Fill in this info	ormation to identify the case:	
Debtor	Tehum Care Services, Inc.	
United States Ba	nkruptcy Court for the: Southern	District of <u>Texas</u> (State)
Case number	23-90086	

Official Form 410 Proof of Claim

04/22

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

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

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

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

Pa	rt 1: Identify the Clain	n
1.	Who is the current creditor?	ADA WEST DERMATOLOGY Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor
2.	Has this claim been acquired from someone else?	✓ No ✓ Yes. From whom?
3.	Where should notices and payments to the creditor be sent? Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Where should notices to the creditor be sent? Where should payments to the creditor be sent? (if different) ADA WEST DERMATOLOGY 1618 S Millennium Way, Suite 100 Meridian, ID 83642, US Contact phone 2088843376 Contact phone Contact email adawestdermatology@gmail.com Uniform claim identifier for electronic payments in chapter 13 (if you use one):
4.	Does this claim amend one already filed?	No Yes. Claim number on court claims registry (if known)
5.	Do you know if anyone else has filed a proof of claim for this claim?	 No Yes. Who made the earlier filing?

Proof of Claim

Part 2: Give Info	ormation Ab	out the Claim as of the Date the Case Was Filed
6. Do you have an		No No
you use to ider debtor?	iury me	Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor:
7. How much is t	he claim?	\$ 20786 Does this amount include interest or other charges?
		No
		Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).
8. What is the bas	sis of the	Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
claim?		Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
		Limit disclosing information that is entitled to privacy, such as health care information.
9. Is all or part of secured?	the claim	No No
Scourcu.		Yes. The claim is secured by a lien on property.
		Nature or property:
		Real estate: If the claim is secured by the debtor's principle residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i> .
		Motor vehicle
		Other. Describe:
		Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
		Value of property: \$
		Amount of the claim that is secured: \$
		Amount of the claim that is unsecured: \$(The sum of the secured and unsecured amount should match the amount in line 7.)
		Amount necessary to cure any default as of the date of the petition: \$
		Annual Interest Rate (when case was filed)%
		Fixed
		Variable
10. Is this claim ba	sed on a	No No
lease?		Yes. Amount necessary to cure any default as of the date of the petition.
11. Is this claim su right of setoff?	bject to a	No
ngni or selon?		Yes. Identify the property:



12. Is all or part of the claim entitled to priority under		No							
11 U.S.C. § 507(a)?		Yes. Che	ck all that apply:		Amount entitled to priority				
A claim may be partly priority and partly nonpriority. For example,			estic support obligations (includi I.S.C. § 507(a)(1)(A) or (a)(1)(B	ng alimony and child support) under).	\$				
in some categories, the law limits the amount entitled to priority.				rchase, lease, or rental of property ousehold use. 11 U.S.C. § 507(a)(7). \$				
entitied to priority.		days		p to \$15,150*) earned within 180 is filed or the debtor's business end 7(a)(4).	s, \$				
		Taxe	es or penalties owed to governm	ental units. 11 U.S.C. § 507(a)(8).	\$				
		Con	tributions to an employee bene	ît plan. 11 U.S.C. § 507(a)(5).	\$				
		Othe	er. Specify subsection of 11 U.S	.C. § 507(a)() that applies.	\$				
		* Amount	s are subject to adjustment on 4/01/2	5 and every 3 years after that for cases beg	oun on or after the date of adjustment.				
Part 3: Sign Below									
The person completing	Check	the appro	priate box:						
this proof of claim must sign and date it.	1	am the cre	ditor.						
FRBP 9011(b).	<u></u> ч	I am the creditor's attorney or authorized agent.							
If you file this claim electronically, FRBP		am the tru	stee, or the debtor, or their autho	prized agent. Bankruptcy Rule 3004.					
5005(a)(2) authorizes courts to establish local rules specifying what a signature is.		am a guar	antor, surety, endorser, or other	codebtor. Bankruptcy Rule 3005.					
A person who files a fraudulent claim could be fined up to \$500,000,				Proof of Claim serves as an acknowl otor credit for any payments received					
imprisoned for up to 5 years, or both.	I have examined the information in this Proof of Claim and have reasonable belief that the information is true and correct.								
18 U.S.C. §§ 152, 157, and 3571.	I declare under penalty of perjury that the foregoing is true and correct.								
	Execu	ited on dat	e <u>08/14/2023</u> MM / DD / YYYY						
			MM / DD / YYYY						
		<i>omphane</i> lignature	Phimmasone						
	Print the name of the person who is completing and signing this claim:								
	Name		Somphane Phimmasone						
			First name	Middle name La	stname				
	Title		President						
	Compa	any	Ada West Dermatology						
			Identify the corporate servicer as the	e company if the authorized agent is a servi	cer.				

