	EH	AB	193 32	13.5		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 ☐ ☒

26. PATIENT'S ACCOUNT NO.: [redacted]017A

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

28. TOTAL CHARGE: $ 918 97

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.)

ADA County Paramedics

05 09 2023

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

a. b.

33. BILLING PROVIDER INFO & PH # (208) 287 2950

ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498

a. [redacted]9987 b.

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)

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA

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): [redacted]91ID

PATIENT AND INSURED INFORMATION

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)
Bennett Steven J	[redacted] 1970 M X F	ICC ID CorrecCenter
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
14601 Pleasant Valley Road	Self Spouse Child Other X	ATTEN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): (325)614-1303		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-2760
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
Bennett Steven J		
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]0716	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M 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: Veterans Office of Community Care	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X 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 SIGNATURE ON FILE DATE 09 10 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
09 10 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R1030 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 83634

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 09102021	09102021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	986 64	1		NPI	
2 09102021	09102021	41	Y	MILEAGE A0425	EH	A	189 02 13.2			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	X	[redacted]029A	X YES NO	$ 1175 66	$ 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)287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]9829
MORLEY JAMIE L	[redacted]1977 ☐ X	PRISON DOC WOMENS
13200 S Pleasant Valley Rd 2	X	ATTEN LARRY HEINZ
Kuna ID		Boise ID
83634 385 224-1269		83707
	X	X
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 10 2021	SIGNATURE ON FILE
09 10 2021 431		
[redacted]		
	0	
R42		83634-2720

				AMBULANCE SERVICE - ALS1							
09102021	09102021	41	Y	A0427	EH		A	1145 77	1		PI
				MILEAGE							
09102021	09102021	41	Y	A0425	EH		A	179 00	12.5		NPI
											NPI
											NPI
											NPI
											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
[redacted]0277	☐ X	[redacted]165A	☐ YES X NO	$ 1324 77	$ 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) 287 2950
ADA County Paramedics	FROM: 13200 S Pleasant Valley Rd Kuna, ID 83634-2720 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b:
SIGNED 05 09 2023 DATE		

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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)	
	[redacted]57ID	
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)
Hibbard Randy L	[redacted] 1984 M [X] F [ ]	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self [ ] Spouse [ ] Child [ ] Other [X]	ATTN MEDICAL
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
Kuna / ID		Boise / ID
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
83634 / (208) 616-6144		83707 / (208) 331-1195
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
		[redacted] 1967 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 SIGNATURE ON FILE DATE 09 11 2021

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
09 11 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) [redacted]		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. R0602 B. Z8616 C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634
I. J. K. L.		

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 09112021	09112021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	AB	1042 86	1		NPI	
2 09112021	09112021	41	Y	MILEAGE A0425	EH	AB	197 62	13.8		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
[redacted]0277 [ ] [X]	[redacted]176A	YES [ ] NO [X]	$ 1240 48	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]79ID
Fuller Christopher L	[redacted]1971 X	ICC ID CorrecCenter
14601 S Pleasant Valley Rd	X	ATTEN MEDICAL
Kuna ID		Boise ID
83634		83707 (208) 331-2760
	X	
	X NO	
	X	Corizon
		X
SIGNATURE ON FILE	09 11 2021	SIGNATURE ON FILE
09 11 2021 431		
[redacted]		
A T8140XA B		0
E F J		83634

				AMBULANCE SERVICE - ALS1								
09112021	09112021	41	Y	A0427	SH		A	983	45	1		
				MILEAGE								
09112021	09112021	41	Y	A0425	SH		A	187	59	13.1	NPI	
											NPI	
											NPI	
											NPI	
											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
[redacted]0277	X	[redacted]237A	YES X NO	$ 1171 04	$ 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) 287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	a. Boise, ID 83704-1309 b.	[redacted]9987 b.

