CHETOIRI BEASLEY [redacted]

.ALTH INSURANCE CLAIM FORM

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

PICA PICA

CARRIER

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER		(For Program in Item 1)
						X	[redacted]		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
BEASLEY, CHETOIRI			[redacted]	M	F X		BEASLEY, CHETOIRI		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
[redacted]			Self X	Spouse	Child	Other	[redacted]		
CITY		STATE	8. RESERVED FOR NUCC USE				CITY		STATE
[redacted]		OH					[redacted]		
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
[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		
[redacted]									
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH	SEX	
			YES	NO X			[redacted]	M	F
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)		
			YES X	NO	OH				
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES	NO X			CHETOIRI BEASLEY		
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 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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 01 11 15 QUAL 431

15. OTHER DATE QUAL 439 MM DD YY 01 14 15

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)

20. OUTSIDE LAB? YES NO X $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9

A 847.0 B 847.1 C 847.2 D E F G H I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 01 14 15	01 14 15	11		99204		A,B,C	350.00	1		NPI	1003892217
2 01 14 15	01 14 15	11		20553		A,B,C	800.00	1		NPI	1003892217
3 01 14 15	01 14 15	11		J1040		A,B,C	80.00	1		NPI	1003892217
4 01 14 15	01 14 15	11		E0730		A,B,C	500.00	1		NPI	1003892217
5 01 28 15	01 28 15	11		99213		A,B,C	150.00	1		NPI	1003892217
6 01 28 15	01 28 15	11		20553		A,B,C	800.00	1		NPI	1003892217

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
270796590	X	[redacted]	X YES NO	$ 2680.00	$ 0.00	

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

SIGNED CHABRIAL MD DATE 03 10 15

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319
1669702841

33. BILLING PROVIDER INFO & PH # (330) 331 7207
CLEARWATER BILLING SERVICES LLC
P.O BOX 1243
BATH, OH 44210
1487982112

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

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

EXHIBIT 32

CHETOIRI BEASLEY [redacted]

ALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER [redacted] (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE [redacted] SEX M F X

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

5. PATIENT'S ADDRESS (No., Street) [redacted]

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

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE [redacted]

8. RESERVED FOR NUCC USE

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 (La[redacted]

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

6 INSURED'S DATE OF BIRTH [redacted] SEX M F X

b. RESERVED FOR NUCC USE

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

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: CHETOIRI BEASLEY

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 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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 02 11 15 QUAL. 431

15. OTHER DATE QUAL. 439 MM DD YY 01 11 15

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES X NO $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9

A 847.0 B 847.1 C 847.2 D

E F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 01 28 15	01 28 15	11		J1040		A,B,C	80.00	1		NPI	1003892217
2 02 11 15	02 11 15	11		99213		A,B,C	150.00	1		NPI	1003892217
3 02 11 15	02 11 15	11		20553		A,B,C	800.00	1		NPI	1003892217
4 02 11 15	02 11 15	11		J1040		A,B,C	80.00	1		NPI	1003892217
5 02 18 15	02 18 15	11		99213		A,B,C	150.00	1		NPI	1003892217
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN X

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 1260.00

29. AMOUNT PAID $ 0 00

30. Rsvd for NUCC Use

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

SIGNED [redacted] DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319

a. 1669702841

33. BILLING PROVIDER INFO & PH # (330)331 7207
CLEARWATER BILLING SERVICES LLC
P.O BOX 1243
BATH, OH 44210

b. 1487982112

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

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

1500

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

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	3. PATIENT'S BIRTH DATE [redacted] SEX M [X] 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 [X] 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 [X]	a. INSURED'S DATE OF BIRTH SEX [redacted] M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State) OH	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	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 [X] If yes, return to and complete item 9 a-d.

