Table of Comments
2016

[When multiple comments are received from one organization, the latest submission comes first]

Healthe SYSTEMS
Transforming healthcare.

April 26, 2016

The Industrial Commission of Arizona
P.O. Box 19070
Phoenix, Arizona 85005-9070
Attention: Ms. Jacqueline Kurth

Healthesystems appreciates the opportunity to offer our feedback regarding the fee schedule rulemaking process. We offer our comments below in regard to the Commission's staff recommendations for the proposed 2016 Physicians & Pharmaceutical Fee Schedule. Our remarks are focused on reimbursement of pharmaceutical benefits.

Designation of MediSpan for Purposes of Determining Average Wholesale Price (AWP)

Healthesystems supports continued retention of MediSpan as the data source for determining AWP under the Physicians and Pharmaceutical Fee Schedule. MediSpan's drug database is updated in real time, and is widely used by most pharmacies, pharmacy benefit managers, medical bill review vendors, insurance carriers and other claims administrators. The MediSpan database is incorporated by reference into a majority of the states' workers' compensation medical fee schedules as a designated data source for AWP.

Thank you in advance for your consideration of these comments. Please feel free to contact the undersigned directly with any questions or comments in regard to this information.

Sincerely,

Sandy Shtab
Director, Regulatory and Legislative Affairs
Direct phone number: 813-868-2264
E-mail address: sshtab@healthesystems.com

ARIZONA MEDICAL ASSOCIATION

Nathan Laufer, MD
President

Chic Older
Executive Vice President

May 10, 2016

James Ashley, Director
Industrial Commission of Arizona
800 W. Washington Street, Suite 307
Phoenix, AZ 85007

Dear Mr. Ashley:

Please accept this letter as the comments of the Arizona Medical Association (ArMA) relative to the 2016 physician's fee schedule.

Anesthesia Conversion Factor:
Currently the anesthesia conversion factor for ICA cases is $58.10. A review of twelve states shows a wide disparity across the country. ArMA was able to identify a low of $29.49 (Florida) to a high of $121.82 (Alaska). The 12 states we reviewed (CA, WA, OR, TX, FL, CO, KS, TN, IL, NM, ID, AK) included four that are currently used for development of the Arizona fee schedule.

Our research in the private market shows that commercial carriers in Arizona use an anesthesia conversion factor for anesthesia services between $70.00 - $100.00. CMS has acknowledged that anesthesia services for Medicare ($23.00) are a third of appropriate community rates.

Anesthesia Recommendation
The ICA staff recommendation to maintain the current conversion factor for anesthesia at $58.10 will keep ICA fees below community norms in Arizona ($70.00-$100.00). It is rare for patients to pick their anesthesiologist and these physicians are often secured by virtue of their affiliation and experience with the primary surgeon. It is our belief that the ICA fee schedule for anesthesia needs to consider this aspect of their participation in the ICA health care team.

It is ArMA's recommendation the Arizona conversion factor for anesthesia be raised to $61.00, a 5% increase. Based on table 5.5C of the PCG report, anesthesia services account for 2.8% of total annual costs, so the net financial impact will be minimal to the annual outlay of ICA payments to physicians. This increase is important to ensure the highest quality of physician anesthesia services remain available.

RBRVS Fiscal Impact Study
From the standpoint of the Arizona Medical Association, there are several premises that we are basing our comments upon:

1. Our system in Arizona works well and is cost effective.
2. The recommendation for the study was to determine if there was a better way to set fees and not rely on other states (i.e. there was not a stated assessment by the ICA that the current fee schedule itself is flawed)
3. Participation in the Arizona worker's compensation system by the medical community is robust; excellent physicians from all specialties are available to treat injured workers.
4. Changes to the system should clearly enhance functionality.

ArMA continues to fully support an annual review for all codes. We recognize the administrative burden this places on the ICA staff using the current 7 state comparison system. It is important to note that although the current system is time intensive, it does work and already relies on several states (four) that use an RBRVS system.

810 W. Bethany Home Rd.
Phoenix, AZ 85013
Tel 602.246.8901
Toll Free 800.482.3480
Fax 602.242.6283
azmed.org
facebook.com/azmedicine

ARIZONA MEDICAL ASSOCIATION

Nathan Laufer, MD
President

Chic Older
Executive Vice President

PCG was not charged with measuring physician attitudes toward a new system. ArMA does not anticipate that converting to an RBRVS based system, which will result in a fee redistribution, in and of itself will present obstacles to the medical community. The aspect of the recommendations that is of substantial concern is the actual impact of implementing the RBRVS system without a carefully planned phase in period.

Using Table 5.5b and totaling up the expenses in the Projected RBRVS Payments column and comparing it to the FY14 ICA Payments column, the expense totals are not substantially different. Thus the overall cost to the system will not be a factor. What is alarming and of great concern is the impact of the redistribution of payments to a highly significant degree in three specialties: surgery is decreased by 15%, pathology is decreased by 29%, and radiology is decreased by 32%. According to PCG table 5.5c, in 2014 these accounted for 41.1% of all ICA medical expenses.

The proposed reduction identified as the 20% Scenario (table 5.5b), linked only to the initiation of a new system, and fully activated on an unspecified start date, has a strong potential to fracture the foundation of the worker's compensation system provider network. Experience tells us that while physician quality is not determined by compensation, willingness to participate in a system diminishes if major decrease in fees are adopted. ArMA's belef is this will create a strong disincentive to accept workers compensation cases, particularly for orthopedic surgery and medically essential radiological studies, specialties where physicians can determine if they will be a participant in treating injured workers.

Page #2 of the PCG report states: "While a new rate structure would change many reimbursement values, these changes would not destabilize the workers' compensation program. Rather they would result in a robust fee schedule structure and payment distribution that is already familiar to providers." These statements are not compatible and nothing in the report substantiates this conclusion. The understanding that physicians are familiar with a system does not qualify as evidence they will accept dramatic fee reductions as reasonable. Using the projected RBRVS fees compared to Medicare as evidence the medical community will except this new program is a conclusion that needs to be substantiated in a thoughtful, unbiased manner if it is to be accepted as factual. There are a growing number of medical practices across the country who have opted out of the Medicare system. Physicians who have any discretion in determining their patient mix may well decide not participate in the workman's compensation program, or limit the number of workers compensation patients they are willing to accept. This will be particularly problematic outside of Maricopa and Pima Counties.

<u>RBRVS Recommendations</u>
ArMA continues to feel that an annual review of all fees is appropriate.

It is our recommendation that an RBRVS based system be adopted by the ICA where the changes in fees are phased in over time, with a start date of January 1, 2018. Use of this date will allow for the projected CMS unbundling of fees to take effect in October of 2017 and allow for a study of the impact with this major change. ArMA acknowledges that increased reimbursement for cognitive skills under E & M codes will positively impact all physicians and is needed. However, with so many moving pieces a phased-in approach would allow for a true impact study on fee changes and limit possible negative disruptions to the system. At that time, January 1, 2018, we believe that the implementation should be structured so that no fee is cut or raised more than 5% annually until the new RBRVS rates are achieved over time. We believe that budget impact to the system should remain as a net zero increase or decrease and that balancing both cuts and increases by phasing them in will make the new system more acceptable to all medical specialties.

810 W. Bethany Home Rd.
Phoenix, AZ 85013
Tel 602.246.8901
Toll Free 800.482.3480
Fax 602.242.6283
azmed.org
facebook.com/azmedicine

ARIZONA MEDICAL ASSOCIATION

Nathan Laufer, MD
President

Chic Older
Executive Vice President

Network Transparency Recommendation:
In any discussion about ICA physician fees there is an overarching issue that needs be considered and has impact on the entire system: discount networks. Physicians in Arizona often find themselves included in networks to which they have withdrawn or have no knowledge of participation. The problem was so profound that several years ago the ICA adopted a rule that if a provider challenged a network regarding discounted participation, the network would have to prove a physician's agreement to participate. If they are unable to prove participation, the default payment would be the ICA adopted fee schedule. These discount networks continue to exist and compromise the whole basis of the fee schedule.

It is ArMA's estimation that the existence of these "surprise" discount networks has the potential to detract from acceptance of a new RBRVS system. We believe that if the ICA implements a new RBRVS fee setting system with a redistribution of payments, and at the same time adopts regulations that mandate use of the fee schedule for all physicians (disallows use of negotiated discount rates), it will have a positive impact on acceptance of changes. It is our recommendation that the ICA review this concern and incorporate a policy to eliminate discount networks into the adoption of a new RBRVS fee schedule. This will ensure proper parity of the new system and provide the best opportunity for successful implementation.

On behalf of ArMA and our entire physician membership, we appreciate your consideration of our recommendations.