PHYSICIAN OR SUPPLIER INFORMATION

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]70ID
Owens Jedediah G	[redacted] 1994 X	Owens Jedediah G
15505 S Pleasant Valley Rd	X	15505 S Pleasant Valley Rd
Kuna ID		Kuna ID
83634 208 426-0039		83634 (208) 426-0039
	X	[redacted] 1994 X
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 13 2021	SIGNATURE ON FILE
09 14 2021 431		
[redacted]	[redacted]	
L500	0	83634

				AMBULANCE SERVICE - BLS							
09142021	09142021	41	Y	A0429	SH		A	660	94	1	
				MILEAGE							
09142021	09142021	41	Y	A0425	SH		A	196	18	13.7	NPI
											NPI
											NPI
											NPI
											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
[redacted]0277	[ ] [X]	[redacted]588A	[ ] YES [X] NO	$ 857 12	$ 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) 287 2950
ADA County Paramedics	FROM: 15505 S. Pleasant Valley R Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road Boise, ID 83704-1309	Boise ID 83704-8498
SIGNED DATE	a.	[redacted]9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]99ID
RICHARDSON MICHAEL B	[redacted] 1984 X	IMSI Max Security
14601 S Pleasant Valley Rd	X	ATTEN DIANNA
Kuna ID		Boise ID
83634 208 605-0799		83707 (208) 389-0230
	X	X
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 14 2021	SIGNATURE ON FILE

09 14 2021 431

[redacted]

R4182 0

83634-2716

					AMBULANCE SERVICE - ALS1								
09142021	09142021	41	Y	A0427	EH		A	978	15	1			
					MILEAGE								
09142021	09142021	41	Y	A0425	EH		A	164	68	11.5			
													NPI
													NPI
													NPI
													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
[redacted]0277		X	[redacted]680A	YES X NO	$ 1142 83	$ 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)287 2950
ADA County Paramedics	FROM: 13400 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-2716	370 N. Benjamin Lane
	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]45ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MUNOZ PEDRO	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1955 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ICC ID CorrecCenter	
5. PATIENT'S ADDRESS (No., Street): 14601 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-2760	
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: M [ ] 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 SIGNATURE ON FILE DATE 09 15 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
09 15 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R079 B. C. D.		23. PRIOR AUTHORIZATION NUMBER
E. F. G. H.		83634
I. J. K. L.		

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 09152021 09152021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 09152021 09152021	41	Y	MILEAGE A0425	EH	A	189 02	13 2		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [X]	[redacted]833A	YES [ ] NO [X]	$ 1329 49	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	a. Boise, ID 83704-1309 b.	a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]93ID

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)
Van Natta Theodore J	[redacted]1963 M X F	SICI
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13900 S Pleasant Valley Rd	Self Spouse Child Other X	ATTEN VAUGHN
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 333-0037
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 / SEX M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? X YES NO PLACE (State) ID	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 SIGNATURE ON FILE DATE 09 16 2021

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

PATIENT AND INSURED INFORMATION

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
09 16 2021 QUAL. 431	QUAL. 439 09 16 2021	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. IG8911 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 83634

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 09162021	09162021	41	Y	AMBULANCE SERVICE - ALS1 A0427	SH	A	995	13	1	NPI	
2 09162021	09162021	41	Y	MILEAGE A0425	SH	A	191	89	13.4	NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]951A	YES X NO	$ 1187 02	$ 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.)
ADA County Paramedics
SIGNED 05 09 2023 DATE

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13950 S Pleasant Valley Rc
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH.# (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
[redacted]9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]83ID
Snapp Roman J	[redacted] 1983 X	ICC ID CorrecCenter
14601 S Pleasant Valley Rd	X	ATTEN MEDICAL
Kuna ID		Boise ID
83634		83707 (208) 331-2760
	X	
	x	
	X	Corizon
		X
09 16 2021 431		
[redacted]		
	0	
T71162A		83634

AMBULANCE SERVICE - BLS

09162021	09162021	41	Y	A0429	QL		A	1064	08	1

NPI
NPI
NPI
NPI

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	[ ] [X]	[redacted]955A	[ ] YES [X] NO	$ 1064 08	$ 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)287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	a. b.	Boise ID 83704-8498
		a. [redacted]9987 b.

