Fill in this information to identify the case:
Debtor 1 Curae Health Inc.
Debtor 2 (Spouse, if filing)
United States Bankruptcy Court **MIDDLE DISTRICT OF TENNESSEE**
Case number: **18−05665**

FILED
U.S. Bankruptcy Court
MIDDLE DISTRICT OF TENNESSEE
9/5/2018
MATTHEW T. LOUGHNEY, Clerk

Official Form 410
Proof of Claim

04/16

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

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

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

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

Part 1: Identify the Claim

1. **Who is the current creditor?**	LABORATORY CORP OF AMERICA Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor: LabCorp, Laboratory Corporation of America, Laboratory Corporation of America Holdings	
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?** LABORATORY CORP OF AMERICA Name PO BOX 12140 BURLINGTON, NC 27216−2140 Contact phone 8592520093 Contact email kwhitmer@lexlaw.us	**Where should payments to the creditor be sent?** (if different) Name Contact phone Contact email
	Uniform claim identifier for electronic payments in chapter 13 (if you use one):	
4. **Does this claim amend one already filed?**	☑ No ☐ Yes. Claim number on court claims registry (if known) ____ Filed on ____ MM / DD / YYYY	
5. **Do you know if anyone else has filed a proof of claim for this claim?**	☑ No ☐ Yes. Who made the earlier filing?	

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
- ☐ No
- ☑ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 1410

7. **How much is the claim?** $ 95394.84

Does this amount include interest or other charges?
- ☑ No
- ☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**

Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

Limit disclosing information that is entitled to privacy, such as healthcare information.

lab services rendered

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

Nature of property:
- ☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410−A) with this *Proof of Claim*.
- ☐ Motor vehicle
- ☐ Other. Describe:

Basis for perfection:

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $

Amount of the claim that is secured: $

Amount of the claim that is unsecured: $ (The sum of the secured and unsecured amounts should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $

Annual Interest Rate (when case was filed) %
- ☐ Fixed
- ☐ Variable

10. **Is this claim based on a lease?**
- ☑ No
- ☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $

11. **Is this claim subject to a right of setoff?**
- ☑ No
- ☐ Yes. Identify the property:

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**	☑ No ☐ Yes. *Check all that apply*:	**Amount entitled to priority**
A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$
	☐ Up to $2,850* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$
	☐ Wages, salaries, or commissions (up to $12,850*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$
	☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$
	☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$
	☐ Other. Specify subsection of 11 U.S.C. § 507(a)(_) that applies	$

* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

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

Check the appropriate box:

- ☐ I am the creditor.
- ☑ I am the creditor's attorney or authorized agent.
- ☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- ☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this Proof of Claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this Proof of Claim and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 9/5/2018

MM / DD / YYYY

/s/ Karen L Whitmer

Signature

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

Name: Karen L Whitmer

First name Middle name Last name

Title: Attorney

Company: Laboratory Corporation of America

Identify the corporate servicer as the company if the authorized agent is a servicer

Address: 535 Wellington Way, Suite 380

Number Street

Lexington, KY 40503

City State ZIP Code

Contact phone 8592520093 Email kwhitmer@lexlaw.us

23001410 SUMMARY 07/28/18 1

R07-KSB 32,016

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

To avoid collection activity, payment for the overdue balance must be received immediately.

Please call us at 800-343-4407 to discuss any questions you may have concerning this overdue balance and your plans to bring this account within terms.

Please send your payment and the remittance stub in the enclosed envelope. To pay your overdue balance online, go to www.labcorp.com/client billing, select ePayBill and follow the instructions.

(800) 343 - 4407
PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

12,140.67	927.87	64.47	391.91		13,524.92

58292402	6,214.47	_____	59597373	391.91	_____	13,524.92
58620530	5,926.20	_____				
59003521	927.87	_____				
59251533	64.47	_____				

(800) 343 - 4407

Account Number 23001410
TRILAKES MEDICAL CENTER
CONTACT: Hope Schiele
(662) 712-2264