Address

Contact phone

Email



KCC ePOC Electronic Claim Filing Summary

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

Debtor:						
23-90086 - Tehum Care Services, Inc.						
District:						
Southern District of Texas, Houston Division	F					
Creditor:	Has Supporting Documentation:					
ADA WEST DERMATOLOGY	Yes, supporting documentation successfully uploaded					
1618 S Millennium Way, Suite 100	Related Document Statement:					
Meridian, ID, 83642	Has Related Claim:					
US	No					
Phone:	Related Claim Filed By:					
2088843376						
Phone 2:	Filing Party:					
2088843376	Creditor					
Eax:						
Email:						
adawestdermatology@gmail.com Other Names Used with Debtor:	Amends Claim:					
Other Names Osed with Debtor.	No					
	Acquired Claim:					
	No					
Basis of Claim:	Last 4 Digits: Uniform Claim Identifier:					
	No					
Total Amount of Claim:	Includes Interest or Charges:					
20786	No					
Has Priority Claim:	Priority Under:					
No	· · · · · · · · · · · · · · · · · · ·					
Has Secured Claim:	Nature of Secured Amount:					
No	Value of Property:					
Based on Lease:	Annual Interest Rate:					
No						
Subject to Right of Setoff:	Arrearage Amount:					
No	Basis for Perfection:					
	Amount Unsecured:					
Submitted By:						
Somphane Phimmasone on 14-Aug-2023 4:0	08:01 p.m. Eastern Time					
Title:						
President						
Company:						
Ada West Dermatology						

Exhibit A

MEDICAL GROUP SERVICES AGREEMENT

between

CORIZON, LLC

and

ADA WEST DERMATOLOGY

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

WITNESSETH:

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

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

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

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

SECTION 1 Definitions

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

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

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

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

1) Patient (Inmate) name and Department of Correction or Booking Identification number (Inmate Number).

2) Name and Address of Correctional Facility from which the inmate was transported.

3) Patient Date of Birth.

4) Date(s) of Service.

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5) Medical Group Name, Address, Phone number, and Tax Identification number.

6) ICD-9 Diagnostic and Surgical Procedure codes and descriptions.

7) Current industry standard procedure coding (UB-04 Revenue Codes, DRG, HCPCS and CPT codes as appropriate) and descriptions.

8) Detailed billing of charges and units.

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

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

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

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

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

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

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

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

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

SECTION 2 Medical Group's Rights and Obligations

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

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

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

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

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

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

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

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

SECTION 3 Compensation of Medical Group

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4 Term and Termination

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

4.2 <u>**Termination**</u>. This Agreement may be terminated as follows:

- **4.2.1** <u>**Termination without Cause**</u>. Either party may terminate this Agreement, without cause, by giving the other party written notice of termination, not less than thirty (30) days prior to the effective date thereof.
- **4.2.2** <u>Termination for Cause</u>. Corizon Health may terminate this Agreement with Medical Group for cause, including but not limited to the occurrence of any of the following events, which has not been cured within thirty (30) days after written notice from Corizon Health.
 - 4.2.2.1 Medical Group has breached any of the material terms and conditions of this Agreement or the exhibits or attachments hereto; or