Sincerely,

Chic Older
Executive Vice President

810 W. Bethany Home Rd.
Phoenix, AZ 85013
Tel 602.246.8901
Toll Free 800.482.3480
Fax 602.242.6283
azmed.org
facebook.com/azmedicine

CopperPoint Insurance Companies

3030 N 3rd Street | Phoenix AZ | 85012
copperpoint.com

May 11, 2016

Jacqueline Kurth, Medical Resource Officer
The Industrial Commission of Arizona
P.O. Box 19070
Phoenix, AZ 85005-9070

RE: Staff Recommendations and Request for Public Comment for 2016/2017 Arizona Physicians' and Pharmaceutical Fee Schedule.

Dear Ms. Kurth,

CopperPoint appreciates the efforts of the Commission staff to develop and maintain a fair and reasonable Fee Schedule. In response to the request for comment, CopperPoint submits the following:

1. Methodology

Changes made by the Commission staff over the last several years are responsive to stakeholder concerns and are much appreciated. We recognize the substantial time and effort involved. The Physicians' Fee Schedule update processes are now timelier. As indicated within the Public Consulting Group (PCG) RBRVS Fiscal Impact Study, it is advantageous for Arizona to move to an RBRVS based fee schedule. The current survey process already incorporates this methodology indirectly, as several of the survey states utilize a RBRVS methodology. Arizona needs to adopt this national standard as quickly as possible. CopperPoint recommends that the Commission adopt this recommendation for the 2017/2018 Physicians' Fee Schedule. Multiple Arizona specific conversion factors should be established and evaluated by Commission staff on an annual basis.

The change to CMS surgical global periods is supported by CopperPoint.

CopperPoint understands the limitations of the RBRVS methodology with respect to pathology and laboratory service codes. Consideration should be given to the adoption of the CMS Clinical Diagnostic Laboratory Fee Schedule (CDL) for Arizona. The opioid crisis is well documented both nationally and within Arizona. CopperPoint is anxious for the ICA Rule for the use of Work Loss Data Institute's Official Disability Guidelines – Treatment in Workers Compensation (ODG) for injury claims involving chronic pain and the use of opioid medications to finally become part of the Arizona claims process. The usage of evidence based medicine treatment guidelines for all conditions should be embraced within the Arizona process. ODG recommends urinary drug screening as an appropriate component of the medical management of injured workers suffering from chronic pain and receiving opioid medications. Even when the attending physician is located within Arizona, and the sample is collected within Arizona, a predominate portion of urinary drug screening laboratory analysis is performed by out-of-state labs. Correct medical bill coding for these tests is extremely complicated. Upcoding is rampant. Costs for this

CopperPoint Insurance Companies

3030 N 3rd Street | Phoenix AZ | 85012
copperpoint.com

testing vary tremendously. Several multiple page billing examples, along with laboratory results, have been attached for illustration and review. (Example 1 charges $12,314.00, example 2 charges $2,376.00, and example 3 charges $1,500.00.) The methodology proposed by PCG would not seem to put in place appropriate controls. In fact, it would seem to perpetuate both the problems of coding and cost. CMS has recognized, acknowledged and corrected for both these issues. The Commission is encouraged to adopt the CMS methodology.

CopperPoint supports the PCG recommendation relating to consultation and bundling policies.

2. Reimbursement for Participation in Peer Review.

CopperPoint supports the Commission staff recommendations.

3. Designation of Medi-Span.

CopperPoint supports the continued utilization of Medi-Span as the source for determination of average wholesale price. The Commission is encouraged to now, for the 2016/2017 Pharmaceutical Fee Schedule, reevaluate the dispensing fee allowed by the Fee Schedule as it is higher than other jurisdictions and substantially more than commonly paid within the industry.

4. Recommendation for additional source.

Presently the Commission restricts bill review, and potential justification to deny a charge, to only publications which have been formally adopted by reference within the Fee Schedule. The usage and billing for the services of assistant surgeons varies and is not addressed within a currently referenced publication. CopperPoint recommends the Commission adopt the assistant at surgery guidelines as defined by CMS which clearly define when payment for a surgical assistant is allowed. An alternative recommended publication is the Physicians as Assistants at Surgery: 2016 Update which is published by the American College of Surgeons. This publication is supported by many physician groups.

CopperPoint is supportive and appreciative of the substantial changes being made to the Fee Schedule. These enhancements will bring Arizona's workers compensation medical Fee Schedule to a methodology commonly known and accepted within the medical billing industry while continuing to allow the Commission to control payable fees. We welcome any opportunity to collaborate on improvements for the Arizona process.

Sincerely,

Cathy Vines

Cathy Vines, Director
CopperPoint Insurance Companies
602.631.2520

Attachments: 3 bills with reports

Example 1
$12,314.00

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (ID/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] (ID#)	
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)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]
7. INSURED'S ADDRESS (No., Street)	
CITY: GLENDALE / STATE: AZ	8. RESERVED FOR NUCC USE
CITY: GLENDALE / STATE: AZ	
ZIP CODE: 85305 / TELEPHONE (Include Area Code): ( )	
ZIP CODE: 85305 / TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH / SEX	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
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: 01182016

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. [ ] 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0: A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE: ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: 45D2077213

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 10152015 10152015	81		G6043	59	ABCD	110;00	1		NPI	1740686153
2 10152015 10152015	81		G6058	59	ABCD	110;00	1		NPI	1740686153
3 10152015 10152015	81		G6052		ABCD	110;00	1		NPI	1740686153
4 10152015 10152015	81		G6058	59	ABCD	110;00	1		NPI	1740686153
5 10152015 10152015	81		G6044		ABCD	110;00	1		NPI	1740686153
6 10152015 10152015	81		G6056	59	ABCD	110;00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER / SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC use
464853428 [X]		[X]	660;00	0;00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
HB2 LLC 01182016 SIGNED DATE	LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.	HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 (9724165407) a. 1740686153 b.

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

WCMS-1500CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCR-10-ENV / WHCR-10-ENV-SS

07/26/2016

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street)
CITY: GLENDALE STATE: AZ	8. RESERVED FOR NUCC USE	CITY: GLENDALE STATE: AZ
ZIP CODE: 85305 TELEPHONE (Include Area Code)		ZIP CODE: 85305 TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
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.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED: SIGNATURE ON FILE DATE: 01182016

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 45D2077213

	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	10152015	10152015	81		G6036		ABCD	110.00	1		NPI	1740686153
2	10152015	10152015	81		G6034		ABCD	110.00	1		NPI	1740686153
3	10152015	10152015	81		G6043		ABCD	110.00	1		NPI	1740686153
4	10152015	10152015	81		G6043	59	ABCD	110.00	1		NPI	1740686153
5	10152015	10152015	81		G6043	59	ABCD	110.00	1		NPI	1740686153
6	10152015	10152015	81		G6043	59	ABCD	110.00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER SSN EIN: 464853428	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 660.00	29. AMOUNT PAID $ 0.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) HB2 LLC 01182016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.		33. BILLING PROVIDER INFO & PH. # (9724165407) HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.	30. Rsvd for NUCC use

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

WCMS-1500CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-BW / WHCF-10-BW-SS

3

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)				
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)				
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other X					7. INSURED'S ADDRESS (No., Street)				
CITY GLENDALE	STATE AZ	8. RESERVED FOR NUCC USE					CITY GLENDALE	STATE AZ			
ZIP CODE 85305	TELEPHONE (Include Area Code)						ZIP CODE 85305	TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES X					a. INSURED'S DATE OF BIRTH MM DD YY SEX				
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES X PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES X					c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 01182016

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES X NO $ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.			
		23. PRIOR AUTHORIZATION NUMBER 45D2077213			

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 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
5 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
6 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153

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 $ 660.00	29. AMOUNT PAID $ 0.00	30. Rsvd for NUCC use
464853428					

31. SIGNATURE OF PHYSICIAN 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. #
HB2 LLC 01182016 SIGNED DATE	LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.	HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 (9724165407) a. 1740686153 b.