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Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted] 08ID
Deardorff William D	[redacted] 1955 X	SICI
13900 S Pleasant Valley Rd	X	ATTEN VAUGHN
Kuna ID		Boise ID
83634		83707 (208) 333-0037
	X	X
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 17 2021	SIGNATURE ON FILE
09 17 2021 431		
[redacted]		
M545 R001	0	83634-0000

09172021	09172021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH		AB	1140	47	1			
09172021	09172021	41	Y	MILEAGE A0425	EH		AB	196	18	13.7		NPI	
												NPI	
												NPI	
												NPI	
												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
[redacted] 0277	[ ] [X]	[redacted] 090A	[ ] YES [X] NO	$ 1336 65	$ 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 #
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rd	(208) 287 2950
05 09 2023	Kuna, ID 83634-0000	ADA COUNTY PARAMEDICS
SIGNED DATE	TO: 1055 N Curtis Road	370 N. Benjamin Lane
	Boise, ID 83704-1309	Boise ID 83704-8498
	a.	[redacted] 9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]99ID
Mora Peter T	[redacted]1968 X	ICC ID CorrecCenter
14601 S Pleasant Valley Rd	X	ATTEN MEDICAL
Kuna ID		Boise ID
83634 208 386-9588		83707 (208) 331-2760
		[redacted]1607
	X	
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 17 2021	SIGNATURE ON FILE
09 17 2021 431		
[redacted]	[redacted]	
A R509 B F J	0	83634

					AMBULANCE SERVICE - ALS1									
09172021	09172021	41	Y	A0427	EH		A	978	15	1				
					MILEAGE									
09172021	09172021	41	Y	A0425	EH		A	189	02	13.2				
													NPI	
													NPI	
													NPI	
													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
[redacted]0277	X	[redacted]116A	YES X NO	$ 1167 17	$ 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)287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987

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

X [redacted]09ID

Borowiak Clifford [redacted]1981 X Borowiak Clifford

14601 S Pleasant Valley Rd X 14601 S Pleasant Valley Rd

Kuna ID Kuna ID

83634 83634

ICC ID CorrecCenter

[redacted]09 X [redacted]1981 X

X

X Corizon

Centurion of ID IDOC X

09 17 2021 431

[redacted] [redacted]

0

R52

83634

				AMBULANCE SERVICE - BLS					
09172021	09172021	41	Y	A0429	EH	A	725 65	1	
				MILEAGE					
09172021	09172021	41	Y	A0425	EH	A	187 59	13.1	NPI
									NPI
									NPI
									NPI
									NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN: [redacted]0277 [ ] [X]
26. PATIENT'S ACCOUNT NO.: [redacted]169A
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE $ 913 24
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.)
ADA County Paramedics
SIGNED DATE 05 09 2023

32. SERVICE FACILITY LOCATION INFORMATION
FROM: 13500 S PLEASANT VALLEY RI
Kuna, ID 83634
TO: 1055 N Curtis Road
Boise, ID 83704-1309

33. BILLING PROVIDER INFO & PH # (208)287 2950
ADA COUNTY PARAMEDICS
370 N. Benjamin Lane
Boise ID 83704-8498
a. [redacted]9987 b.

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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): [redacted]65ID

PATIENT AND INSURED INFORMATION

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)
Arnold Ferrell D	[redacted] 1977 M X F	ISCI IDAHO
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
13500 S Pleasant Valley Rd	Self Spouse Child Other X	ATTN MEDICAL
CITY: Kuna / STATE: ID	8. RESERVED FOR NUCC USE	CITY: Boise / STATE: ID
ZIP CODE: 83634 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 83707 / TELEPHONE (Include Area Code): (208) 331-1195
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: [redacted] 1967 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 SIGNATURE ON FILE DATE 09 19 2021

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
09 19 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC [redacted]		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. Z9109 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634

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 09192021	09192021	41	Y	AMBULANCE SERVICE - ALS2 A0433	EH	A	1198 82	1		NPI	
2 09192021	09192021	41	Y	MILEAGE A0425	EH	A	193 32	13.5		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 X	[redacted]437A	YES NO X	$ 1392 14	$ 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) 287 2950
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	a. [redacted]9987 b.