- 4.2.2.2 Any activities or actions of Medical Group that, in the reasonable judgment of Corizon Health, are deemed to be detrimental to Corizon Health.
- **4.2.3** <u>Immediate Termination</u>. Corizon Health may immediately terminate this Agreement upon the occurrence of any of the following events:
 - 4.2.3.1 Medical Group's failure to maintain required insurance as provided in this Agreement; or
 - 4.2.3.2 Medical Group's inability to meet its obligations pursuant to this Agreement due to financial insolvency, bankruptcy, or lack of capacity to provide Health Care Services; or
 - 4.2.3.3 Medical Group is found guilty of a criminal offense; or

- 4.2.3.4 Upon termination or expiration of Corizon Health/Client Contract; or
- 4.2.3.5 Medical Group is found liable for gross misconduct in providing care.

SECTION 5 Insurance and Indemnification

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

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

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

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

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

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

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

SECTION 6 Relationship of the Parties

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

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

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

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

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

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

SECTION 7 Construction of Agreement

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

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

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

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

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

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

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

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

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

Corizon Health

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

With a courtesy copy to the Attn: General Counsel

Medical Group

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

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

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

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

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

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

CORIZON, LLC

3

By: Roland Maldonado

I Male

Chief Operations

Date: _____ 4/17/15

ADA WEST DERMATOLOGY

By:

<u>RACTICE</u> MANAGER Title Print Name: <u>Todd J.</u> Rolgers

Date: 3.20.15

TIN: 205276415

NPI: (5/897333)

LaTonya Nicholson Contract Specialist Date:

By: M. Therese Bromfield Vice President, Provider Operation

Date:

(form rev. 10/4/2011, 8/30/12)

EXHIBIT A COMPENSATION SCHEDULE FOR ADA WEST DERMATOLOGY

- **1.1. Procedures billed on CMS-1500.** Claims for Health Care Services rendered in the provider's office or other usual and customary site for rendering Health Care Services shall be billed on a standard CMS-1500 form using industry standard procedure coding (i.e. CPT-4/HCPCS Codes).
- **1.2.** Reimbursement. Corizon Health agrees to reimburse for authorized covered services at the lesser of one-hundred percent (100%) of the Medicare Fee Schedule for Idaho, adjusted annually for locality number "00" or Medical Group's Eligible Charges.

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

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

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Exhibit B



HEALTH INSURANCE CLAIM FORM

		Page 1 of 1				
Corizon PO Box 981639						
HEALTH INSURANCE CLAIM FORM	El P	aso, TX 79998				
			PICA			
1. MEDICARE MEDICAID TRICARE CHAMP		1.J. INSURED'S LD. NUMBER	(For Program in Item 1)			
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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (HUCC) 02/12

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El Paso, TX 79998

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 92/12

Page 1 of 1

Corizon PO Box 981639

El Paso, TX 79998

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5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7, INSURED'S ADDRESS (No., Street)	
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to process this claim, I also request payment of government benefits	either to myself or to the party who accepts assignment		
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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Page 1 of 1

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5. PATIENT'S ADDRESS (No., St	•	_	6. PARENT RELATION		VED ()	7. INSURED'S ADDRESS (No.		
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?		20 AMEQUINT PAID 30. Royd for NUCC
	2E1C017 X YES NO	1 180 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE F	ACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO Ada West Dermato	opathology""
INCOMPANY DECORPTO OF OPPOCNTIAL?		1618 S Millenniu	im Way Ste 220
it certify that the statements on the reverse 1618 S	4111ennium Way Ste 220		
it certify that the statements on the reverse 1618 S	n, 1D 83642-6457	Meridian, ID 836	642-6457
il certify that the statements on the raverse 1618 S	n, 1D 83642-6457	Meridian, ID 830	642-6457
it certify that the statements on the reverse 1618 S apply to this bill and are made a part thereof.) Xeridia	h, 1D 83642-6457		642-6457 b.



