



CHETOIRI BEASLEY

ALTH INSURANCE CLAIM FORM

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

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BOX LUNG (N/A) ☐ OTHER ☒ (N/A)		1a. INSURED'S ID NUMBER (For Program in Part 1)	
2. PATIENT'S NAME (Last, first, middle initial) BEASLEY, CHETOIRI		3. PATIENT'S BIRTH DATE ☐ SEX ☒ F	
4. PATIENT'S ADDRESS (No. Street) [REDACTED]		5. INSURED'S ADDRESS (No. Street) [REDACTED]	
6. CITY STATE OH [REDACTED]		7. CITY STATE [REDACTED]	
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☒ YES ☐ NO OH c. OTHER ACCIDENT? ☐ YES ☒ NO		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. INSURED'S POLICY OR GROUP NUMBER		13. INSURED'S DATE OF BIRTH SEX [REDACTED] M ☐ F ☒	
14. RESERVED FOR NUCC USE		15. OTHER CLAIM ID (Designated by NUCC)	
16. RESERVED FOR NUCC USE		17. INSURANCE PLAN NAME OR PROGRAM NAME CHETOIRI BEASLEY	
18. INSURANCE PLAN NAME OR PROGRAM NAME		19. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 18, 19a, and 19b	
20. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the entity who accepts assignment of benefits. SIGNED: CHETOIRI BEASLEY DATE: 03 10 2015		21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: CHETOIRI BEASLEY	
22. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (MM/DD/YY) QUAL: 431 01/11/15		23. OTHER DATE QUAL: 439 01/11/15	
24. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: MM/DD/YY TO: MM/DD/YY 01/11/15 01/11/15	
26. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		27. OUTSIDE LAB? ☐ YES ☒ NO CHARGES: 0.00	
28. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9) 847.0 847.1 847.2		29. RESUBMISSION CODE ORIGINAL REF. NO.	
30. PRIOR AUTHORIZATION NUMBER		31. PRIOR AUTHORIZATION NUMBER	
32. A. DATE(S) OF SERVICE B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MM. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NN. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VV. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.		33. TOTAL CHARGE 28. AMOUNT PAID 30. Field for NUCC Use \$ 2680.00 \$ 0.00	
34. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS HANCHRIST LLC 215 E WATERLOO #12 AKRON, OH 44319		35. BILLING PROVIDER INFO & PH# 330-331-7207 CLEARWATER BILLING SERVICES LLC P.O. BOX 1243 EATH, OH 44210	
36. SIGNATURE OF PHYSICIAN OR SUPPLIER CHETOIRI BEASLEY		37. SIGNATURE OF PHYSICIAN OR SUPPLIER CHETOIRI BEASLEY	

EXHIBIT 32

Sandra Kurt, Summit County Clerk of Courts



CHETOIRI BEASLEY

HEALTH INSURANCE CLAIM FORM

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

MEDICAID ☐ MEDICARE ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA/LUNG ☐ OTHER ☒ (ID#)		1a. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BEASLEY, CHETOIRI		4. INSURED'S NAME (Last Name, First Name, Middle Initial) BEASLEY, CHETOIRI	
3. PATIENT'S BIRTH DATE [REDACTED]		7. INSURED'S ADDRESS (No. / Street) [REDACTED]	
5. PATIENT'S ADDRESS (No. / Street) [REDACTED]		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Spouse ☒ Spouse ☐ Child ☐ Other ☐		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☒ YES ☐ NO OR c. OTHER ACCIDENT? ☐ YES ☒ NO		11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of government benefits either to myself or to the party who receives assignment of claim.) SIGNED: [REDACTED] DATE: 03 10 2015		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: [REDACTED] DATE: 03 10 2015	
14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY 01/11/15 TO 01/11/15		15. OTHER DATE QUAL 433 01/11/15	
16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY 01/11/15 TO 01/11/15		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES 0.00	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in boxes A through H) (ICD-9) A 847.0 B 847.1 C 847.2 D [REDACTED] E [REDACTED] F [REDACTED] G [REDACTED] H [REDACTED]		21. PRIOR AUTHORIZATION NUMBER	
22. FEDERAL TAX ID NUMBER 270796590		23. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 215 E WATERLOO #12 AKRON, OH 44319	
24. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) [REDACTED]		25. BILLING PROVIDER INFO A PH # (330) 331 7207 CLEARWATER BILLING SERVICES LLC P.O. BOX 1243 BATH, OH 44210	
26. TOTAL CHARGE \$ 1260.00		27. AMOUNT PAID \$ 0.00	
28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) [REDACTED]		29. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials) [REDACTED]	