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 08/10/11

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

14. DATE OF CURRENT: MM DD YY 04 16 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ 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.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 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 I.D. NUMBER SSN EIN 270845852	26. PATIENT'S ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] 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 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301 a. 1669702841 b.	33. BILLING PROVIDER INFO & PH # (330) 331-7207 CLEARWATER BILLING SERVICES P.O BOX 1243 BATH, OH 44210 a. 1487982112 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Printed on Recycled Paper

1500

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

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (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 [X] 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 [X] 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 [X]	a. INSURED'S DATE OF BIRTH [redacted] SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State) OH	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	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 [X] *If yes*, return to and complete item 9 a-d.

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 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.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: 04 16 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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: RICHARD GUNNING,	17a. 17b. NPI 1508856915	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ 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.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05/13/11 05/13/11	11		E0730		1,2	$500.00	1		NPI	1508856915
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) YES [X] NO [ ]	28. TOTAL CHARGE $500.00	29. AMOUNT PAID $0.00	30. BALANCE DUE $500.00
270845852		[redacted]				

31. SIGNATURE OF PHYSICIAN 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 # ( ) 330 331-7207
RICHARD H. GUNNING 08/10/11 SIGNED DATE	HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301 a. 1669702841 b.	CLEARWATER BILLING SERVICES P.O BOX 1243 BATH, OH 44210 a. 1487982112 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Printed on Recycled Paper

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

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

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) [redacted]

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]

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

8. PATIENT STATUS [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] SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

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

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
TAIJUAN CARTER

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.

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 03/12/14

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SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY
12 15 2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. 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. 847.2
3. 847.1
4.

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	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 12/18/13	12/18/13	11		99204		1,2,3	$350.00	1		NPI	1003892217
2 12/18/13	12/18/13	11		20553		1,2	$800.00	1		NPI	1003892217
3 12/18/13	12/18/13	11		J1040		1,2	$80.00	1		NPI	1003892217
4										NPI	
5										NPI	
6										NPI	

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 $1,230.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $1,230.00

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.)
SAN N. GHOUBRIAL, MD
03/12/14
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319
a. 1669702841

33. BILLING PROVIDER INFO & PH #
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 1487982112

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

TAIJUAN CARTER
995 BELLOWS ST
AKRON, OH 44311

1500

HEALTH INSURANCE CLAIM FORM

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

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 [redacted] (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE [redacted] SEX M

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 [X] | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE [redacted]

ZIP CODE [redacted] TELEPHONE (Include Area Code) ([redacted]

8. PATIENT STATUS: Single [X] | Married | Other

Employed [X] | Full-Time Student | Part-Time Student

CITY [redacted] STATE [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 [X]

a. INSURED'S DATE OF BIRTH [redacted] SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: TAIJUAN CARTER

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO [X] If yes, return to and complete item 9 a-d.

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 03/12/14

13. 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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 12 19 2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. F47.0

2. S47.

3. F47.2

4. 309.81

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	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 01/17/14	01/17/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
2 01/31/14	01/31/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
3 01/31/14	01/31/14	12		E0730		1,2,3	$500.00	1		NPI	1508856915
4 02/14/14	02/14/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
5 02/14/14	02/14/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN

26. PATIENT'S ACCOUNT NO [redacted]

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

28. TOTAL CHARGE $1,100.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $1,100.00

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 03/12/14

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319

a. 1669702841

33. BILLING PROVIDER INFO & PH #

CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210

a. 1487952112

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

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 [redacted]

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

3. PATIENT'S BIRTH DATE [redacted] SEX

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 [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS [redacted]

CITY [redacted] STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY [redacted] STATE

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

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH [redacted] SEX M [X] F [ ]

9b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

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

b. EMPLOYER'S NAME OR SCHOOL NAME

9c. EMPLOYER'S NAME OR SCHOOL NAME

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

c. INSURANCE PLAN NAME OR PROGRAM NAME: TAIJUAN CARTER

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

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 03/12/14

13. 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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 12 09 2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. R47.0

2. S47.1

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 01/03/14	01/03/14	11		99213		1,2,3	$150.00	1		NPI	1508095803
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270795590 SSN EIN

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $150.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $150.00

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.)