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

V/CMS-1500CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WRCF-10-BNV / WRCF-10-BNV-SS

01/28/2016

4

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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)

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self [ ] Spouse [ ] Child [ ] Other [X]	

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
GLENDALE	AZ		GLENDALE	AZ

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
85305		85305	

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 SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
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: 01182016

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

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

A. M76.52	B. Z96.652	C. M25.562	D. M79.605
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 45D2077213

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 10152015	10152015	81		G6053	59	ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
5 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
6 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153

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
464853428 X		X YES NO	$ 660.00	$ 0.00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
HB2 LLC	LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426	HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197
01182016	a. 1740686153 b.	( ) 9724165407 a. 1740686153 b.
SIGNED DATE		

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

WCMS-1500CS-12

FIRST FOLD WHCF-10-ENV-SS SECOND FOLD

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

5

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor DoD#) (Member ID#) (ID#) (DoD#) (VA File #) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other X	7. INSURED'S ADDRESS (No., Street)
CITY GLENDALE	STATE AZ	8. RESERVED FOR NUCC USE	CITY GLENDALE	STATE AZ
ZIP CODE 85305	TELEPHONE (Include Area Code) (	ZIP CODE 85305	TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES X NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
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 01182016

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	16. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE ON SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? $ CHARGES YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 45D2077213

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 10152015 10152015	81		G6056	59	ABCD	110,00	1		NPI	1740686153
2 10152015 10152015	81		G6056	59	ABCD	110,00	1		NPI	1740686153
3 10152015 10152015	81		G6056	59	ABCD	110,00	1		NPI	1740686153
4 10152015 10152015	81		G6031		ABCD	110,00	1		NPI	1740686153
5 10152015 10152015	81		G6031	59	ABCD	110,00	1		NPI	1740686153
6 10152015 10152015	81		G6051		ABCD	110,00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER SSN EIN 464853428 X	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 660,00	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.) HB2 LLC 01182016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.	33. BILLING PROVIDER INFO & PH # HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b. (9724165407			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHEN USING WINDOW ENVELOPE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

6

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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)

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street)

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
GLENDALE	AZ		GLENDALE	AZ

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
85305			85305	

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]	a. INSURED'S DATE OF BIRTH SEX

b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM) I authorize 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 01182016

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

SIGNED SIGNATURE ON FILE

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
DN SHEBA SHAH		1861613267	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
EXPANDED CONFIRMATION TEST	

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.	

	23. PRIOR AUTHORIZATION NUMBER
	45D2077213

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 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
5 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
6 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153

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 $ 660.00	29. AMOUNT PAID $ 0.00	30. Rsvd for NUCC use
464853428					

31. SIGNATURE OF PHYSICIAN 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. # (9724165407)
HB2 LLC 01182016 SIGNED DATE	LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.	HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.

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

WCMS-1500CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCR-10-ENV / WHCR-10-ENV-SS

9 10 2 9 2 / 1 0

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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)

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY: GLENDALE | STATE: AZ

8. RESERVED FOR NUCC USE

CITY: GLENDALE | STATE: AZ

ZIP CODE: 85305 | TELEPHONE (Include Area Code): (

ZIP CODE: 85305 | TELEPHONE (Include Area Code):

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X]

a. INSURED'S DATE OF BIRTH SEX

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [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: 01182016

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

SIGNED: SIGNATURE ON FILE

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH

17a.

17b. NPI 1861613267

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): INITIAL SCREEN TEST

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

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

A. M76.52 B. Z96.652 C. M25.562 D. M79.605
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 45D2077213

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 10152015	10152015	81		G0431		ABCD	3000.00	1		NPI	1740686153
2 10152015	10152015	81		82570		ABCD	55.00	1		NPI	1740686153
3 10152015	10152015	81		81003		ABCD	44.00	1		NPI	1740686153
4 10152015	10152015	81		84311		ABCD	33.00	1		NPI	1740686153
5 10152015	10152015	81		80302		ABCD	800.00	8		NPI	1740686153
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 464853428 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 3932.00

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.)

HB2 LLC

01182016

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:
LLC, HB2
14812 VENTURE DR B
FARMERS BRANCH, TX 75234-2426
a. 1740686153 b.

33. BILLING PROVIDER INFO & PH # (9724165407)
HB2 LLC
PO BOX 702197
DALLAS, TX 75370-2197
a. 1740686153 b.

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

WCMS-1500CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-IGENV / WHCF-IG-ENV-SS

8

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH 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 [X] (ID#)

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

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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street)
CITY: GLENDALE STATE: AZ	8. RESERVED FOR NUCC USE	CITY: GLENDALE STATE: AZ
ZIP CODE: 85305 TELEPHONE (Include Area Code): (		ZIP CODE: 85305 TELEPHONE (Include Area Code):
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
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.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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: 01182016

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 45D2077213

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 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
5 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
6 10152015	10152015	81		G6053		ABCD	110.00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER: 464853428 SSN EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO	28. TOTAL CHARGE $ 660.00	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.) HB2 LLC 01182016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.	33. BILLING PROVIDER INFO & PH # ( ) HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-12-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

9

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER [X] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1)
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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]		7. INSURED'S ADDRESS (No., Street)
CITY: GLENDALE STATE: AZ	8. RESERVED FOR NUCC USE		CITY: GLENDALE STATE: AZ
ZIP CODE: 85305 TELEPHONE (Include Area Code)			ZIP CODE: 85305 TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]		a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]		c. INSURANCE PLAN NAME OR PROGRAM NAME
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: 01182016

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

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 45D2077213

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 10152015	10152015	81		G6058		ABCD	110,00	1		NPI	1740686153
2 10152015	10152015	81		G6058	59	ABCD	110,00	1		NPI	1740686153
3 10152015	10152015	81		G6058	59	ABCD	110,00	1		NPI	1740686153
4 10152015	10152015	81		G6030		ABCD	110,00	1		NPI	1740686153
5 10152015	10152015	81		G6037		ABCD	110,00	1		NPI	1740686153
6 10152015	10152015	81		G6032		ABCD	110,00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER: 464853428 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 660,00	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.) HB2 LLC 01182016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.		33. BILLING PROVIDER INFO & PH # ( ) 9724165407 HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.		

CARRIER

PATIENT AND INSURED INFORMATION

9 10 7 92 1 0

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCR-10-BN / WHCR-10-BN-SS

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

10

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX

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

5. PATIENT'S ADDRESS (No., Street)

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

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

CITY GLENDALE STATE AZ

8. RESERVED FOR NUCC USE

CITY GLENDALE STATE AZ

ZIP CODE 85305 TELEPHONE (Include Area Code)

ZIP CODE 85305 TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY SEX

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

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 01182016

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

SIGNED SIGNATURE ON FILE

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN SHEBA SHAH

17a. 17b. NPI 1861613267

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) EXPANDED CONFIRMATION TEST

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

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

A. M76.52 B. Z96.652 C. M25.562 D. M79.605

E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER 45D2077213

	24. A. DATE(S) OF SERVICE From	To	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10152015	10152015	81		G6042	59	ABCD	110 00	1		NPI	1740686153
2	10152015	10152015	81		G6042	59	ABCD	110 00	1		NPI	1740686153
3	10152015	10152015	81		G6058	59	ABCD	110 00	1		NPI	1740686153
4	10152015	10152015	81		G6042	59	ABCD	110 00	1		NPI	1740686153
5	10152015	10152015	81		G6042	59	ABCD	110 00	1		NPI	1740686153
6	10152015	10152015	81		G6042	59	ABCD	110 00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER 464853428 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 660 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.)
HB2 LLC
01182016
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
LLC,HB2
14812 VENTURE DR B
FARMERS BRANCH, TX 75234-2426
a. 1740686153 b.

33. BILLING PROVIDER INFO & PH # (972) 4165407
HB2 LLC
PO BOX 702197
DALLAS, TX 75370-2197
a. 1740686153 b.

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

WCMS-1500CS-12

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER [X] (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						
3. PATIENT'S BIRTH DATE MM DD YY SEX						
4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street)						
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]						
7. INSURED'S ADDRESS (No., Street)						
CITY: GLENDALE	STATE: AZ					
8. RESERVED FOR NUCC USE						
CITY: GLENDALE	STATE: AZ					
ZIP CODE: 85305	TELEPHONE (Include Area Code)					
ZIP CODE: 85305	TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
10. IS PATIENT'S CONDITION RELATED TO:						
11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER						
a. EMPLOYMENT? (Current or Previous) YES [X] NO						
a. INSURED'S DATE OF BIRTH SEX						
b. RESERVED FOR NUCC USE						
b. AUTO ACCIDENT? YES [X] NO PLACE (State)						
b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE						
c. OTHER ACCIDENT? YES [X] NO						
c. INSURANCE PLAN NAME OR PROGRAM NAME						
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 (IF 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: 01182016

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

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES [X] NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER: 45D2077213	

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 10152015	10152015	81		G6045		ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6056		ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6046		ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
5 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
6 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER SSN EIN: 464853428	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO	28. TOTAL CHARGE $ 660.00	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.) HB2 LLC 01182016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.		33. BILLING PROVIDER INFO & PH # ( ) 9724165407 HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WMCF-1500-ENV / WMCF-1500-ENV-SS

9107.97 v1.0

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

WCMS-1500CS-12

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street)
CITY: GLENDALE STATE: AZ	8. RESERVED FOR NUCC USE	CITY: GLENDALE STATE: AZ
ZIP CODE: 85305 TELEPHONE (Include Area Code): ( )		ZIP CODE: 85305 TELEPHONE (Include Area Code):
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
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.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 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.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM
SIGNED: SIGNATURE ON FILE DATE: 01182016

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER 45D2077213

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 10152015	10152015	81		G6031	59	ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6031	59	ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6031	59	ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		G6031	59	ABCD	110.00	1		NPI	1740686153
5 10152015	10152015	81		G6031	59	ABCD	110.00	1		NPI	1740686153
6 10152015	10152015	81		G6031	59	ABCD	110.00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER SSN EIN: 464853428	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 660.00	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.) HB2 LLC 01182016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.		33. BILLING PROVIDER INFO & PH # ( ) 9724165407 HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.		