1500

KISLING, NESTICO & REDICK
3412 WEST MARKET STREET
AKRON, OH 44333

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE ☐ (Medicare #)		MEDICAID ☐ (Medicaid #)		TRICARE ☐ (Sponsor's SSN)		CHAMPVA ☐ (Member ID#)		GROUP HEALTH PLAN ☐ (SSN or ID)		FECA BLK LUNG ☒ (SSN)		OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN								3. PATIENT'S BIRTH DATE MM DD YY [REDACTED]		SEX M ☒ F ☐		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN																			
5. PATIENT'S ADDRESS (No., Street) [REDACTED]								6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐				7. INSURED'S ADDRESS (No., Street) [REDACTED]																			
CITY [REDACTED]				STATE [REDACTED]				8. PATIENT STATUS [REDACTED]				CITY [REDACTED]																			
ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) [REDACTED]				[REDACTED]				ZIP CODE [REDACTED]																			
[REDACTED]				[REDACTED]				[REDACTED]				[REDACTED]																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO:								11. INSURED'S POLICY GROUP OR FECA NUMBER															
a. OTHER INSURED'S POLICY OR GROUP NUMBER								a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO								a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED]															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY [REDACTED]								b. AUTO ACCIDENT? ☒ YES ☐ NO								b. EMPLOYER'S NAME OR SCHOOL NAME															
c. EMPLOYER'S NAME OR SCHOOL NAME								c. OTHER ACCIDENT? ☐ YES ☒ NO								c. INSURANCE PLAN NAME OR PROGRAM NAME KISLING, NESTICO & REDICK															
d. INSURANCE PLAN NAME OR PROGRAM NAME								10d. RESERVED FOR LOCAL USE								d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 a-d.															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 08/10/11																13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE															
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 04/18/2011																15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE																18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE																20. OUTSIDE LAB? ☒ YES ☐ NO \$ CHARGES															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.0 2. 846.0 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 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802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000.																22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.															
23. PRIOR AUTHORIZATION NUMBER																24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04/22/11 04/22/11															
B. PLACE OF SERVICE EMG																C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER															
E. DIAGNOSIS POINTER																F. \$ CHARGES															
G. DAYS OR UNITS																H. EPSDT Family Plan															
I. ID. QUAL																J. RENDERING PROVIDER ID. #															
1 04/22/11 04/22/11 11 99204 1,2 \$350.00 1 NPI 1508856915																2 05/13/11 05/13/11 11 99213 1,2 \$150.00 1 NPI 1508856915															
3 05/13/11 05/13/11 11 L0631 1,2 \$1,500.00 1 NPI 1508856915																4 06/03/11 06/03/11 11 99213 1,2 \$150.00 1 NPI 1508856915															
5 06/24/11 06/24/11 11 99213 1,2 \$150.00 1 NPI 1508856915																6 07/15/11 07/15/11 11 99213 1,2 \$150.00 1 NPI 1508856915															
25. FEDERAL TAX ID NUMBER 270845852																26. PATIENT ACCOUNT NO.															
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) ☒ YES ☐ NO																28. TOTAL CHARGE \$2,450.00															
29. AMOUNT PAID \$0.00																30. BALANCE DUE \$2,450.00															
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.) RICHARD H. GUNNING 08/10/11																32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301															
33. BILLING INFORMATION CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210																a. 1487982112 b.															