JOSHUA M. JONES, MD 03/12/14

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

RANCHRIST LLC
315 E WATERLOO #12
AKRON, OH 44319

a. 1669702841

33. BILLING PROVIDER INFO & PH #

CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210

a. 1487982112

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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) — X OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAIJUAN	3. PATIENT'S BIRTH DATE [redacted] SEX X 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: X 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. [illegible] PATIENT 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 [redacted] SEX X M / F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M / F	b. AUTO ACCIDENT? X YES / NO PLACE (State) OH
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME TAIJUAN CARTER	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
9. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO If yes, return to and complete item 9 a-d.	

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 03/12/14

13. 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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 12 15 2013	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES / X 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. 847.1 3. 847.2 4.	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	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12/18/13 12/18/13	11		99204		1,2,3	$350.00	1		NPI	1003892217
2 12/18/13 12/18/13	11		20553		1,2	$800.00	1		NPI	1003892217
3 12/18/13 12/18/13	11		J1040		1,2	$80.00	1		NPI	1003892217
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN / EIN	26. PATIENT'S ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES / NO	28. TOTAL CHARGE $1,230.00	29. AMOUNT PAID $0.00	30. BALANCE DUE $1,230.00

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.)
SAM N. GHOUBRIAL, MD 03/12/14
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319
a. 1669702841

33. BILLING PROVIDER INFO & PH # (330) 331-7207
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 1487982112

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

Ghoubrial_000627

NUCC Instruction Manual available at: www.nucc.org
Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]

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

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

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

5. [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. [redacted]

CITY [redacted] STATE

8. PATIENT STATUS [redacted]

CITY [redacted] STATE

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. [redacted]

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 [redacted] SEX M X F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: TAIJUAN CARTER

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

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 03/12/14

13. 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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 12 15 2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ 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. 847.1
3. 847.2
4. 309.81

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	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01/17/14	01/17/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
2 01/31/14	01/31/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
3 01/31/14	01/31/14	11		E0730		1,2,3	$500.00	1		NPI	1508856915
4 02/14/14	02/14/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
5 02/28/14	02/14/14	11		99213		1,2,3	$150.00	1		NPI	1508856915
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 270796590

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $1,100.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $1,100.00

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 03/12/14

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319

a. 1669702841 b.

33. BILLING PROVIDER INFO & PH #

CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
330 331 7207

a. 1487982112 b.

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

Ghoubrial_000628

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Mfd. by Medical Arts Press #14716 - Medical Arts Press

Call toll-free: 1-800-328-2179 Use with Envelope #14145 (gummed) or #14146 (self-seal)

TAIJUAN CARTER [redacted]

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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) — X OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]

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

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

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

b. INSURED'S DATE OF BIRTH [redacted] SEX M X F

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. INSURANCE PLAN NAME OR PROGRAM NAME: TAIJUAN CARTER

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

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 03/12/14

13. 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: MM DD YY 12 15 2013 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X 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. 847.2

2. 847.1 4.

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	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01/03/14	01/03/14	11		99213		1,2,3	$150.00	1		NPI	1508095803
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 270796590

26. PATIENT'S ACCOUNT NO [redacted]

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

28. TOTAL CHARGE $150.00

29. AMOUNT PAID $0.00

30. BALANCE DUE $150.00

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.)