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

WCMS-1500CS-12

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

FIRST FOLD WHCS-10-ENV / WHCS-10-ENV-ASS — SECOND FOLD

01/26/2016

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER [X] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1)
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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]		7. INSURED'S ADDRESS (No., Street)
CITY: GLENDALE	STATE: AZ	8. RESERVED FOR NUCC USE	CITY: GLENDALE / STATE: AZ
ZIP CODE: 85305	TELEPHONE (Include Area Code)		ZIP CODE: 85305 / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME
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: 01182016

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

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. [ ] 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 45D2077213

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 10152015	10152015	81		83992		ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6056	59	ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		G6040		ABCD	110.00	1		NPI	1740686153
5 10152015	10152015	81		G6040	59	ABCD	110.00	1		NPI	1740686153
6 10152015	10152015	81		G6042		ABCD	110.00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER: 464853428 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 660.00	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.) HB2 LLC SIGNED: 01182016 DATE	32. SERVICE FACILITY LOCATION INFORMATION LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.		33. BILLING PROVIDER INFO & PH # (972)4165407 HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.	

CARRIER

PATIENT AND INSURED INFORMATION

SECOND FOLD

FIRST FOLD WHCP-DEN/WHCP-16-EMASS

PHYSICIAN OR SUPPLIER INFORMATION

01/26/2016

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

WCMS-1500CS-12

14

COPPER POINT

PO BOX 33069
PHOENIX, AZ 85067

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER [X] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1)
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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]		7. INSURED'S ADDRESS (No., Street)
CITY: GLENDALE STATE: AZ	8. RESERVED FOR NUCC USE		CITY: GLENDALE STATE: AZ
ZIP CODE: 85305 TELEPHONE (Include Area Code):			ZIP CODE: 85305 TELEPHONE (Include Area Code):
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [X]		a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [X] PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [X]		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [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: 01182016

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN SHEBA SHAH	17a. 17b. NPI 1861613267	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): EXPANDED CONFIRMATION TEST		20. OUTSIDE LAB? YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. M76.52 B. Z96.652 C. M25.562 D. M79.605 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER 45D2077213

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 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
2 10152015	10152015	81		G6058	59	ABCD	110.00	1		NPI	1740686153
3 10152015	10152015	81		G6055		ABCD	110.00	1		NPI	1740686153
4 10152015	10152015	81		82570	91	ABCD	55.00	1		NPI	1740686153
5 10152015	10152015	81		81003	91	ABCD	44.00	1		NPI	1740686153
6 10152015	10152015	81		84311	91	ABCD	33.00	1		NPI	1740686153

25. FEDERAL TAX I.D. NUMBER: 464853428 SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 462.00	29. AMOUNT PAID $ 0.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) HB2 LLC 01182016 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION LLC,HB2 14812 VENTURE DR B FARMERS BRANCH, TX 75234-2426 a. 1740686153 b.		33. BILLING PROVIDER INFO & PH. # (9724165407) HB2 LLC PO BOX 702197 DALLAS, TX 75370-2197 a. 1740686153 b.	30. Rsvd for NUCC use

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

9 1 6 7 9 2 1 0

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

PROGRESSIVE DIAGNOSTICS

Progressive Labs Logo
35 Nutmeg Drive. (P) 888-503-8803
Suite 303 (F) 888-503-3516
Trumbull, CT 06611

Patient Name: I
DOB: Age: Sex:
Lab ID: 10354032
Collected: 10/15/2015 Received: 10/17/2015
Comments:
Medications: FENTANYL, HYDROCODONE, ZOLPIDEM

Requesting Physician: S SHAH MD (PEORIA/PROG)
Facility: PINNACLE CARE INT MED
MRN:
Reported: 10/19/2015

01/29/2016

Drug/Metabolite	Concentration	Units	Interp/Remark
Hydrocodone	2242.0	ng/mL	POSITIVE - Consistent with prescriptions.
norHydrocodone	2584.8	ng/mL	POSITIVE - Consistent with prescriptions.
Hydromorphone	82.0	ng/mL	Below Reporting Limit
Fentanyl	11.5	ng/mL	POSITIVE - Consistent with prescriptions.
norFentanyl	38.6	ng/mL	POSITIVE - Consistent with prescriptions.
Tramadol	1568.8	ng/mL	POSITIVE - **INCONSISTENT**
Tramadol metabolite	575.9	ng/mL	POSITIVE - **INCONSISTENT**
REMARK			

Comments: **The requisition received did not include physician orders for confirmation of prescribed medication <ZOLPIDEM>. If you would like to receive the medication correlation and confirmation results for <ZOLPIDEM>, please contact the lab for further information.**

All tested drugs ordered by the physician, other than results indicated above, are negative. Concentrations <5 ng/mL and >2000 ng/mL are outside validated linear range.
***Qualitative method.**

Specimen Validity Testing	Normal Range	Results	Comments
Creatinine (mg/dL)	20.0-200.0	276.0	This specimen is unusually concentrated.
Oxidants (ug/mL)	-20.0-499.0	-5.0	NORMAL
pH	4.6-8.9	4.9	NORMAL
Specific Gravity	1.002-1.035	1.031	NORMAL

Tested Drugs and Metabolites

Drug/Metabolite	Cutoff (ng/mL)	Drug/Metabolite	Cutoff (ng/mL)	Drug/Metabolite	Cutoff (ng/mL)
Alprazolam metabolite	100	Amitriptyline	50	Amphetamine	100
Buprenorphine	10	Butalbital	100	Carboxy-THC	50
Carisoprodol	50	Clonazepam metabolite	100	Cocaine metabolite	50
Codeine	100	Cotinine	400	Cyclobenzaprine	50
EthylGlucuronide	400	EthylSulfate	200	Fentanyl	10
Flunitrazepam metabolite	100	Flurazepam metabolite	100	Gabapentin	1000
Heroin metabolite	30	Hydrocodone	100	Hydromorphone	100
Lorazepam	100	Meperidine	100	Meprobamate	50
Methadone	50	Methadone metabolite	50	Methamphetamine	100
Morphine	100	norBuprenorphine	10	norDiazepam	100
norFentanyl	10	norHydrocodone	100	norMeperidine	100
norOxycodone	100	norOxymorphone	100	Nortriptyline	50

Confirmatory testing performed at Pacific Labs (CLIA# 45D2009077). This test was developed and its performance characteristics determined by Pacific Labs. It has not been cleared or approved by the FDA. However, such approval/clearance is not required, as the laboratory is regulated and qualified under CLIA to perform high-complexity testing. This test is used for clinical purposes, and should not be regarded as investigational or for research.
INCONSISTENT Inconsistent with prescriptions.

Electronically Signed by: Pallavi Upadhyay, PhD Date: 10/19/2015 19:19

Pallavi

PROGRESSIVE DIAGNOSTICS

Progressive Labs Logo
35 Nutmeg Drive. (P) 888-503-8803
Suite 303 (F) 888-503-3516
Trumbull, CT 06611

Patient Name:
DOB: Age: Sex:
Lab ID: 10354032
Collected: 10/15/2015 Received: 10/17/2015
Comments:
Medications: FENTANYL, HYDROCODONE, ZOLPIDEM

Requesting Physician: S SHAH MD (PEORIA/PROG)
Facility: PINNACLE CARE INT MED
MRN:
Reported: 10/19/2015

01/29/2016

Tested Drugs and Metabolites

Drug/Metabolite	Cutoff (ng/mL)	Drug/Metabolite	Cutoff (ng/mL)	Drug/Metabolite	Cutoff (ng/mL)
Oxazepam	100	Oxycodone	100	Oxymorphone	100
Tapentadol	100	Temazepam	100	Tramadol	100
Tramadol metabolite	100				

Confirmatory testing performed at Pacific Labs (CLIA# 45D2009077). This test was developed and its performance characteristics determined by Pacific Labs. It has not been cleared or approved by the FDA. However, such approval/clearance is not required, as the laboratory is regulated and qualified under CLIA to perform high-complexity testing. This test is used for clinical purposes, and should not be regarded as investigational or for research.
INCONSISTENT Inconsistent with prescriptions.