Page 1 of 1

		Page 1 of 1	
	Cori PO B	zon ox 981639	
HEALTH INSURANCE CLAIM FORM	El P	aso, TX 79998	
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1. MEDICARE MEDICAID TRICARE CHA		19. INSURED'S LO. NUMBER	(For Pregrammer II
	ber (D#) (D#) (D#)	115729	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. IN SURED'S NAME (Last Name	, First Name, Middle Initial)
Lundquist,	MIA DD 1957 M X F	Lundquist,	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., S	treati
15505 South Pleasant Valley R	Self X Spouse Child Other	15505 South Pl	easant Valley R
CITY STAT		Сігу	STATE
Kuna II		Kuna	ID
ZIP CODE TELEPHONE (Include Area Code)	-	2IP CODE	TELEPHONE (Include Area Code)
83634 (208) 3369959		83634	(208) 3369959
COTHER INSURED'S NAME (Lost Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GEOUP	OR FECA HUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT2 (Current or Previous)	a. INSURED'S DATE OF BIRTH MM-1 DO 1 YY	\$EX
	YES X NO	1 195	7 M 🗶 F
U RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM IP (Designated	by NUCC)
	YES X NO		
c. RESERVED FOR NUCC USE	c. OTHER ACCIDEN17	C INSURANCE PLAN NAME OR	PROGRAM NAME
	YES X NO	Corizon	
	10d CLAIM CODES (Designated by NUGC)	6.1S THERE ANOTHER HEALTH	BENEFIT PLAN?
d. INSURANCE PLAN NAME OR PROGRAM NAME	tool Genin Gebes (Senighteed by Good)	YES X NO IF	yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLET	I NG & SIGNING THIS FORM.	13. INSUBED'S OR AUTHORIZE	D PERSON'S SIGNATURE Lauthenze
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Lauthorize the to process this claim. Laks request payment of government benefits of below.	release of any medical or other information necessary	payment of medical benefits services described below.	to the undersigned physician or supplier for
SOF	DATE	SIGNED SOF	
SIGNED	15. OTHER DATE	16 DATES PATIENT UNABLE TO	NVORK IN CURRENT OCCUPATION
MM DD YY QUAL	OUAL. MM DD YY	MM I DO I	то
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	7a.	18. HOSPITALIZATION DATES F	RELATED TO CURRENT SERVICES
DN Gregory L Wells MD	175. NPI 1871609370	FROM	TO L
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	\$ CHARGES
		VES X NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to s	ervice tine below (24E) ICD Ind 0	22. RESUBMISSION CODE I	ORIGINAL REF. NO.
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	ан н L	20. PRIOR AUTHORIZATION NU	BADE 1
	к L	1302047540	
24. A. DATE(S) OF SERVICE B. C. D. PF From To PLATE OF (E	OCEDURES, SERVICES, OR SUPPLIES E. xplain Unusual Circumstances) DIAGNOSIS HCPCS I MODIFIER POINTER	F. O. LIAYS S CHARGES LINITS	fanis di la
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	6ADW4C017	\$ 866 00	* 0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE	E FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO	&PH# (208) 9915665
INCLUDING DEGREES OR CREDENTIALS Adda W	est Dermatopathology 5 Millennium Way Ste 220	Ada West Dermate 1618 S Millennii	m Way Ste 220
apply to this bill and are made a part thereof.) Meric	Lan, 1D 83642-6457	Meridian, ID 836	642-6457
SOF		1	
SOF Christine Mudsham SKANED MD DATE WYWYNON a.	t.	1760730436	b.