JOSHUA M. JONES, MD 03/12/14

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

HANCHRIST LLC
215 E WATERLOO #12
AKRON, OH 44319

a. 1669702841

33. BILLING PROVIDER INFO & PH #

CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
330-331-7207

a. 1487982112

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

Ghoupnal_000629

NUCC Instruction Manual available at: www.nucc.org

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

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CARTER, TAI JUAN	3. PATIENT'S BIRTH DATE [redacted] SEX M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) CARTER, TAI JUAN	
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) [redacted]	
CITY [redacted] STATE	8. RESERVED FOR NUCC USE
CITY [redacted] STATE	
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 X
a. INSURED'S DATE OF BIRTH [redacted] SEX M F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State) OH
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 SLATER & ZURZ LLP	
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 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.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 06 15 QUAL. 431	15. OTHER DATE QUAL. 439 MM DD YY 10 06 15
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)	20. OUTSIDE LAB? YES NO X $ CHARGES 0.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. S46.119A B. S23.3XXA C. S33.8XXA D. M25.461 E. S46.119D F. S23.3XXD G. S33.8XXD H. S13.4XXD I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 14 15 10 14 15	11		99203		A,B,C,	300.00	1		NPI	1003892217
2 10 14 15 10 14 15	11		20553		A,B,C,	800.00	1		NPI	1003892217
3 10 14 15 10 14 15	11		J1040		A,B,C,	80.00	1		NPI	1003892217
4 10 14 15 10 14 15	11		E0730		A,B,C,	500.00	1		NPI	1003892217
5 10 21 15 10 21 15	11		99213		E,F,G,	150.00	1		NPI	1003892217
6 10 28 15 10 28 15	11		99213		H,F,G,	150.00	1		NPI	1003892217

25. FEDERAL TAX I.D. NUMBER SSN EIN 270796590 X	26. PATIENT'S ACCOUNT NO. [redacted]	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE $ 1980.00	29. AMOUNT PAID $ 0.00	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SAM N. GHOUBRIAL, MD DATE 12 01 15

32. SERVICE FACILITY LOCATION INFORMATION
AKRON CHIROPRACTOR
S ARLINGTON ST
AKRON, OH 44306
a. 1669702841

33. BILLING PROVIDER INFO & PH # (330) 331 7207
CLEARWATER BILLING SERVICES LLC
P.O BOX 1243
BATH, OH 44210
b. 1487982112

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Ghoubrial_000645

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

FOR ATTORNEY EYES ONLY - CONFIDENTIAL SUBJECT TO PROTECTIVE ORDER

SLATER & ZURZ LLP
ONE CAD[illegible]E PLAZA #2210
AKRON, OH 44308

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CARTER, TAI JUAN

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CARTER, TAI JUAN

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: [redacted]

8. RESERVED FOR NUCC USE

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

CITY: [redacted] STATE: [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 X NO

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

b. RESERVED FOR NUCC USE

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

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: SLATER & ZURZ LLP

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: 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.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 10 06 15 QUAL. 431

15. OTHER DATE: QUAL. 439 MM DD YY 10 06 15

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):

20. OUTSIDE LAB? YES X NO $ CHARGES: 0.00

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

A. S13.4XXD B. S23.3XXD C. S33.8XXD D. M25.461
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 28 15	10 28 15	11		20553		A,B,C,	800.00	1			1003892217 NPI
2 10 28 15	10 28 15	11		J1040		A,B,C,	80.00	1			1003892217 NPI
3 11 11 15	11 11 15	11		99213		A,B,C,	150.00	1			1003892217 NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: SSN EIN 270796590

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

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

28. TOTAL CHARGE: $ 1030.00

29. AMOUNT PAID: $ 0.00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SAM N. GHOUBRIAL, MD 12 01 15

32. SERVICE FACILITY LOCATION INFORMATION
AKRON CHIROPRACTOR
S ARLINGTON ST
AKRON, OH 44306
a. 1669702841

33. BILLING PROVIDER INFO & PH # (330) 331 7207
CLEARWATER BILLING SERVICES LLC
P.O BOX 1243
BATH, OH 44210
1487982112

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Ghoubrial - 000646

KIMBERLY FIELDS [redacted]

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]

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

3. PATIENT'S BIRTH DATE [redacted] SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street) [redacted]

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

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE [redacted]

8. RESERVED FOR NUCC USE

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 [X]

a. INSURED'S DATE OF BIRTH [redacted] SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

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

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: KIMBERLY FIELDS

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: 10 26 2017

13. 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) 9 20 17 QUAL. 431

15. OTHER DATE QUAL. 439 09 20 17

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. [ ] 17b. NPI [ ]