Electronically Signed by: Pallavi Upadhyay, PhD Date: 10/19/2015 19:19

Pallavi

RAPID TOX SCREEN LAB

Rapid Tox Screen
14812 Venture Dr
Ste F
Farmers Branch, TX 75234

Final Copy
Organization: Orange Medical Pain Management
Location: Chandler

Patient:	Birth:	Accession:	34297
Patient ID:	Age:	Provider:	Shah, Sheba
Home Phone:	Gender:	Collected:	10/15/2015 11:00 AM

Test Name	Result	Units	Prescription	Flag	Reference Range
Qualitative					*Run by: TS on 10/16/2015 08:42 PM*
Amphetamines	Negative	ng/mL			1000
Barbiturates	Negative	ng/mL			200
Benzodiazepines	Negative	ng/ml			200
Cannabinoid (THC)	Negative	ng/mL			50
Cocaine Metabolite	Negative	ng/mL			300
Ethyl Alcohol	Negative	mg/dL			100
Methadone	Negative	ng/mL			300
Opiates	979.3	ng/mL		Positive	300
Oxycodone	198.9	ng/mL		Positive	100
Phencyclidine	Negative	ng/mL			25
Buprenorphine	Negative	ng/mL			10
ETG	Negative	ng/mL			500
Tricyclics	Negative	ng/mL			500
XTC	Negative	ng/mL			500
K2 Spice	Negative	ng/mL			100
Carisoprodol	Negative	ng/mL			100
Tramadol	469.0	ng/mL		Positive	200
Fentanyl	6.8	ng/mL		Positive	2.0
6-MAM	Negative	ng/mL			10
EDDP	Negative	ng/mL			1000
Validity					*Run by: TS on 10/16/2015 08:42 PM*
Specific Gravity	1.023			Normal	1.010-1.025
Creatinine	278.1	mg/dL		High	80-200
pH	5.5			Normal	3-11
Oxidants	-16			Normal	200

01/29/2016

CLIA#: 45D2066767
Originally Printed: Oct-22-2015 04:42 PM
Printed: 10/22/2015 04:43 PM

Medical Director: Gregory Cuesta
Accession: 34297 Patient ID:

Example 2

$2,376.00

HEALTH INSURANCE CLAIM FORM

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

RISING MEDICAL SOLUTIONS SCF
PO BOX 2915
PHOENIX AZ 85062

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)			3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)				
			Self X Spouse Child Other						
CITY		STATE	8. RESERVED FOR NUCC USE		CITY		STATE		
PHOENIX		AZ			PHOENIX		AZ		
ZIP CODE	TELEPHONE (Include Area Code)				ZIP CODE	TELEPHONE (Include Area Code)			
85009	( )				85009	( )			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH		SEX		
			X YES NO						
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)				
			YES X NO						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME				
			YES X NO		RISING MEDICAL SOLUTIONS SCF				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
					YES NO If yes, complete items 9, 9a and 9d.				

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE 12212015

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

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE PATEL, SANJAY	17a. 17b. NPI 1568550127	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) Z79899	ICD Ind. 0	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10222015	10222015	11		80361		A	448 00	7		NPI	1568550127
2 10222015	10222015	11		80364		A	128 00	2		NPI	1568550127
3 10222015	10222015	11		80369		A	64 00	1		NPI	1568550127
4 10222015	10222015	11		80371		A	64 00	1		NPI	1568550127
5 10222015	10222015	11		80373		A	64 00	1		NPI	1568550127
6 10222015	10222015	11		83992		A	64 00	1		NPI	1568550127

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
47-2335561	X	010074	X YES NO	$ 832 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # ( )
PATEL, SANJAY MD 12212015	ADVANCED DIAGNOSTIC LAB LLC 3330 N 2ND STREET SUITE 200 PHOENIX AZ 85012	ADVANCED DIAGNOSTICS LABS, LLC DEPT # 880094 PO BOX 29650 PHOENIX AZ 85038-9650
SIGNED DATE	a. 1730572074 b.	a. 1730572074 b.

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

WCMS-1500CS-12

PICA — CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

FIRST FOLD — WHCP-10-ENV / WHCP-10-ENVSS — SECOND FOLD — Scanned: 12/2/2015

Scanned 12/24/2015

HEALTH INSURANCE CLAIM FORM

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

PICA

RISING MEDICAL SOLUTIONS SCF
PO BOX 2915
PHOENIX AZ 85062

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
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)
5. PATIENT'S [illegible]	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S [illegible]
CITY PHOENIX STATE AZ	8. RESERVED FOR NUCC USE	CITY PHOENIX STATE AZ
ZIP CODE 85009 TELEPHONE (Include Area Code) ( )		ZIP CODE 85009 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [X] YES [ ] NO	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	5. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME RISING MEDICAL SOLUTIONS SCF
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 12212015		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	16. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE PATEL, SANJAY	17a. 17b. NPI 1568550127	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. 279899 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10222015	10222015	11		80361		A	448 00	7		NPI	~~1568550127~~
2 10222015	10222015	11		80364		A	128 00	2		NPI	~~1568550127~~
3 10222015	10222015	11		80369		A	64 00	1		NPI	~~1568550127~~
4 10222015	10222015	11		80371		A	64 00	1		NPI	~~1568550127~~
5 10222015	10222015	11		80373		A	64 00	1		NPI	~~1568550127~~
6 10222015	10222015	11		83992		A	64 00	1		NPI	~~1568550127~~

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
47-2335561 [ ] [X]	010074	[X] YES [ ] NO	$ 832 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # ( )
PATEL, MD, SANJAY 12212015 SIGNED DATE	ADVANCED DIAGNOSTIC LAB LLC 3330 N 2ND STREET SUITE 200 PHOENIX AZ 85012 a. ~~1730572074~~ b.	ADVANCED DIAGNOSTICS LABS, LLC DEPT # 880094 PO BOX 29650 PHOENIX AZ 85038-9650 a. ~~1730572074~~ b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

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

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

Scanned 12/24/2015

HEALTH INSURANCE CLAIM FORM

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

RISING MEDICAL SOLUTIONS SCF
PO BOX 2915
PHOENIX AZ 85062

CARRIER

PICA ☐ | PICA ☐

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

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

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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY PHOENIX STATE AZ	8. RESERVED FOR NUCC USE	CITY PHOENIX STATE AZ
ZIP CODE 85009 TELEPHONE (Include Area Code) ( )		ZIP CODE 85009 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME RISING MEDICAL SOLUTIONS SCF
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 12212015

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE PATEL, SANJAY	17a. 17b. NPI 1568550127	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. 279899 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10222015	10222015	11		80302		A	64 00	1		NPI	1568550127
2 10222015	10222015	11		80320		A	64 00	1		NPI	1568550127
3 10222015	10222015	11		80345		A	64 00	1		NPI	1568550127
4 10222015	10222015	11		80346		A	64 00	1		NPI	1568550127
5 10222015	10222015	11		80349		A	64 00	1		NPI	1568550127
6 10222015	10222015	11		80350		A	64 00	1		NPI	1568550127

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 384 00	29. AMOUNT PAID $	30. Rsvd for NUCC use
47-2335561 ☒	010074				

31. SIGNATURE OF PHYSICIAN 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. #
PATEL, SANJAY MD 12212015 SIGNED DATE	ADVANCED DIAGNOSTIC LAB LLC 3330 N 2ND STREET SUITE 200 PHOENIX AZ 85012 a. 1730572074 b.	ADVANCED DIAGNOSTICS LABS, LLC DEPT # 880094 PO BOX 29650 PHOENIX AZ 85038-9650 a. 1730572074 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FIRST FOLD WRAP-TO-BEW / WRAP-TO-BEW-SS

SECOND FOLD

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

Scanned 12/22/2015

HEALTH INSURANCE CLAIM FORM

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

RISING MEDICAL SOLUTIONS SCF
PO BOX 2915
PHOENIX AZ 85062

CARRIER

PICA ☐ PICA ☐

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

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)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY PHOENIX STATE AZ	8. RESERVED FOR NUCC USE	CITY PHOENIX STATE AZ
ZIP CODE 85009 TELEPHONE (Include Area Code) ( )		ZIP CODE 85009 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME RISING MEDICAL SOLUTIONS SCF
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a and 9d.