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Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]21ID
Hernandez Valdez Lupe	[redacted] 1975 X	ICC ID CorrecCenter
14601 S Pleasant Valley Rd	X	ATTEN MEDICAL
Kuna ID		Boise ID
83634		83707 (208) 331-2760
	X	
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 19 2021	SIGNATURE ON FILE
09 19 2021 431		
[redacted]	[redacted]	
R0602	0	83634

AMBULANCE SERVICE - ALS1														
09192021	09192021	41	Y	A0427	SH		A	1205	18	1				
MILEAGE														
09192021	09192021	41	Y	A0425	SH		A	189	02	13.2			NPI	
													NPI	
													NPI	
													NPI	
													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
[redacted]0277	[ ] [X]	[redacted]483A	[ ] YES [X] NO	$ 1394 20	$ 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)287 2950
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]44ID
Cogswell Samuel	[redacted] 1952 X	ISCI IDAHO
13500 S Pleasant Valley Rd	X	ATTN MEDICAL
Kuna ID		Boise ID
83634)		83707 (208) 331-1195
Cogswell Samuel		
[redacted]44	X	[redacted] 1967 X
	X	
	X	Corizon
Centurion of ID IDOC		X
SIGNATURE ON FILE	09 19 2021	SIGNATURE ON FILE
09 19 2021 431		
[redacted]		
A R079 B	0	
E F J		83634

					AMBULANCE SERVICE - ALS1									
09192021	09192021	41	Y	A0427	EH		A	1205	18	1			PI	
				MILEAGE										
09192021	09192021	41	Y	A0425	EH		A	199	05	13.9				
													NPI	
													NPI	
													NPI	
													NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	X	[redacted]511A	X YES NO	$ 1404 23	$ 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 #
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	(208)287 2950 ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	[redacted]9987 b

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Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]51ID
Best Larry D	[redacted] 1953 X	ICC ID CorrecCenter
14601 S Pleasant Valley Rd	X	ATTEN MEDICAL
Kuna ID		Boise ID
83634		83707 (208) 331-2760
Best Larry D		
[redacted]51	X	
	X	
	X	Corizon
Centurion of ID IDOC		X
SIGNATURE ON FILE	09 20 2021	SIGNATURE ON FILE
09 20 2021 431		
[redacted]		
R079	0	N
		83634

					AMBULANCE SERVICE - ALS1								
09202021	09202021	41	Y	A0427	SH		A	1205	18	1			
					MILEAGE								
09202021	09202021	41	Y	A0425	SH		A	189	02	13.2		NPI	
												NPI	
												NPI	
												NPI	
												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
[redacted]0277	[ ] [X]	[redacted]620A	[ ] YES [X] NO	$ 1394 20	$ 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 #
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	(208)287 2950
SIGNED DATE	a.	[redacted]9987 b.

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Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]63ID
Wolf Lee T	[redacted] 1953 X	ISCI IDAHO
13500 S Pleasant Valley Rd	X	ATTN MEDICAL
Kuna ID		Boise ID
83634		83707 (208) 331-1195
Wolf Lee T		
[redacted]63	X	[redacted] 1967 X
	X NO	
	X	Corizon
Centurion of ID IDOC		X
SIGNATURE ON FILE	09 21 2021	SIGNATURE ON FILE
09 21 2021 431		N
	[redacted]	
	0	
R079		83634

				AMBULANCE SERVICE - ALS1								
09212021	09212021	41	Y	A0427	EH		A	1205	18	1		
				MILEAGE								
09212021	09212021	41	Y	A0425	EH		A	196	18	13.7		NPI
												NPI
												NPI
												NPI
												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
[redacted]0277	[ ] [X]	[redacted]756A	[ ] YES [X] NO	$ 1401 36	$ 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 #
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS (208)287 2950
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road Boise, ID 83704-1309	Boise ID 83704-8498 a. [redacted]9987 b.