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HEALTH INSURANCE CLAIM FORM	El P	aso, TX 79998	
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Rieser,	MM DD 1966 M F	Rieser,	
5. PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
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CITY STATE		CIT?	STATE
Twin Falls		Twin Falls	ID
ZIP CODE TELEPHONE (Include Area Code)	-	ZIP CODE TELEPHONE Include Area Co	ude)
83301 (208) 6447900		83301 (208) 64479	00
P. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA MUMBER	
			STATE ID ode) 00
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current or Previous)	a INSURED S LIATE OF FIRTH SEX	
	YES 🗶 NO	1966 M X	F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	5. OTHER CLAIM ID (Designated by NUCC)	
	YES X NO		
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	5. INSURANCE PLAN NAME OR PROGRAM NAME	
	YES X NO	Corizon	
	10d CLAIM CODES (Designated by NUCO)	6. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
U INSURANCE PLAN NAME OR PROGRAM NAME	100 CLARK COLLES (COLLEGING, COLY FOR 2	YES X NO If yes, complete items 9 9a and	d 9a
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a second and the contract of the store of th	alarsta of any meticul or other information neoglassian	psyment of medical penetits to the underspoed pitysician r sarvices percribed below.	a safatasi ta
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SOF	DATE		
SIGNED	5. OTHER DATE MM , DD , YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUP MM 1 DD 1 YY MM 1 DD	PATION T YY
TARA DD YY QUAL.	OUAL.	FROM	1
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 1	7a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVI	i Yr
DN Christopher T Scholes MD	75. MPI 1760491542	FROM I FO	<u> </u>
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
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	э. Цн Ц	23. PRIOR AUTHORIZATION NUMBER	
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34. A. DATE(S) OF SERVICE B. C D. PRO	DCEDURES, SERVICES, OR SUPPLIES E. plan Unusual Circumstagers) DIAGNOSIS	F. G. H. L. J. Levis (1991) (P. Gault 10) S CHARCES USER No. 0001. PROVIDE	RING
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AFPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE INUCC) 02/12

Page 1 of 1

CARRIER ---

Corizon PO Box 981639

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PATIENT'S OR AUTHORIZED P to process this claim. Lalso requ	ERSON'S SIGNATURE. La uest payment of governme	withouize the rale int banefits eane	ease of any medic trito myself or to	tal or other inform the party who ac	nation necessary cepts associment	payment of medical benefits services described below.	to the unders	gried physician or	supplier fo
below.									
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE INUCCI 02/12

Page 1 of 1

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HEALTH INSURANCE CLAIM FORM	F1 D	aso, TX 79998	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 62/12	- 11 -	aso, in 19990	
			PICA
1. MEDICARE MEDICAID TRICARE CHAM	rBUS LUNG r	19. INSURED'S LO. NUMBER 48900	(For Progration Item 3)
[Medicare #] (Medicard #) (I/O#/DQD#) [Member 30] 2. PATIENT'S NAME (Lost Name, First Name, Middle hitral) (Member 30) [Member 30]	اسب اسب	4. IN SURED'S NAME (Last Name, First)	lame, Middle biltal)
Hansen,	3. PATIENT'S BIRTH DATE SEX MM DD YY 1962 M	Hansen,	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7, INSURED'S ADDRESS (No., Street)	
15505 South Pleasant Valley R	Sett 🗶 SpouseChildOther	15505 South Pleas	
CITY STATE	8. RESERVED FOR NUCC USE	CITY	STATE ID HONE Include Ara Code) (208) 3369959 CANUMBER SEX MXF F
Kuna ID	4	Kuna	HONE Include Area Code)
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEF	208) 3369959
83634 (208) 3369959	10.13 PATIENT'S CONDITION FELATED TO:	11. INSURED'S POLICY GROUP OR FE	CANUMBER
6. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	IQ ISTRACT & CONCRETE DOD TO		
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	VES X NO	1962	M X F
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	YES X NO	C. INSURANCE PLAN NAME OR PROG	RAM NAME
c. RESERVED FOR NUCC USE			
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READ BACK OF FORM BEFORE COMPLETIN	I G & SIGNING THIS FORM.	11 INSURFORS OF AUTHORIZED FER	SON'S SIGNATURE Lawrence
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Lauthorize the re to process this claim. Latio request payment of government benefits en	testa of any medical or other information necessary	payment of medical benefits to the services described below.	andersigned physician or supplier for
to process this claim. Laiso request payment of government owners en- below.	12) to Hitsen of the one bord core stands a constant		
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THE DETE OF CONNENT TELEVEOUS INSOME OF THE PROPERTY OF	5. OTHER DATE MM DD YY	16 DATES PATIENT UNABLE TO WOR MM DD YY	MM I DD I YY
17, NAME OF REFERRING PROVIDER OR OTHER SOURCE 17	l	FROM 15. HOSPITALIZATION DATES RELATE	D TO CURRENT SERVICES
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NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-1197 FORM)O (U