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

1500

KISLING, NESTICO & REDICK
3412 WEST MARKET STREET
AKRON, OH 44333

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE ☐ (Medicare #)		MEDICAID ☐ (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 297707566							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN								3. PATIENT'S BIRTH DATE [REDACTED]		SEX M ☒ F ☐		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN									
5. PATIENT'S ADDRESS (No. Street) [REDACTED]								6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No. Street) [REDACTED]											
CITY [REDACTED]				STATE [REDACTED]				8. PATIENT STATUS [REDACTED]				CITY [REDACTED]		STATE [REDACTED]							
ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) [REDACTED]				ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) [REDACTED]									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER								a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO				a. INSURED'S DATE OF BIRTH [REDACTED] M ☒ F ☐									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐								b. AUTO ACCIDENT? ☒ YES ☐ NO				b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME								c. OTHER ACCIDENT? ☐ YES ☒ NO				c. INSURANCE PLAN NAME OR PROGRAM NAME KISLING, NESTICO & REDICK									
d. INSURANCE PLAN NAME OR PROGRAM NAME								10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete Item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 08/10/11 NED DATE																					
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED																					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 04/16/2011				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE RICHARD GUNNING,				17a. NPI 1508856915				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. RESERVED FOR LOCAL USE																					
20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES																					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.0 3. 2. 846.0 4. 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																					
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTNER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 05/13/11 05/13/11 11						E0730				1,2		\$500.00		1						1508856915	
2																				NPI	
3																				NPI	
4																				NPI	
5																				NPI	
6																				NPI	
25. FEDERAL TAX ID NUMBER 270845852				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) ☒ YES ☐ NO				28. TOTAL CHARGE \$500.00		29. AMOUNT PAID \$0.00		30. BALANCE DUE \$500.00			
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.) RICHARD H. GUNNING 08/10/11																					
32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301 a. 1669702841																					
33. BILLING INFORMATION CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210 a. 1487982112																					

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

TAIJUAN CARTER

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNION OF CLAIM ADJUSTERS OF OH

PICA

PICA

MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐		1a. INSURED'S ID NUMBER [REDACTED]	
1. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	
2. PATIENT'S ADDRESS (No. Street) [REDACTED]		7. INSURED'S ADDRESS (No. Street) [REDACTED]	
3. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐		8. INSURED'S DATE OF BIRTH [REDACTED]	
5. PATIENT STATUS [REDACTED]		9. EMPLOYER'S NAME OR SCHOOL NAME TAIJUAN CARTER	
6. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) ☐ YES ☐ NO b. AUTO ACCIDENT ☐ YES ☐ NO c. OTHER ACCIDENT ☐ YES ☐ NO		10. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		12. INSURED'S DATE OF BIRTH [REDACTED]	
12. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]		13. EMPLOYER'S NAME OR SCHOOL NAME TAIJUAN CARTER	
13. OTHER INSURED'S DATE OF BIRTH MM DD YY [REDACTED]		14. INSURANCE PLAN NAME OR PROGRAM NAME TAIJUAN CARTER	
14. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO	
15. INSURANCE PLAN NAME OR PROGRAM NAME [REDACTED]		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED

SIGNATURE ON FILE

DATE

03/12/14

SIGNED

SIGNATURE ON FILE

17. DATE OF CURRENT ILLNESS (or INJURY, disability, or PREGNANCY LIMIT) MM DD YY 12 15 2013		18. IS PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY [REDACTED]		19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]	
20. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [REDACTED]		21. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]		22. OUTSIDE LAB CHARGES ☐ YES ☒ NO	
23. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (Please include ICD-9-CM code) 847.1		24. MEDICAID RESUBMISSION CODE [REDACTED]		25. PRIOR AUTHORIZATION NUMBER [REDACTED]	

A	B	C	D	E	F	G	H	I	J
DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE
12/16/13	12/18/13	11	99204	1, 2, 3	\$350.00	1			1003892217
12/16/13	12/18/13	11	20553	1, 2	\$600.00	1			1003892217
12/16/13	12/18/13	11	J1040	1, 2	\$60.00	1			1003892217

26. RECEIPT NUMBER 270-96533		27. PATIENT'S ASSIGNMENT NO. [REDACTED]		28. TOTAL CHARGE \$1,230.00		29. AMOUNT PAID \$0.00		30. BALANCE DUE \$1,230.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER HANCHRIST LLC 215 E WATERLOO #12 AKRON, OH 44319		32. SERVICE FACILITY LOCATION INFORMATION [REDACTED]		33. PHYSICIAN OR SUPPLIER CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210		34. DATE 03/12/14		35. DATE 03/12/14	