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0.00

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

A. S16.1XXA B. S23.3XXA C. S16.1XXD D. S23.3XXD
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID #
1 10 11 17	10 11 17	11		99203		A,B	300.00	1		NPI	1003892217
2 10 11 17	10 11 17	11		E0730		A,B	500.00	1		NPI	1003892217
3 10 18 17	10 18 17	11		99213		C,D	150.00	1		NPI	1003892217
4 10 18 17	10 18 17	11		20553		C,D	1000.00	1		NPI	1003892217
5 10 18 17	10 18 17	11		J1030		C,D	50.00	1		NPI	1003892217
6 10 18 17	10 18 17	11		A4556		C,D	160.00	1		NPI	1003892217

25. FEDERAL TAX I.D. NUMBER 270796590 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. [redacted]

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

28. TOTAL CHARGE $ 2160.00

29. AMOUNT PAID $ 0.00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SAM N. GHOUBRIAL, MD 10 26 17
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
AKRON CHIROPRACTOR
S ARLINGTON ST
AKRON, OH 44306
a. 1669702841 b.

33. BILLING PROVIDER INFO & PH # (330) 331-7207
CLEARWATER BILLING SERVICES LLC
P.O BOX 1243
BATH, OH 44210
a. 1487982112 b.

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PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION | CARRIER

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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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 [X] (ID)

1a. INSURED'S I.D. NUMBER [redacted] (For Program in Item 1)

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

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

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

5. PATIENT'S ADDRESS (No., Street): [redacted]

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

a. INSURED'S DATE OF BIRTH [redacted] SEX M [ ] F [X]

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

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

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 [X] If yes, return to and complete item 9 a-d.

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 09/23/13

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 7 29 2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

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

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	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08/02/13	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										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 270796590 SSN EIN

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] 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
SIGNED 09/23/13 DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
1134 BROWN ST
AKRON, OH 44301
a. 166970284 b.

33. BILLING PROVIDER INFO & PH # (330) 331-7207
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 148798211 b.

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#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14140 (self-seal)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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 [X] (ID)

1a. INSURED'S I.D. NUMBER [redacted] (For Program in Item 1)

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial): HARBOUR, RICHIE A

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] 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 [X] NO

a. INSURED'S DATE OF BIRTH [redacted] SEX M [X] F [ ]

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] 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 [X] NO *If yes,* return to and complete item 9 a-d.

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 08/03/12

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 10 2012

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] 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
2. 847.0
3. 847.2
4.

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	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual 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 05/23/12 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) [X] YES [ ] NO

28. TOTAL CHARGE $ $2,110.00

29. AMOUNT PAID $ $0.00

30. BALANCE DUE $ $2,110.00

SIGNATURE OF PHYSICIAN 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. GHOUBRIAL, MD
SIGNED 08/03/12 DATE

32. SERVICE FACILITY LOCATION INFORMATION
HANCHRIST LLC
1134 BROWN ST
AKRON, OH 44301
a. 1669702841 b.

33. BILLING PROVIDER INFO & PH # (330) 331-7207
CLEARWATER BILLING SERVICES
P.O BOX 1243
BATH, OH 44210
a. 1487982112 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org
Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14146 (self-seal)

KNR05041

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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

CARRIER

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) X	1a. INSURED'S I.D. NUMBER [redacted] (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARBOUR, RICHIE A	3. PATIENT'S BIRTH DATE [redacted] SEX X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARBOUR, RICHIE A
5. [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self X 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 X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX [redacted] M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? PLACE (State) X YES NO LOH	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X 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 X NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 06 10 2012	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 847.2 3. ____ 2. ____ 4. ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
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2 06/20/12 06/20/12	11		J1040		1	$80.00	1		NPI	1003892217
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. BALANCE DUE
270845852	[redacted]	X YES NO	$ $2,110.00	$ $0.00	$ $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. GHOUBRIAL, MD SIGNED 08/03/12 DATE	32. SERVICE FACILITY LOCATION INFORMATION HANCHRIST LLC 1134 BROWN ST AKRON, OH 44301 a. 1669702841 b.	33. BILLING PROVIDER INFO & PH # (330) 331-7207 CLEARWATER BILLING SERVICES P.O BOX 1243 BATH, OH 44210 a. 1487982112 b.

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