PO BOX 12140 BURLINGTON, NC 27216-2140

R07-KSB 32,016

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

02/24/18	INVOICE		57985689		6,907.32
07/24/18	PAYMENT	13735		Check	3,527.62CR
06/29/18	PAYMENT	13584		Check	3,379.70CR
				INVOICE BALANCE	0.00
03/31/18	INVOICE		58292402		7,549.66
06/05/18	PAYMENT	13318		Check	1,335.19CR
				INVOICE BALANCE	6,214.47
04/28/18	INVOICE		58620530		5,926.20
				INVOICE BALANCE	5,926.20
06/02/18	INVOICE		59003521		927.87
				INVOICE BALANCE	927.87
06/30/18	INVOICE		59251533		64.47
				INVOICE BALANCE	64.47
				PRIOR PERIOD BALANCE	13,133.01

23002120 SUMMARY 07/28/18

R07-MSB 32,035

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * A T T E N T I O N * * *

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(800) 343 - 4407
PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

578.93	15.00	46.39	15.00	655.32

57714249	51.58	_____	59220077	15.00	_____	655.32
58176377	198.45	_____	59434286	46.39	_____	
58342622	165.29	_____	59800125	15.00	_____	
58671932	163.61	_____				

(800) 343 - 4407

Account Number 23002120
TRILAKES MEDICAL CENTER
CONTACT: Jamie Harper

PO BOX 12140 BURLINGTON, NC 27216-2140

(662) 712-2261

R07-MSB 32,035

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

01/27/18	INVOICE	57714249		51.58
			INVOICE BALANCE	51.58
02/24/18	INVOICE	58176377		198.45
			INVOICE BALANCE	198.45
03/31/18	INVOICE	58342622		165.29
			INVOICE BALANCE	165.29
04/28/18	INVOICE	58671932		163.61
			INVOICE BALANCE	163.61
06/02/18	INVOICE	59220077		15.00
			INVOICE BALANCE	15.00
06/30/18	INVOICE	59434286		46.39
			INVOICE BALANCE	46.39
			PRIOR PERIOD BALANCE	640.32

23001420 SUMMARY 07/28/18

R07-MSB 32,017

TRILAKES MEDICAL CENTER
WOMEN'S DEPARTMENT
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN A/P
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606-

* * * A T T E N T I O N * * *

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(800) 343 - 4407
PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

665.78	644.74	.00	230.00	1,540.52

57985690	210.00	_____	59760696	230.00	_____	1,540.52
58582279	217.37	_____				
58620531	238.41	_____				
59055197	644.74	_____				

(800) 343 - 4407

Account Number 23001420
TRILAKES MEDICAL CENTER
CONTACT: MALLORY HAIRE

PO BOX 12140 BURLINGTON, NC 27216-2140

(662) 563-2[illegible]

R07-MSB 32,017

TRILAKES MEDICAL CENTER
WOMEN'S DEPARTMENT
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN A/P
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606-

* * * PRIOR PERIODS SUMMARY * * *

02/24/18	INVOICE	57985690		210.00
			INVOICE BALANCE	210.00
03/31/18	INVOICE	58582279		217.37
			INVOICE BALANCE	217.37
04/28/18	INVOICE	58620531		238.41
			INVOICE BALANCE	238.41
06/02/18	INVOICE	59055197		644.74
			INVOICE BALANCE	644.74
			PRIOR PERIOD BALANCE	1,310.52

R07-MSB 32,093

TRILAKES-NON COC TOX

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

**** N O T I C E ****

** YOUR ACCOUNT IS NOW 60 DAYS PAST DUE. **

Prompt attention must be given to this matter. Please return payment for the overdue balance in the enclosed envelope immediately. To pay your overdue balance online, go to www.labcorp.com/clientbilling, select ePayBill and follow the instructions.

If there is a problem delaying payment, please call us at 800-343-4407, fax us at 877-867-8266, or visit us online at www.labcorp.com/clientbilling. Written correspondence can be mailed to LabCorp Client Billing, PO Box 2250, Burlington, NC 27216-2250.

(800) 343 - 4407
PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

815.57CR	1,832.37	2,208.04	2,733.06	5,957.90

57694667	1,388.94CR	_____	58922484	1,832.37	_____	5,957.90
57985709	1,472.38CR	_____	59251550	2,208.04	_____	
58292423	239.97	_____	59550246	2,733.06	_____	
58620550	1,805.78	_____				