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1 MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐		2 INSURED'S ID NUMBER [REDACTED]	
3 PATIENT'S NAME (Last, First, Middle Initial) CARTER, TAIJUAN		4 INSURED'S NAME (Last, First, Middle Initial) CARTER, TAIJUAN	
5 PATIENT'S ADDRESS (Street) [REDACTED]		6 PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	
7 PATIENT'S STATUS [REDACTED]		8 INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
9 OTHER INSURED'S NAME (Last, First, Middle Initial) [REDACTED]		10 INSURED'S DATE OF BIRTH [REDACTED]	
11 OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]		12 EMPLOYER'S NAME OR SCHOOL NAME TAIJUAN CARTER	
13 INSURANCE PLAN NAME OR PROGRAM NAME NO RESERVED FOR LOCAL USE		14 IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes return to and complete item 9a-1	
15 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNATURE ON FILE		16 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE SIGNATURE ON FILE	
17 DATE OF CURRENT ILLNESS (First symptoms or injury) (Month, Day, Year) 12-09-2013		18 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19 NAME OF REFERRAL PROVIDER OR OTHER SOURCE [REDACTED]		20 HOSPITALIZATION DATES RELATED TO CURRENT SERVICE FROM MM DD YY TO MM DD YY	
21 RESERVED FOR LOCAL USE		22 OUTSIDE LAB* YES ☐ NO ☒	
23 DIAGNOSIS OF NATURE OF ILLNESS OR INJURY (ICD-9-CM Code) 847.1		24 ALCOHOL/DRUG SUBMISSION CODE ORIGINAL REF NO	
25 PRIOR AUTHORIZATION NUMBER [REDACTED]			
26 PATIENT'S ACCOUNT NO. [REDACTED]		27 ACCEPT ASSIGNMENT YES ☒ NO ☐	
28 TOTAL CHARGE \$150.00		29 AMOUNT PAID \$0.00	
30 BALANCE DUE \$150.00			
31 SIGNATURE OF PHYSICIAN OR SUPPLIER JOSHUA M. JONES, MD		32 SERVICE FACILITY LOCATION INFORMATION HANCRIST LLC 315 E WATERLOO #12 AKRON, OH 44319	
33 DATE 03/12/14		34 PROVIDER IDENTIFICATION NUMBER 1487982112	

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FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

TAIJUAN CARTER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/06

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA RAILROAD OTHER		10. INSURED'S I.D. NUMBER	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)		8. PATIENT RELATIONSHIP TO INSURED	
6. PATIENT STATUS		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	
13. INSURED'S DATE OF BIRTH		14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident or PREGNANCY/CLMPL)	
15. EMPLOYER'S NAME OR SCHOOL NAME		16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
17. INSURANCE PLAN NAME OR PROGRAM NAME		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE	
19. IS THERE ANOTHER HEALTH BENEFIT PLAN?		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line)		22. MEDICAID RESUBMISSION CODE	
23. A. DATE(S) OF SERVICE		24. B. PROCEDURES, SERVICES, OR SUPPLIES	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.	
27. SIGNATURE OF PHYSICIAN OR SUPPLIER		28. TOTAL CHARGE	
29. SERVICE FACILITY LOCATION INFORMATION		29. AMOUNT PAID	
30. SIGNATURE OF PHYSICIAN OR SUPPLIER		30. BALANCE DUE	