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED SIGNATURE ON FILE DATE 12212015

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE PATEL, SANJAY	17a. 17b. NPI 1568550127	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. Z79899 B. C. D. E. F. G. H. I. J. K. L.		22. 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 10222015	10222015	11		80353		A	64 00	1		NPI	1568550127
2 10222015	10222015	11		80354		A	64 00	1		NPI	1568550127
3 10222015	10222015	11		80358		A	64 00	1		NPI	1568550127
4 10222015	10222015	11		80359		A	64 00	1		NPI	1568550127
5 10222015	10222015	11		82570		A	41 00	1		NPI	1568550127
6 10222015	10222015	11		83986		A	31 00	1		NPI	1568550127

25. FEDERAL TAX I.D. NUMBER 47-2335561	SSN EIN ☒	26. PATIENT'S ACCOUNT NO. 010074	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 328 00	29. AMOUNT PAID $	30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) PATEL, MD SANJAY 12212015 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION ADVANCED DIAGNOSTIC LAB LLC 3330 N 2ND STREET SUITE 200 PHOENIX AZ 85012 a. 1730572074 b.	33. BILLING PROVIDER INFO & PH. # ( ) ADVANCED DIAGNOSTICS LABS, LLC DEPT # 880094 PO BOX 29650 PHOENIX AZ 85038-9650 a. 1730572074 b.

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

WCMS-1500CS-12

FIRST FOLD WMCF-10-ENV / WMCF-10-ENVSS SECOND FOLD 23

Scanned 12/24/2015 - 31

15

Arizona Pain and Rehabilitation Associates, PLC
3330 N. 2nd St # 200
Phoenix, AZ 85012

Chart Cover

Print Date : 10/13/2016
Print Time : 11:16 am
Print User:

Phoenix, AZ 85009

Provider Patel, Sanjay R
Referral N/A

Account No
Home Phone
Cell Phone
Home Fax
Pager
Financial Group WC

Date of Birth
SSN
Gender
DL #
Marital Status
First Visit Date

Employment Information

Patient Position
e-mail

Office Phone (602)t
Office Fax

Guarantor Information

Phoenix, AZ 85009

Account No
Home Phone
Home Fax
e-mail

Gender
Date of Birth
DL #
SSN

Insurance Information

Insurance Company / Address	Office Phone / City	Code / State	Policy Holder / Zip	Policy Number / Group Number	Copayment	Deductible	% Ins
SCF Arizona P.O. BOX 33069	(602)631-2300 Phoenix	WC AZ	 85012		$0.00	$0.00	100%

Health Summary

Collected By
Marcella Kemp
@ 1:25
on 10/13/15
UA Temp: 75.5 F

Current Medications

Tizanidine HCl 4mg Tablet Take 1 - 2 tabs po every day at bedtime
[redacted] Tablet 1 PO QID
Gabapentin 800mg Tablet 1 pill 3 times a day.
Meloxicam 15mg Tablet Take one tablet by mouth twice daily

Notes

Advanced Diagnostics Labs LLC

3330 N 2nd St, Suite 200
Phoenix, AZ 85012
Tel. (951)699-0303

Name:
Patient ID No.:
Date Of Birth: Age: Sex:
Doctor:
SSN:
Comment 1: Hemolysis: Lipemia: Fasting:
Comment 2:

Draw Date: 10-13-2015 01:26 PM Run Date: 10-22-2015 11:55 AM

Test Name	Result	Units	Flag	Reference Range
6AM	0.0	ng/mL		0 - 0
METH	65	ng/mL		0 - 0
THC50	0	ng/mL		0 - 0
PCP	0	ng/mL		0 - 0
XTSY	0	ng/mL		0 - 0
SPICE	0	ng/mL		0 - 0
OXYC	2	ng/mL		0 - 0
BUP	3	ng/mL		0 - 0
OP300	0	ng/mL		0 - 0
AMPH	104	ng/mL		0 - 0
BARB	26	ng/mL		0 - 0
BENZ	56	ng/mL		0 - 0
ETHA	0.5	mg/dL		0 - 0
METD	0	ng/mL		0 - 0
EDDP	0	ng/mL		0 - 0
TRAM	0	ng/mL		0 - 0
COCM	0	ng/mL		0 - 0
CARIS	6	ng/mL		0 - 0
FENT	0.0	ng/mL		0 - 0
MEPER	6	ng/mL		0 - 0
TAPEN	0	ng/mL		0 - 0
TCA	11	ng/mL		0 - 300
HYDR	0	ng/mL		0 - 0
ETG	144	ng/mL		0 - 0
UCREA	343.9	mg/dL		0 - 0
PH	5.93	pH		0 - 0

---- End of Report ----

Reviewed by: _____ Date: 10-22-15

DOCUMENTATION FOR PRESUMPTIVE URINE DRUG TESTING (UDT)

The patient's medical record should include all required documentation to support the medical necessity of ordered test(s). Criteria to establish medical necessity for drug testing must be based on patient-specific elements identified during the clinical assessment, and documented by the clinician in the patient's medical record. Additionally, documentation of the clinicians' review of test results and use in the treatment plan is recommended to support medical necessity. Guidance from experts and professional organizations also suggests documentation of a risk stratification approach to support testing frequency for the safe management of prescribed controlled substances and/or in identifying and treating substance use disorders.

Pursuant to the guideline ODG Treatment in Workers' Comp 2013, Eleventh Edition, Procedure Summary – Pain, page 1427, under Urine drug testing (UDT), *"Recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. The frequency of urine drug testing may be dictated by state and local laws."*

Patient Name: _____ **DOI:** _____

Carrier: _____ **Claim #:** _____

ICD9 Diagnosis Code(s): _____

REASON(S) FOR PRESUMPTIVE UDT TEST(S) (based on results and reported medications)

- ☐ New patient testing as part of history and exam to rule out baseline substance use disorder and support initial treatment decisions
- ☒ Identify specific medication(s) or drug(s) in a class (e.g., benzodiazepines, barbiturates, opioids)
- ☐ Identify a negative, or confirm a positive UDT result inconsistent with a patient's self-report, presentation, medical history, or current prescribed medication
- ☐ Rule out an error as the cause of an unexpected UDT result
- ☒ Identify non-prescribed medication or illicit drug use for ongoing safe prescribing of controlled substances
- ☒ Identify substances that may present high risk for additive or synergistic interaction with prescription medication (e.g., alcohol)
- ☐ Random testing not associated with visit and documented as part of the treatment plan
- ☐ Other: _____

CURRENT MEDICATIONS

SUMMARY OF PRESUMPTIVE UDT RESULTS

☒ Results as expected = consistent with history and prescribed medication(s), specifically:

_____

☐ Results unexpected = inconsistent with history and prescribed medication(s), specifically:

- ☐ Absence of prescribed medication(s): _____
- ☐ Presence of non-prescribed medication(s): _____
- ☐ Presence of illicit substance(s): _____

☐ Other findings: The urine drug test also showed the following findings:

_____

TREATMENT PLAN (check all that apply)

☒ Continue medications as prescribed.
☐ Counsel/educate patient regarding use of prescribed medication(s), non-prescribed medication(s) and/or illicit drugs.
☐ Change, modify, or discontinue prescribed medication(s).
☐ Refer patient for further evaluation and/or to rule-out substance use disorder.
☐ Other: _____

Clinician Signature: S Patel, MD
Sanjay Patel, M.D.

Date: 10-12-15

Example 5
$1,500.00

1 INTEGRITY TRANSITIONAL H 2803 SOUTH MAYHILL ROAD DENTON TX 762085910 8883615514	2 INTEGRITY TRANSITIONAL H	3a PAT. CNTL # SST1602100034 b. MED REC. # 0141	
		5 FED. TAX NO. 30-0384056	6 STATEMENT COVERS PERIOD FROM 020416 THROUGH 020416

8 PATIENT NAME	9 PATIENT ADDRESS	10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
				9 9					01													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	34 CODE	OCCURRENCE SPAN FROM	THROUGH	35 CODE	OCCURRENCE SPAN FROM	THROUGH	37

38 COPPER POINT PO BOX 2915 PHOENIX, AZ 85062		39 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

	42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES	49
1	0300	Laboratory-General	80365	020416	1.00	0 00		
2	0300	Laboratory-General	80354	020416	1.00	0 00		
3	0300	Laboratory-General	80373	020416	1.00	0 00		
4	0300	Laboratory-General	80368	020416	1.00	0 00		
5	0300	Laboratory-General	83986	020416	1.00	0 00		
6	0300	Laboratory-General	84311	020416	1.00	0 00		
7	0300	Laboratory-General	80304	020416	1.00	1500 00		
8	0300	Laboratory-General	82570	020416	1.00	0 00		
23	001	PAGE 1 OF 1	CREATION DATE	021816		1500 00	0 00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1033204342
COPPER POINT	PAPER	Y	Y			57 OTHER PRV ID	