(800) 343 - 4407

Account Number 23003950
TRILAKES-NON COC TOX
CONTACT: . Schiele

PO BOX 12140 BURLINGTON, NC 27216-2140

(662) 712-4284

R07-MSB 32,093

TRILAKES-NON COC TOX

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

01/27/18	INVOICE	57694667			1,388.94
06/08/18	PAYMENT	13426	Check		1,388.94CR
06/29/18	PAYMENT	13584	Check		1,388.94CR
			INVOICE BALANCE		1,388.94CR
02/24/18	INVOICE	57985709			1,847.57
07/24/18	PAYMENT	13735	Check		1,472.38CR
06/08/18	PAYMENT	13426	Check		1,847.57CR
			INVOICE BALANCE		1,472.38CR
03/31/18	INVOICE	58292423			2,354.93
06/08/18	PAYMENT	13426	Check		2,114.96CR
			INVOICE BALANCE		239.97
04/28/18	INVOICE	58620550			1,805.78
			INVOICE BALANCE		1,805.78
06/02/18	INVOICE	58922484			1,832.37
			INVOICE BALANCE		1,832.37
06/30/18	INVOICE	59251550			2,208.04
			INVOICE BALANCE		2,208.04
			PRIOR PERIOD BALANCE		3,224.84

23500700 SUMMARY 07/28/18 1

R04-MSB 32,564

GILMORE MEMORIAL REG MED CTR
CO
1105 EARL FRYE BLVD
AMORY, MS 38821

GILMORE MEMORIAL REG MED CTR

1105 EARL FRYE BLVD
AMORY, MS 38821-5500

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

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Please call us at 800-343-4407 to discuss any questions you may have concerning this overdue balance and your plans to bring this account within terms.

Please send your payment and the remittance stub in the enclosed envelope. To pay your overdue balance online, go to www.labcorp.com/client billing, select ePayBill and follow the instructions.

(800) 343 - 4407
PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

1,865.69	276.78	510.12	308.85	2,961.44

58620694	1,865.69	_____
58922637	276.78	_____
59251699	510.12	_____
59580077	308.85	_____

2,961.44

(800) 343 - 4407

Account Number 23500700
GILMORE MEMORIAL REG MED CTR
CONTACT: TOMMY GANN

PO BOX 12140 BURLINGTON, NC 27216-2140

(662) 256-6021

R04-MSB 32,564

GILMORE MEMORIAL REG MED CTR
CO
1105 EARL FRYE BLVD
AMORY, MS 38821

GILMORE MEMORIAL REG MED CTR

1105 EARL FRYE BLVD
AMORY, MS 38821-5500

* * * PRIOR PERIODS SUMMARY * * *

04/28/18	INVOICE	58620694		1,865.69
			INVOICE BALANCE	1,865.69
06/02/18	INVOICE	58922637		276.78
			INVOICE BALANCE	276.78
06/30/18	INVOICE	59251699		510.12
			INVOICE BALANCE	510.12
			PRIOR PERIOD BALANCE	2,652.59

R04-MSB 32,572

GILMORE MEMORIAL HOSPITAL
INTERFACE ACCOUNT
1105 EARL FRYE BLVD
AMORY, MS 38821

GILMORE MEMORIAL HOSPITAL
INTERFACE ACCOUNT
1105 EARL FRYE BLVD
AMORY, MS 38821-5500

* * * A T T E N T I O N * * *

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(800) 343 - 4407
PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

2,823.79	4,091.12	4,117.45	2,806.27	13,838.63

58620697	2,823.79	_____
58922640	4,091.12	_____
59251702	4,117.45	_____
59550415	2,806.27	_____

13,838.63

(800) 343 - 4407

Account Number 23501685
GILMORE MEMORIAL HOSPITAL
CONTACT: JERRY WALDEN

PO BOX 12140 BURLINGTON, NC 27216-2140

(662) 256-6218

R04-MSB 32,572

GILMORE MEMORIAL HOSPITAL
INTERFACE ACCOUNT
1105 EARL FRYE BLVD
AMORY, MS 38821

GILMORE MEMORIAL HOSPITAL
INTERFACE ACCOUNT
1105 EARL FRYE BLVD
AMORY, MS 38821-5500

* * * PRIOR PERIODS SUMMARY * * *

04/28/18	INVOICE	58620697		2,823.79
			INVOICE BALANCE	2,823.79
06/02/18	INVOICE	58922640		4,091.12
			INVOICE BALANCE	4,091.12
06/30/18	INVOICE	59251702		4,117.45
			INVOICE BALANCE	4,117.45
			PRIOR PERIOD BALANCE	11,032.36