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

TAIJUAN CARTER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA (BY EMPLOYER) ☒ OTHER ☐		2. INSURED'S I.D. NUMBER (For Program in Item 1)	
3. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	
5. PATIENT'S ADDRESS [REDACTED]		6. INSURED'S ADDRESS [REDACTED]	
7. CITY [REDACTED]		8. CITY [REDACTED]	
9. STATE [REDACTED]		10. STATE [REDACTED]	
11. ZIP CODE [REDACTED]		12. ZIP CODE [REDACTED]	
13. TELEPHONE (Include Area Code) [REDACTED]		14. TELEPHONE (Include Area Code) [REDACTED]	
15. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		16. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
17. OTHER INSURED'S POLICY OR GROUP NUMBER		18. OTHER INSURED'S POLICY OR GROUP NUMBER	
19. OTHER INSURED'S DATE OF BIRTH MM DD YY		20. OTHER INSURED'S DATE OF BIRTH MM DD YY	
21. OTHER INSURED'S SEX M ☐ F ☐		22. OTHER INSURED'S SEX M ☐ F ☐	
23. EMPLOYER'S NAME OR SCHOOL NAME		24. EMPLOYER'S NAME OR SCHOOL NAME	
25. INSURANCE PLAN NAME OR PROGRAM NAME		26. INSURANCE PLAN NAME OR PROGRAM NAME TAIJUAN CARTER	
27. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 & d.		28. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 & d.	
29. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits, either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 03/12/14		30. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
31. 14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident or PREGNANCY/CLMP) 12/19/2013		32. 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
33. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		34. 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
35. 18. OUTSIDE LAST 5 CHARGES ☐ YES ☒ NO		36. 19. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO.	
37. 20. PRIOR AUTHORIZATION NUMBER		38. 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please list items 1, 2, 3 or 4 by item 24E by line) 847.0 847.1 309.81	
39. 22. A. DATES OF SERVICE From MM DD YY To MM DD YY		40. 23. B. PLACE OF SERVICE EMG	
41. 24. C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS MODIFIER		42. 25. E. DIAGNOSIS POINTER	
43. 26. F. \$ CHARGES		44. 27. G. DATES OF SERVICE MM DD YY	
45. 28. H. I.D. NO.		46. 29. J. PROVIDER ID #	
47. 30. 1. 01/17/14 01/17/14 11 99213 1,2,3 \$150.00 1 NPI 1508856915		48. 31. 2. 01/31/14 01/31/14 11 99213 1,2,3 \$150.00 1 NPI 1508856915	
49. 32. 3. 01/31/14 01/31/14 11 E0730 1,2,3 \$500.00 1 NPI 1508856915		50. 33. 4. 02/14/14 02/14/14 11 99213 1,2,3 \$150.00 1 NPI 1508856915	
51. 34. 5. 02/28/14 02/14/14 11 99213 1,2,3 \$150.00 1 NPI 1508856915		52. 35. 6. 02/28/14 02/14/14 11 99213 1,2,3 \$150.00 1 NPI 1508856915	
53. 36. 25. FEDERAL TAX ID NUMBER 270796590		54. 37. 26. PATIENT'S ACCOUNT NO. [REDACTED]	
55. 38. 27. ACCEPT ASSIGNMENT? ☒ YES ☐ NO		56. 39. 28. TOTAL CHARGE \$1,100.00	
57. 40. 29. AMOUNT PAID \$0.00		58. 41. 30. BALANCE DUE \$1,100.00	
59. 42. 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to the bill and are made a part thereof.) RICHARD H. GUNNING 03/12/14		60. 43. 32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 215 E WATERLOO #12 AKRON, OH 44319	
61. 44. 33. BILLING ADDRESS P.O. BOX 1243 BATH, OH 44210		62. 45. 34. BILLING PHONE 330-231-7207	
63. 46. 35. SIGNATURE OF PATIENT OR AUTHORIZED PERSON [REDACTED]		64. 47. 36. DATE 03/12/14	
65. 48. 37. SIGNATURE [REDACTED]		66. 49. 38. DATE 03/12/14	

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TAIJUAN CARTER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LING ☒ OTHER ☐		1b. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	
3. PATIENT'S BIRTH DATE [REDACTED]		7. INSURED'S ADDRESS (Street) [REDACTED]	
5. PATIENT'S ADDRESS (Street) [REDACTED]		8. INSURED'S ADDRESS (Street) [REDACTED]	
6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐		9. INSURED'S ADDRESS (City) [REDACTED]	
10. PATIENT STATUS [REDACTED]		11. INSURED'S ADDRESS (State) [REDACTED]	
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		13. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
14. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]		15. INSURED'S DATE OF BIRTH [REDACTED]	
16. OTHER INSURED'S DATE OF BIRTH MM DD YY		17. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]	
18. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED]		19. INSURANCE PLAN NAME OR PROGRAM NAME TAIJUAN CARTER	
20. INSURANCE PLAN NAME OR PROGRAM NAME [REDACTED]		21. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.			
SIGNATURE ON FILE [REDACTED]		SIGNATURE ON FILE [REDACTED]	
14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) 12/15/2013		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please list items 1, 2, 3 or 4 in Item 24E by Line) 847.0 847.1 847.2		22. MEDICAL RESUBMISSION ORIGINAL REF. NO. [REDACTED]	
23. PRIOR AUTHORIZATION NUMBER [REDACTED]		24. SERVICE FACILITY LOCATION INFORMATION	
25. FEDERAL TAX I.D. NUMBER 270796590		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. ACCEPT ASSIGNMENT? ☒ YES ☐ NO		28. TOTAL CHARGE \$150.00	
29. AMOUNT PAID \$0.00		30. BALANCE DUE \$150.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JOSHUA M. JONES, MD 03/12/14		32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 215 E WATERLOO #12 AKRON, OH 44319	
33. BILLING PROVIDER INFORMATION CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210		34. BILLING PROVIDER INFORMATION [REDACTED]	

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SLATER & ZURZ LLP
ONE CADE PLAZA #2210
AKRON, OH 44308