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

	X	[redacted]09ID
BURNINGHAM ROWE L	[redacted] 1964 X	SICI
13900 S Pleasant Valley Rd	X	ATTEN VAUGHN
Kuna ID		Boise ID
83634 208 965-1760		83707 (208) 333-0037
	X	X
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 23 2021	SIGNATURE ON FILE
09 23 2021 431		
[redacted]	[redacted]	
T50904A	0	83634-0000

				AMBULANCE SERVICE - ALS1									
09232021	09232021	41	Y	A0427	EH		A	1140	47	1			
				MILEAGE									
09232021	09232021	41	Y	A0425	EH		A	196	18	13.7		NPI	
												NPI	
												NPI	
												NPI	
												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
[redacted]0277	[ ] [X]	[redacted]182A	[ ] YES [X] NO	$ 1336 65	$ 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)287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634-0000	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

PICA | 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#)	[redacted]63ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Berkheimer Jack L	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1935 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ISCI IDAHO	
5. PATIENT'S ADDRESS (No., Street): 13500 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTN MEDICAL	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): (208) 336-0740	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 331-1195	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): ISCI IDAHO	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]63	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 1967 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: Centurion of ID IDOC	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] 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 SIGNATURE ON FILE DATE 09 23 2021

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 23 2021 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC [redacted]		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. R079 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER 83634

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 09232021	09232021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1140 47	1		NPI	
2 09232021	09232021	41	Y	MILEAGE A0425	EH	A	197 62 13 8			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [ ] [X]	[redacted]195A	[ ] YES [X] NO	$ 1338 09	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]31ID
Moreno Jose	[redacted]1999 X	ICC ID CorrecCenter
14601 S Pleasant Valley Rd	X	ATTEN MEDICAL
Kuna ID		Boise ID
83634 208 331-2760		83707 (208) 331-2760
	X	
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 24 2021	SIGNATURE ON FILE

09 24 2021 431

[redacted]

0

S0181XA

83634

				AMBULANCE SERVICE - ALS1										
09242021	09242021	41	Y	A0427	SH			A		986	64	1		
				MILEAGE										
09242021	09242021	41	Y	A0425	SH			A		189	02	13.2		
														NPI
														NPI
														NPI
														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
[redacted]0277	X	[redacted]324A	YES X NO	$ 1175 66	$ 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 #
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI	(208)287 2950
05 09 2023	Kuna, ID 83634	ADA COUNTY PARAMEDICS
SIGNED DATE	TO: 1055 N Curtis Road	370 N. Benjamin Lane
	Boise, ID 83704-1309	Boise ID 83704-8498
	a.	[redacted]9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]65ID
Arnold Ferrell D	[redacted] 1977 X	ISCI IDAHO
13500 S Pleasant Valley Rd	X	ATTN MEDICAL
Kuna ID		Boise ID
83634		83707 (208) 331-1195
	X	[redacted] 1967 X
	X NO	
	X	Corizon
		X
SIGNATURE ON FILE	09 25 2021	SIGNATURE ON FILE
09 25 2021 431		
[redacted]		
		0
A T782XXA B		
E F		
J		83634

				AMBULANCE SERVICE - ALS2							
09252021	09252021	41	Y	A0433	EH		A	1489 50	1		
				MILEAGE							
09252021	09252021	41	Y	A0425	EH		A	186 16 13.0			
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277	X	[redacted]507A	YES X NO	$ 1675 66	$ 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 #
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane
05 09 2023	TO: 1055 N Curtis Road	Boise ID 83704-8498
SIGNED DATE	Boise, ID 83704-1309	(208)287 2950 a [redacted]9987 b

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

	X	[redacted]28ID
LAVATTA BRIAN J	[redacted]1989 X	LAVATTA BRIAN J
13400 S Pleasant Valley Rd	X	13400 S Pleasant Valley Rd
Kuna ID		Kuna ID
83634		83634
	X	[redacted]1989 X
	X	
	X	Corizon
		X
09 27 2021 431		
[redacted]		
	0	
R0602		
		83634

				AMBULANCE SERVICE - ALS1							
09272021	09272021	41	Y	A0427	SH		A	1140 47	1		
				MILEAGE							NPI
09272021	09272021	41	Y	A0425	SH		A	161 82 11 3			
											NPI
											NPI
											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
[redacted]0277	[ ] [X]	[redacted]680A	[ ] YES [X] NO	$ 1302 29	$ 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 #
ADA County Paramedics	FROM: 14601 S PLEASANT VALLEY RI Kuna, ID 83634	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498
05 09 2023	TO: 1055 N Curtis Road Boise, ID 83704-1309	(208)287 2950 a [redacted]9987 b.
SIGNED DATE	a. b.	