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
	18			

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX											69
0	Z5181	Z79899	Z79891								

67 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	

80 REMARKS			
	81CC a	83	284300000X
	b		
	c		
	d		

76 ATTENDING	NPI		QUAL	
LAST		FIRST		
77 OPERATING	NPI		QUAL	
LAST		FIRST		
78 OTHER	DN	NPI 1861613267	QUAL	
LAST SHAH		FIRST SHEBA		
79 OTHER	NPI		QUAL	
LAST		FIRST		

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

INTEGRITY TRANSITIONAL H
2813 SOUTH MAYHILL ROAD
DENTON TX 762085910
8883615514

INTEGRITY TRANSITIONAL H

3a PAT. CNTL #
b. MED REC. #

0141

5 FED. TAX NO. 20 0204056

6 STATEMENT COVERS PERIOD FROM 020916 THROUGH 020916

8 PATIENT NAME
9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE 9 | 15 SRC 9 | 16 DHR | 17 STAT 01

50 PAYER NAME / 38:

COOPER POINT WC
3030 N. 3RD STREET
PHOENIX, AZ 85012

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0300	Laboratory-General	80365	020916	1.00	800 00	
0300	Laboratory-General	80366	020916	1.00	409 75	
0300	Laboratory-General	80370	020916	1.00	412 50	
0300	Laboratory-General	83986	020916	1.00	120 00	
0300	Laboratory-General	84311	020916	1.00	120 00	
0300	Laboratory-General	80304	020916	1.00	2000 00	
0300	Laboratory-General	82570	020916	1.00	300 00	
001	PAGE 1 OF 1	CREATION DATE	021916	TOTALS	4162 25	0 00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
COOPER POINT WC	PAPER	Y	Y			1033204342

57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL 18 | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX 0 | Z79899 | Z79891 | Z5181

67

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI | QUAL
LAST | FIRST

77 OPERATING NPI | QUAL
LAST | FIRST

78 OTHER DN NPI 1861613267 | QUAL
LAST SHAH | FIRST SHEBA

79 OTHER NPI | QUAL
LAST | FIRST

80 REMARKS

81CC a B3 284300000X
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997
Env 4249 Page 2 of 2 Job #

NUBC LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Integrity Transitional Hospital
3315 Colorado (P) 940-387-7228
Suite 101 (F) 940-387-7209
Denton, TX 76210
Alvin M. Spiekerman, PhD CLIA#45D1062541

Patient Name: Requesting Physician: S SHAH MD (ITH/SAN-CHAN)
DOB: Age: Sex: Facility: ORANGE MD PN MG (ITH-SHAH-(
Lab ID: XRef: MRN:
Collected: Received: 02/13/2016 Reported: 02/14/2016
Comments:
Medications: Pregabalin Oxycodone Cyclobenzaprine

Drug/Metabolite	Concentration	Units	Cutoff ng/mL	Interp/Remark
Oxycodone	2039.49	ng/mL	100	POSITIVE - Consistent with prescriptions
norOxycodone	1435.72	ng/mL	100	POSITIVE - Consistent with prescriptions
Oxymorphone	637.724	ng/mL	100	POSITIVE - Consistent with prescriptions
norOxymorphone	364.705	ng/mL	100	POSITIVE - Consistent with prescriptions
Gabapentin	0	ng/mL	2000	NEGATIVE
Pregabalin	5500	ng/mL	1000	POSITIVE - Consistent with prescriptions
Carisoprodol	0	ng/mL	50	NEGATIVE
Meprobamate	0	ng/mL	50	NEGATIVE
Cyclobenzaprine	0	ng/mL	50	NEGATIVE **INCONSISTENT**
Baclofen	0	ng/mL	50	NEGATIVE

Specimen Validity Testing	Normal Range	Results	Comments
Creatinine (mg/dL)	20.0-200.0	216.0	This specimen is unusually concentrated.
Oxidants (ug/mL)	-20.0-499.0	2.0	NORMAL
pH	4.6-8.9	4.5	LOW
Specific Gravity	1.002-1.035	1.004	NORMAL

PRE-SCREENING RESULTS

Prescreen Assay	Cutoff(ng/mL)	Result	Prescreen Assay	Cutoff(ng/mL)	Result	Prescreen Assay	Cutoff(ng/mL)	Result
PS_AMPHETAMINES	150	NEGATIVE	PS_ANTIPSYCHOTICS	50	NEGATIVE	PS_BARBITURATES	50	NEGATIVE
PS_BUPRENORPHINE	5	NEGATIVE	PS_BENZODIAZEPINE	30	NEGATIVE	PS_COTININE	100	NEGATIVE
PS_CARBOXYTHC	20	NEGATIVE	PS_SYNTH AMPHET	50	NEGATIVE	PS_BATH SALTS	30	NEGATIVE
PS_DEXTROMETHOR	50	NEGATIVE	PS_ETOMIDATE	200	NEGATIVE	PS_FENTANYL	5	NEGATIVE
PS_GABAPREGAB	1000	POSITIVE	PS_LUCITS	20	NEGATIVE	PS_KETAMINE	50	NEGATIVE
PS_MEPERIDINE	30	NEGATIVE	PS_METHADONE	30	NEGATIVE	PS_MUSCLE RELAX	30	NEGATIVE
PS_NALTREXNALOXEUTORI	50	NEGATIVE	PS_OPIATES	30	NEGATIVE	PS_OXYCODONE	30	POSITIVE
PS_SEDATIVES	20	NEGATIVE	PS_K2/SPICE	20	NEGATIVE	PS_TAPENTADOL	30	NEGATIVE
PS_ANTIDEPRSNTS	30	NEGATIVE	PS_TRAMADOL	30	NEGATIVE			

Confirmatory testing performed at HealthTrackRx (CLIA# 45D2103708)Medical Director: John K. Granger, M.D. This test was developed and its performance characteristics determined by HealthTrackRx. It has not been cleared or approved by the FDA. However, such approval/clearance is not required, as the laboratory is regulated and qualified under CLIA to perform high-complexity testing. This test is used for clinical purposes, and should not be regarded as investigational or for research.
INCONSISTENT Inconsistent with prescriptions.

Electronically Signed by: Carolyne McLaren, B.A. Date: 02/14/2016 18:02

Carolyne McLaren

03/21/2016

Scanned 04/07/2016 - 38

HEALTH INSURANCE CLAIM FORM

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

RISING MEDICAL SOLUTIONS SCF
PO BOX 2915
PHOENIX AZ 85062

CARRIER

PICA ☐ PICA ☐

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

1 IER (For Program In Item 1)

(Last Name, First Name, Middle Initial)

3 PATIENT'S BIRTH DATE SEX M ☐ F ☐

4 (Middle Initial)

(Street)

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

7 (No., Street)

STATE

8. RESERVED FOR NUCC USE

TELEPHONE (Include Area Code) ( )

TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11 JOY 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

b. RESERVED FOR NUCC USE

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

UCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME RISING MEDICAL SOLUTIONS SCF

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED SIGNATURE ON FILE DATE

13. 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 08013YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE PATEL, SANJAY

17a. 1568550127

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 0

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

279899

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03022016	03022016	11		80302		A	700 00	7		NPI	1568550127
2 03022016	03022016	11		80301		A	100 00	1		NPI	1568550127
3 03022016	03022016	11		82570		A	41 00	1		NPI	1568550127
4 03022016	03022016	11		83986		A	31 00	1		NPI	1568550127
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 47-2335561 SSN EIN ☒

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 872 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

PATEL SANJAY MD 03312016

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ADVANCED DIAGNOSTIC LAB LLC
3330 N 2ND STREET SUITE 200
PHOENIX AZ 85012
1730572074
a. b.