HEALTH INSURANCE CLAIM FORM

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

FICA ☐		FICA ☐	
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LNK ☐ OTHER ☒ (ID#)		18. INSURED'S POLICY NUMBER	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAI JUAN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAI JUAN	
3. PATIENT'S BIRTH DATE ☐ SEX ☒ M ☐ F		7. INSURED'S ADDRESS (Include Zip Code)	
5. PATIENT'S ADDRESS (Include Zip Code)		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☒ YES ☐ NO OH c. OTHER ACCIDENT? ☐ YES ☒ NO		11. INSURED'S DATE OF BIRTH ☐ SEX ☒ M ☐ F	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNATURE ON FILE DATE 12 01 2015		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 10 06 15 QUAL 431		15. OTHER DATE 10 06 15 QUAL 439	
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. OUTSIDE LAB ☐ YES ☒ NO \$ CHARGES 0.00	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-C to service line below (245) A. S46.119A B. S23.3XXA C. S33.8XXA D. M25.461 E. S46.119D F. S23.3XXD G. S33.8XXD H. S13.4XXD		21. PRIOR AUTHORIZATION NUMBER	
22. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE ENG C. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. DAYS (if applicable) G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.		23. TOTAL CHARGE \$ 1980.00 24. AMOUNT PAID \$ 0.00	
25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this request apply to this bill and are made a part thereof.) SAM S. GHOSH, MD DATE 12 01 19		26. SERVICE FACILITY LOCATION INFORMATION AKRON CHIROPRACTOR S ARLINGTON ST AKRON, OH 44306	
27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this request apply to this bill and are made a part thereof.) SAM S. GHOSH, MD DATE 12 01 19		28. SERVICE FACILITY LOCATION INFORMATION AKRON CHIROPRACTOR S ARLINGTON ST AKRON, OH 44306	
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99. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this request apply to this bill and are made a part thereof.) SAM S. GHOSH, MD DATE 12 01 19		100. SERVICE FACILITY LOCATION INFORMATION AKRON CHIROPRACTOR S ARLINGTON ST AKRON, OH 44306	

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER



SLATER & ZURZ LLP
ONE CADE PLAZA #2210
AKRON, OH 44308

HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN MECA BLACK/REG (ID#) OTHER (ID#)		15. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAI JUAN		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAI JUAN	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
6. CITY [REDACTED] STATE [REDACTED]		8. CITY [REDACTED] STATE [REDACTED]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO b. AUTO ACCIDENT? ☒ YES ☐ NO OH c. OTHER ACCIDENT? ☐ YES ☒ NO	
11. INSURED'S POLICY OR GROUP NUMBER		12. INSURED'S DATE OF BIRTH [REDACTED] SEX ☒ M ☐ F	
13. RESERVED FOR NUCC USE		14. INSURANCE PLAN NAME OR PROGRAM NAME SLATER & ZURZ LLP	
16. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO # you complete items 9, 10, and 11.		17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) [REDACTED]	
18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other 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 01 2015		19. 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	
20. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 06 15 QUAL 431		21. OTHER DATE MM DD YY 10 06 15 QUAL 439	
22. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		23. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		25. OUTSIDE LAB? \$ CHARGES ☐ YES ☒ NO 0.00	
26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. S13.4XXD B. S23.3XXD C. S33.8XXD D. M25.461 E. F. G. H. I. J. K. L.		27. PRIOR AUTHORIZATION NUMBER	
28. A. DATES OF SERVICE From MM DD YY To MM DD YY 1. 10 28 15 10 28 15 11 20553 2. 10 28 15 10 28 15 11 11040 3. 11 11 15 11 11 15 11 99213 4. 11 11 15 11 11 15 11 5. 11 11 15 11 11 15 11 6. 11 11 15 11 11 15 11		29. B. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) C. PT/NCPOS D. MODIFIER E. DIAGNOSIS POINTER 1. A,B,C 800.00 1 1003892217 2. A,B,C 80.00 1 1003892217 3. A,B,C 150.00 1 1003892217 4. 5. 6.	
29. FEDERAL TAX I.D. NUMBER 270796590		30. TOTAL CHARGE \$ 1030.00 31. AMOUNT PAID \$ 0.00 32. Held for NUCC Use	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the assignments on this invoice apply to this bill and are made in part thereof.) SIGNED: GHOURBIAL, MD DATE 12 01 15 1669702841		34. BILLING PROVIDER INFO & Ref # 330 3331 7207 CLEARWATER BILLING SERVICES LLC P.O. BOX 1243 BATH, OH 44210	
35. SERVICE FACILITY LOCATION INFORMATION AKRON CHIROPRACTOR S ARLINGTON ST AKRON, OH 44306		36. BILLING PROVIDER INFO & Ref # 1487982112 Ghoubrial_000646	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMS-0238-1197 FORM 1500 (02-12)