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Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]25ID
GULLICKSON LEE	[redacted]1961 X	GULLICKSON LEE
13900 S Pleasant Valley Rd	X	13900 S Pleasant Valley Rd
Kuna ID		Kuna ID
83634		83634
	X	[redacted]1961 X
	X	
	X	Corizon
		X
SIGNATURE ON FILE	09 27 2021	SIGNATURE ON FILE
09 27 2021 431	M	
[redacted]		
R0602 U071	0	83634

				AMBULANCE SERVICE - BLS								
09272021	09272021	41	Y	A0429	SH		AB	660	94	1		
				MILEAGE								
09272021	09272021	41	Y	A0425	SH		AB	196	18	13.7		NPI
												NPI
												NPI
												NPI
												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
[redacted]0277	[ ] [X]	[redacted]683A	[ ] YES [X] NO	$ 857 12	$ 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)287 2950
ADA County Paramedics	FROM: 13900 S Pleasant Valley Rc	ADA COUNTY PARAMEDICS
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987 b.

Corizon
PO Box 981639
El Paso, TX 79998

	X	[redacted]70ID
DOYLE JOSHUA T	[redacted] 1991 X	DOYLE JOSHUA T
14601 S Pleasant Valley Rd	X	14601 S Pleasant Valley Rd
Kuna ID		Kuna ID
83634		83634)
	X	[redacted] 1991 X
	X	
	X	Corizon
		X

09 27 2021 431												
[redacted]					[redacted]							
M549								0			83634	
				AMBULANCE SERVICE - ALS1								
09272021	09272021	41	Y	A0427	EH			A		978 15 1		
				MILEAGE								
09272021	09272021	41	Y	A0425	EH			A		189 02 13.2		
											NPI	
											NPI	
											NPI	
											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
[redacted]0277	[ ] [X]	[redacted]749A	[ ] YES [X] NO	$ 1167 17	$ 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 #
ADA County Paramedics	FROM: 13500 S PLEASANT VALLEY RI	ADA COUNTY PARAMEDICS (208)287 2950
05 09 2023	Kuna, ID 83634	370 N. Benjamin Lane
SIGNED DATE	TO: 1055 N Curtis Road	Boise ID 83704-8498
	Boise, ID 83704-1309	[redacted]9987

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

HEALTH INSURANCE CLAIM FORM

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

Corizon
PO Box 981639
El Paso, TX 79998

CARRIER

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#)	[redacted]72ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Tilford Alan P	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1959 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): IMSI Max Security	
5. PATIENT'S ADDRESS (No., Street): 13400 S Pleasant Valley Rd	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street): ATTEN DIANNA	
CITY: Kuna STATE: ID	8. RESERVED FOR NUCC USE
CITY: Boise STATE: ID	
ZIP CODE: 83634 TELEPHONE (Include Area Code): ( )	
ZIP CODE: 83707 TELEPHONE (Include Area Code): (208) 389-0230	
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 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 SIGNATURE ON FILE DATE 09 27 2021

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

PATIENT AND INSURED INFORMATION

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
09 27 2021 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
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC[redacted]		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. I959 B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 83634-2716

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 09272021 09272021	41	Y	AMBULANCE SERVICE - ALS1 A0427	EH	A	1157 47	1		NPI	
2 09272021 09272021	41	Y	MILEAGE A0425	EH	A	187 59	13.1		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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
[redacted]0277 [ ] [X]	[redacted]828A	[X] YES [ ] NO	$ 1345 06	$ 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) 287 2950
ADA County Paramedics 05 09 2023 SIGNED DATE	FROM: 13400 S Pleasant Valley Rc Kuna, ID 83634-2716 TO: 1055 N Curtis Road Boise, ID 83704-1309	ADA COUNTY PARAMEDICS 370 N. Benjamin Lane Boise ID 83704-8498 [redacted]9987 b