R07-MSB 32,110

PANOLA MED CTR-EMPLOYEE HEALTH

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

PANOLA MED CTR-EMPLOYEE HEALTH

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * A T T E N T I O N * * *

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(800) 343 - 4407
PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

803.31	255.29	231.66	259.04		1,549.30

58016622	226.66	_____	59283673	231.66	_____	1,549.30
58365099	317.61	_____	59623208	259.04	_____	
58690658	259.04	_____				
58953827	255.29	_____				

(800) 343 - 4407

Account Number 23004600
PANOLA MED CTR-EMPLOYEE HEALTH
CONTACT: Laura Allgood

PO BOX 12140 BURLINGTON, NC 27216-2140

(662) 712-2266

R07-MSB 32,110

PANOLA MED CTR-EMPLOYEE HEALTH
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

PANOLA MED CTR-EMPLOYEE HEALTH
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

02/24/18	INVOICE	58016622		226.66
			INVOICE BALANCE	226.66
03/31/18	INVOICE	58365099		317.61
			INVOICE BALANCE	317.61
04/28/18	INVOICE	58690658		259.04
			INVOICE BALANCE	259.04
06/02/18	INVOICE	58953827		255.29
			INVOICE BALANCE	255.29
06/30/18	INVOICE	59283673		231.66
			INVOICE BALANCE	231.66
			PRIOR PERIOD BALANCE	1,290.26

JCBB 08-29-18
LCBS **Client Bill Balances List** 08:59:42
HL More:

Client Account: 23005260 Report to Name1: PANOLA MEDICAL CENTER
Corp Account : Bill to Name1 : LABORATORY
O ("O"pen or "A"ll)

Client Balance	Client Payments	Client Adjustments
23,329.41	0.00	0.00

Sel	Bill Number	Bill Switch	Bill Date	Billed Amount	Balance
_	58843574	Y	04-28-18	14,043.25	1,392.07
_	58922500	Y	06-02-18	56,238.50	5,223.23
_	59251564	Y	06-30-18	28,416.39	5,146.52
_	59550260	Y	07-28-18	4,648.78	4,648.78
_	59838799	N		6,918.81	6,918.81

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
F11=TRAN BAL F13=PMNTSRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT
Tran: ____

pre-petition $16,510.60

JCBB
LCBS
HL

08-28-18
14:27:54
More:

Client Bill Balances List

Client Account: 23350007 Report to Name1: N.W. MISS. REGIONAL MED. CNT.
Corp Account : Bill to Name1 : N.W. MISS. REGIONAL MED. CNT.

O ("O"pen or "A"ll)

Client Balance	Client Payments	Client Adjustments
49,803.14	0.00	0.00

Sel	Bill Number	Bill Switch	Bill Date	Billed Amount	Balance
_	58620599	Y	04-28-18	11,678.33	11,678.33
_	58922539	Y	06-02-18	12,166.93	12,166.93
_	59224324	Y	06-30-18	7,992.40	7,992.40
_	59550297	Y	07-28-18	7,018.55	7,018.55
_	59838848	N		10,946.93	10,946.93

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
F11=TRAN BAL F13=PMNTSRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT
Tran: ____

pre-petition $38,856.21

MIDDLE DISTRICT OF TENNESSEE
Claims Register

3:18-bk-05665 Curae Health Inc.

Judge: Charles M Walker **Chapter:** 11

Office: Nashville **Last Date to file claims:**

Trustee: **Last Date to file (Govt):**

Creditor: (6718283)
LABORATORY CORP OF AMERICA
PO BOX 12140
BURLINGTON, NC 27216-2140

Claim No: 11
Original Filed Date: 09/05/2018
Original Entered Date: 09/05/2018

Status:
Filed by: CR
Entered by: admin
Modified:

Amount claimed: $95394.84

History:

Details 11-1 09/05/2018 Claim #11 filed by LABORATORY CORP OF AMERICA, Amount claimed: $95394.84 (admin)

Description:

Remarks: (11-1) Account Number (last 4 digits):1410

Claims Register Summary

Case Name: Curae Health Inc.
Case Number: 3:18-bk-05665
Chapter: 11
Date Filed: 08/24/2018
Total Number Of Claims: 1

Total Amount Claimed*	$95394.84
Total Amount Allowed*	

*Includes general unsecured claims

The values are reflective of the data entered. Always refer to claim documents for actual amounts.

	Claimed	Allowed
Secured		
Priority		
Administrative		