KIMBERLY FIELDS

HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☒ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) FIELDS, KIMBERLY		3. PATIENT'S BIRTH DATE ☐ M ☐ F ☒ SEX	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐	
7. INSURED'S ADDRESS (No., Street) [REDACTED]		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State) OH	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? ☐ YES ☒ NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH ☐ M ☒ F SEX	
a. INSURED'S DATE OF BIRTH		b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME KIMBERLY FIELDS		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, complete items 9, 9a, and 9d.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____ DATE 10 26 2017		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 9 20 17 QUAL. 431	
15. OTHER DATE QUAL. 439 09 20 17		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES ☐ YES ☒ NO 0.00	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. S16.1XXA B. S23.3XXA C. S16.1XXD D. S23.3XXD ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID QUAL J. RENDERING PROVIDER ID #	
10 11 17 10 11 17 11 99203 A, B 300.00 1		1003892217	
10 11 17 10 11 17 11 E0730 A, B 500.00 1		1003892217	
10 18 17 10 18 17 11 99213 C, D 150.00 1		1003892217	
10 18 17 10 18 17 11 20553 C, D 1000.00 1		1003892217	
10 18 17 10 18 17 11 J1030 C, D 50.00 1		1003892217	
10 18 17 10 18 17 11 A4556 C, D 160.00 1		1003892217	
25. FEDERAL TAX I.D. NUMBER SSN EIN 270796590		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For prev. claims, see back) ☒ YES ☐ NO	
28. TOTAL CHARGE \$ 2160.00		29. AMOUNT PAID \$ 0.00	
30. RESERVED FOR NUCC USE		31. BILLING PROVIDER INFO & PH # 330-331-7207	
32. SERVICE FACILITY LOCATION INFORMATION AKRON CHIROPRACTOR S ARLINGTON ST AKRON, OH 44306		33. BILLING PROVIDER INFO & PH # CLEARWATER BILLING SERVICES LLC P.O. BOX 1243 BATH, OH 44210	
34. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degrees or Credentials) certify that the statements on the reverse apply to this bill and are made a part thereof. SAM N. GHOBRIAL, MD 10 26 17		35. SIGNATURE OF PATIENT OR AUTHORIZED PERSON [REDACTED]	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

KISLING, NESTICO & REDICK
3412 WEST MARKET STREET
AKRON, OH 44333

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP ☐ FECA ☐ OTHER ☒		1a. INSURED'S I.D. NUMBER (For Program In Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) NORRIS, MONIQUE		4. INSURED'S NAME (Last Name, First Name, Middle Initial) NORRIS, MONIQUE	
5. PATIENT'S ADDRESS (No. Street) [REDACTED]		7. INSURED'S ADDRESS (No. Street) [REDACTED]	
CITY [REDACTED]	STATE [REDACTED]	CITY [REDACTED]	STATE [REDACTED]
ZIP CODE [REDACTED]	TELEPHONE (Include Area Code) [REDACTED]	ZIP CODE [REDACTED]	TELEPHONE (Include Area Code) [REDACTED]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH [REDACTED] SEX M ☐ F ☒	
b. OTHER INSURED'S DATE OF BIRTH [REDACTED] SEX M ☐ F ☐		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME KISLING, NESTICO & REDICK	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 u-i.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED _____ DATE 09/23/13		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 7/29/2013		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 846.0 2. 847.1 3. 840.9 4. [REDACTED]		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSTI Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1 08/02/13 08/02/13 11 99204 1,2,3 \$350.00 1 NPI 150885691		2 08/02/13 08/02/13 11 E0730 1,2,3 \$500.00 1 NPI 150885691	
3		4	
5		6	
25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN		26. PATIENT'S ACCOUNT NO. [REDACTED]	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☒ NO		28. TOTAL CHARGE \$850.00 29. AMOUNT PAID \$0.00 30. BALANCE DUE \$850.00	
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. RICHARD H. GUNNING 09/23/13 SIGNED _____ DATE		32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301 a. 166970284 b. [REDACTED]	
33. BILLING PROVIDER INFO. & PH CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210 a. 1487982112 b. [REDACTED]			