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

Page 1 of 1

Corizon PO Box 981639

El Paso, TX 79998

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to process this claim. Latso requi	uest payment of govern	ment canadis anna	r to myself or to th	e party who accept	s assignment	services described below.	is to the order	signera provstoran	or supplier tor
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Page 1 of 1

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Page 1 of 1

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Page 1 of 1

Corizon PO Box 981639

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5 RESERVED FOR NUCC USE			B. AUTO ASCIDE	YES X	PLACE (State) O					
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to process this claim, I also req below.	liest payment or government						OF			
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HEALTH INSURANCE CLAIM FORM

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

Page 1 of 1

Corizon PO Box 981639

El Paso, TX 79998

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ITY		STATE	8. RESERVE	ED FOR NUCC I	JSE		CITY			*****	STAT	Ē
Kuna		ID					Kuna				II)
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Page 1 of 1

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		ZIP CODE TELEPHONE (Include Area Code)
<u>83634</u> (208) 3312760		83634 (208) 3312760
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	0 11 INSURED'S POLICY GROUP OR FECA NUMBER
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AND A CONTRACTOR OF CONTRACTOR		E (State) b. OTHER CLAIM ID (Designated by NUCC)
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INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	
	6 Stouble This Sector	YES X NO Hyes, complete itoms 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Lauthorize the rule to process this claim. Lalso request payment of government beneaits entre below.	and of one made of or other information parion	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthenze payment of mudical benefits to the undersigned physician or supplier for services described below.
SOF		SOF
		SIGNED
JEM DD YY QUAL. OL		16. DATES PATIENT UNABLE TO WORK IN CUBRENT OCCUPATION MM DD YY MM DD YY FROM TO
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and the second		20. OUTSIDE LAB? \$ CHARGES
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HEALTH INSURANCE CLAIM FORM

		Page 1 of 1	¥								
	Corizon PO Box 961639										
HEALTH INSURANCE CLAIM FORM	El P	aso, TX 79998	CARRIER								
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		PICA []	rn↓								
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Page 1 of 1

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PATIENT'S OR AUTHORIZED PER- to process this claim. Lalso reques below.	K OF FORM BEFORE SON'S SIGNATURE, La Reprinent of governme	adhorize the rale	ase of any mer	lical or other interna	tion necessary praises onner t		benefits to		SIGNATURE Lauthonze ghed physician or subplier fo		
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Page 1 of 1

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Corizon PO Box 981639

El Paso, TX 79998

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Page 1 of 1

	Corizon PO Box 981639								
HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE INUCC) 02/12	El 9	aso, 11X 79998							
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE INUCC 02/12

Page 1 of 1

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PO Box 981639

Corizon

El Paso, TX 79998

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HEALTH INSURANCE CLAIM FORM

Page 1 of 1

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APPROVED 5 CNATIONAL UNIFORM CLAIM COMMITTEE INUCC) 02/12

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