33. BILLING PROVIDER INFO & PH. #
ADVANCED DIAGNOSTICS LABS, LLC
DEPT # 880094 PO BOX 29650
PHOENIX AZ 85038-9650
1730572074
a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCS-10-DW / WHCS-10-SNN-SS

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

WCMS-1500CS-12

Advanced Diagnostics Labs LLC

3330 N 2nd St, Suite 200
Phoenix, AZ 85012
Tel. (951)699-0303

Name:
Patient ID No.:
Date Of Birth:
Doctor:
Draw Date: 2016 11:42 AM

SSN:
Comment 1: Hemolysis: Lipemia: Fasting:
Comment 2:

Test Name	Result	Units	Flag	Reference Range
6AM	0.2	ng/mL		0 - 10
METH	67	ng/mL		0 - 500
THC50	0	ng/mL		0 - 50
PCP	0	ng/mL		0 - 25
XTSY	0	ng/mL		0 - 500
OXYC	22	ng/mL		0 - 300
BUP	2	ng/mL		0 - 20
OP300	42	ng/mL		0 - 300
AMPH	0	ng/mL		0 - 1000
BARB	29	ng/mL		0 - 200
BENZ	62	ng/mL		0 - 200
ETHA	1.0	mg/dL		0 - 100
METD	20	ng/mL		0 - 300
EDDP	235	ng/mL		0 - 299
TRAM	559H	ng/mL		0 - 200
COCM	0	ng/mL		0 - 299
CARIS	6	ng/mL		0 - 100
FENT	0.0	ng/mL		0 - 2
MEPER	136	ng/mL		0 - 200
TAPEN	116	ng/mL		0 - 200
TCA	62	ng/mL		0 - 300
HYDR	1	ng/mL		0 - 100
ETG	436	ng/mL		0 - 1000
UCREA	99.0	mg/dL		10 - 300
PH	5.70	pH		3 - 11

---- End of Report ----

Reviewed by: _____ Date: 3-2-16

SSN:

(1)

DOCUMENTATION FOR URINE DRUG TESTING (UDT)

Urine drug testing is being performed. The follow is the test menu which identifies which tests will be done. 6AM, METH, THC50, PCP, XTSY, SPICE, OXYC, BUP, OP300, AMPH, BARB, BEN, ETHA, METD, EDDP, TRAM, COCM, CARIS, FENT, MEPER, TAPEN, TCA, HYDRO, ETG, UCREA, and PH

The patient's medical record should include all required documentation to support the medical necessity of ordered test(s). Criteria to establish medical necessity for drug testing must be based on patient-specific elements identified during the clinical assessment, and documented by the clinician in the patient's medical record. Additionally, documentation of the clinicians' review of test results and use in the treatment plan is recommended to support medical necessity. Guidance from experts and professional organizations also suggests documentation of a risk stratification approach to support testing frequency for the safe management of prescribed controlled substances and/or in identifying and treating substance use disorders.

Pursuant to the guideline ODG Treatment in Workers' Comp 2013, Eleventh Edition, Procedure Summary – Pain, page 1427, under Urine drug testing (UDT), *"Recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. The frequency of urine drug testing may be dictated by state and local laws."*

Patient Name: _____ **DOI:** _____

Carrier: _____ **Claim #:** _____

REASON(S) FOR PRESUMPTIVE UDT TEST(S) (based on results and reported medications)

- ☐ New patient testing as part of history and exam to rule out baseline substance use disorder and support initial treatment decisions
- ☒ Identify specific medication(s) or drug(s) in a class (e.g., benzodiazepines, barbiturates, opioids)
- ☐ Identify a negative, or confirm a positive UDT result inconsistent with a patient's self-report, presentation, medical history, or current prescribed medication
- ☐ Rule out an error as the cause of an unexpected UDT result
- ☒ Identify non-prescribed medication or illicit drug use for ongoing safe prescribing of controlled substances
- ☒ Identify substances that may present high risk for additive or synergistic interaction with prescription medication (e.g., alcohol)
- ☐ Random testing not associated with visit and documented as part of the treatment plan
- ☐ Other: _____

CURRENT MEDICATIONS: Please see chart cover

SUMMARY OF PRESUMPTIVE UDT RESULTS

☒ Results as expected = consistent with history and prescribed medication(s), specifically:
Tramadol

☒ Results unexpected = inconsistent with history and prescribed medication(s), specifically:

- ☒ Absence of prescribed medication(s): OP300
- ☐ Presence of non-prescribed medication(s): _____
- ☐ Presence of illicit substance(s): _____

☐ Other findings: The urine drug test also showed the following findings:

_____

TREATMENT PLAN (check all that apply)

- ☒ Continue medications as prescribed.
- ☒ Counsel/educate patient regarding use of prescribed medication(s), non-prescribed medication(s) and/or illicit drugs.
- ☐ Change, modify, or discontinue prescribed medication(s).
- ☐ Refer patient for further evaluation and/or to rule-out substance use disorder.
- ☐ Other: _____

Clinician Signature: S Patel, M Sanjay Patel, M.D. **Date:** 3-26

OrthoArizona

May 12, 2016

Mr. James Ashley, Director
Industrial Commission of Arizona
800 Washington Street, Suite 307
Phoenix, Arizona 85007

RE: 2016 Physician's Fee Schedule Commentary

Dear Mr. Ashley:

Respectfully, we offer the following comments and recommendations regarding the 2016 ICA Physician's Fee Schedule. Our perspective is from that of the leading provider of orthopedic and musculoskeletal care in Arizona, and considerable experience in dealing with both the prior ICA physician fee schedule as well as a variety of schedules based on an RBRVS system over the last 20 years. We understand the intent of the Commission is not to lower physician payment, but rather convert the Fee Schedule to a generally accepted methodology, which is updated and adjusted nationally on an annual basis.

OrthoArizona supports the conversion of the current ICA Physician Fee Schedule to one based on a RBRVS system. However, the RBRVS system has certain known flaws that can be identified, and therefore subsequently modified, to improve its fairness to those providers who care for injured workers. Such a change to RBRVS, as well, may be difficult for those whose entire practice careers have been based on the current ICA fee schedule and applicable rules. All of our recommendations seek to improve upon the RBRVS reimbursement formula, allow an orderly transition to this fee schedule, and increase the efficiency of the reimbursement system, while at the same time always assuring adequate access to care for the worker and fairness in compensation to the providers of that care.

1. One of the major deficiencies of the RBRVS system is that, over the many years of its existence, changes in the value units of the CPT codes has effectively decreased the value of some of these codes to the level well below the work and/or practice expense required for the particular service rendered. The three components of RBRVS are work expense, practice expense and liability expense. However, the original RBRVS proposal was based on non-worker compensation patients, with far less practice expense considerations compared to a worker compensation population and the much greater demand of these patients from an administrative perspective.

   We recognize that adoption of a RBRVS payment schedule will decrease surgical reimbursement in many, if not most, instances as this has been demonstrated clearly over the last many years. **Our strong**

2355 East Camelback Road, Suite 325, Phoenix, AZ 85016
P: (602) 772-3796 | F: (602) 772-3801

recommendation is that any decrease in conversion to RBRVS for surgical services is equally offset by appropriate increase in evaluation and management services, so as to keep the overall payment neutral compared to the current ICA schedule. Effectively, we suggest that the overall payment to providers is kept whole, while recognizing there will be some increases and decreases in conversion to RBRVS. Furthermore, the PCG analysis is flawed in that the re-bundling of procedures was not fully accounted for. This is a nuance of the old ICA fee schedule and a function of individual lobbying at hearing. Nonetheless it will effectively lower physician payments.

2. Unfortunately, too often administrative intermediaries and shadow or phantom networks by payers take advantage of providers and injured workers by non-transparent, reduced ICA fee schedules. **We have an opportunity to stop this activity and strongly recommend ICA institute a ban, as a matter of law, on any network for workers compensation patients that would pay less than 90% of the ICA adopted physician fee schedule.** We have had unfortunate experiences in this area in the past with substantial financial loss to our providers due solely to clandestine and dishonest business practices by some payers. These abuses must stop going forward. Effectively, these networks have limited access of injured workers to providers once it is discovered that their employer utilizes such a network.

3. Implementation to RBRVS from the more traditional ICA Fee Schedule in use, as well as recommendations #2 and #3 above, will take appropriate learning **these changes on a reliable and efficient basis.** A 3-year implementation plan should mitigate potential system disruptions and avoid provider and patient discontent alike.

4. **We recommend universal adoption of ICD-10 coding at the same time the RBRVS fee schedule is instituted.** ICD-10 is now the norm across the United States and has been the case since October 1, 2015. This only makes sense to incorporate this ICD-10 system concurrent with the RBRVS fee schedule as it will be necessary anyway at a later time, and providers are now very much used to this coding system. Additionally, most offices now on electronic record systems are fully integrated with ICD-10 coding and nothing else.

5. **We recommend adoption of electronic billing and payment concurrent with the use of the RBRVS fee schedule use.** Such electronic forms of billing and payment are also now the norm throughout the non-worker compensation payer systems and the time is now for this transition in the worker compensation arena as well. Again, electronic record platforms have effectively integrated this into most, if not all, provider offices at this time.

OrthoArizona

We truly appreciate your consideration of our recommendations itemized above in transition to the new RBRVS fee schedule.

Respectfully,

Doug Vang
Chief Executive Officer

John K. Bradway, MD
President

David M. Ott, MD
Senior Vice President of Operations

Steven R. Kassman, MD

2355 East Camelback Road, Suite 325, Phoenix, AZ 85016
P: (602) 772-3796 | **F:** (602) 772-3801