KISLING, NESTICO & REDICK
3412 WEST MARKET STREET
AKRON, OH 44333

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐										PICA ☐									
1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARBOUR, RICHIE A										3. PATIENT'S BIRTH DATE ☐ SEX ☒ F ☐ M									
5. PATIENT'S ADDRESS (No., Street) [REDACTED]										6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐									
7. INSURED'S NAME (Last Name, First Name, Middle Initial) HARBOUR, RICHIE A										8. INSURED'S ADDRESS (No., Street) [REDACTED]									
CITY STATE										CITY STATE									
ZIP CODE TELEPHONE (Include Area Code)										ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐										b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State) OH									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? ☐ YES ☒ NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. INSURED'S DATE OF BIRTH MM DD YY M ☒ F ☐																			
b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. INSURANCE PLAN NAME OR PROGRAM NAME KISLING, NESTICO & REDICK																			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 a-d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other 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 08/03/12										13. 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: 10/2012 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 343.9 3. 847.2 2. 847.0 4. [REDACTED]										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. S CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 05/23/12 05/23/12 11 99204 1,2,3 \$350.00 1 NPI 1003892217																			
2 05/23/12 05/23/12 11 E0730 1,2,3 \$500.00 1 NPI 1003892217																			
3 06/06/12 06/06/12 11 99213 1,2,3 \$150.00 1 NPI 1003892217																			
4 06/20/12 06/20/12 11 99213 1,2,3 \$150.00 1 NPI 1003892217																			
5 06/06/12 06/06/12 11 20552 2 \$400.00 1 NPI 1003892217																			
6 06/06/12 06/06/12 11 J1040 2 \$80.00 1 NPI 1003892217																			
25. FEDERAL TAX I.D. NUMBER SSN EIN 270845852										26. PATIENT'S ACCOUNT NO. [REDACTED]									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO										28. TOTAL CHARGE \$2,110.00 29. AMOUNT PAID \$0.00 30. BALANCE DUE \$2,110.00									
NATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SAM N. GHOU BRIAL, MD 08/03/12 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301 a. 1669702841 b. [REDACTED]									
33. BILLING PROVIDER INFO & PH # (380) 331-1207 CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210 a. 1487982112 b. [REDACTED]																			

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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

KISLING, NESTICO & REDICK
3412 WEST MARKET STREET
AKRON, OH 44333

PICA										PICA									
1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☒										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARBOUR, RICHIE A										3. PATIENT'S BIRTH DATE ☐ SEX ☒ F ☐									
5. PATIENT'S ADDRESS (No. Street) [REDACTED]										4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARBOUR, RICHIE A									
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☒ Child ☐ Other ☐										7. INSURED'S ADDRESS (No. Street) [REDACTED]									
CITY ☐ STATE ☐										CITY ☐ STATE ☐									
ZIP CODE ☐ TELEPHONE (Include Area Code) ☐										ZIP CODE ☐ TELEPHONE (Include Area Code) ☐									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M ☐ F ☐										b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State) LOH									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? ☐ YES ☒ NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH MM DD YY M ☒ F ☐									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other 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 08/03/12										12. PATIENT'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									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 3/10/2012										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.2										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. CHART J. RENDERING PROVIDER ID. #										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. CHART J. RENDERING PROVIDER ID. #									
1 06/20/12 06/20/12 11 20552 1 \$400.00 1 NPI 100389221										1 06/20/12 06/20/12 11 J1040 1 \$80.00 1 NPI 100389221									
2 06/20/12 06/20/12 11 J1040 1 \$80.00 1 NPI 100389221										2 06/20/12 06/20/12 11 J1040 1 \$80.00 1 NPI 100389221									
3										3									
4										4									
5										5									
6										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN 270845852										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) ☒ YES ☐ NO										28. TOTAL CHARGE \$ \$2,110.00									
29. AMOUNT PAID \$ \$0.00										30. BALANCE DUE \$ \$2,110.00									
31. NATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SAM N. GHOBRIAL, MD										32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301									
33. BILLING PROVIDER INFO & PH # (380 331-7207) CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210										33. BILLING PROVIDER INFO & PH # (380 331-7207) CLEARWATER BILLING SERVICES P.O. BOX 1243 BATH, OH 44210									
SIGNED 08/03/12										SIGNED 08/03/12									