

Fill in this information to identify the case:

Debtor 1 <u>Curae Health Inc.</u>
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
9/13/2018
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?	<u>Optum360</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____																
3. Where should notices and payments to the creditor be sent?	<table border="0"> <tr> <td style="background-color: #cccccc;">Where should notices to the creditor be sent?</td> <td style="background-color: #cccccc;">Where should payments to the creditor be sent? (if different)</td> </tr> <tr> <td><u>Optum360</u></td> <td>_____</td> </tr> <tr> <td>Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)</td> <td>Name</td> </tr> <tr> <td>Name</td> <td>Name</td> </tr> <tr> <td><u>CDM-ATTN: Bankruptcy 185 Asylum Street 03B Hartford, CT 06103</u></td> <td>Contact phone _____</td> </tr> <tr> <td>Contact phone <u>952-979-6215</u></td> <td>Contact phone _____</td> </tr> <tr> <td>Contact email <u>jayson_ronning@uhc.com</u></td> <td>Contact email _____</td> </tr> <tr> <td>Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____</td> <td></td> </tr> </table>	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)	<u>Optum360</u>	_____	Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Name	Name	Name	<u>CDM-ATTN: Bankruptcy 185 Asylum Street 03B Hartford, CT 06103</u>	Contact phone _____	Contact phone <u>952-979-6215</u>	Contact phone _____	Contact email <u>jayson_ronning@uhc.com</u>	Contact email _____	Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____	
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Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____																	
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____																

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

<p>6. Do you have any number you use to identify the debtor?</p>	<p><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: <u>2640</u></p>
<p>7. How much is the claim?</p>	<p>\$ <u>267.08</u></p> <p>Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).</p>
<p>8. What is the basis of the claim?</p>	<p>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.</p> <p><u>Unpaid invoices for coding materials</u></p>
<p>9. Is all or part of the claim secured?</p>	<p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property.</p> <p>Nature of property: <input type="checkbox"/> Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i>. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Other. Describe: _____</p> <p>Basis for perfection: _____</p> <p>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.)</p> <p>Value of property: \$ _____</p> <p>Amount of the claim that is secured: \$ _____</p> <p>Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)</p> <p>Amount necessary to cure any default as of the date of the petition: \$ _____</p> <p>Annual Interest Rate (when case was filed) _____ %</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Variable</p>
<p>10. Is this claim based on a lease?</p>	<p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition. \$ _____</p>
<p>11. Is this claim subject to a right of setoff?</p>	<p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____</p>

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?	<input checked="" type="checkbox"/> No	
	<input type="checkbox"/> 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.	<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
	<input type="checkbox"/> 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).	\$ _____
	<input type="checkbox"/> 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).	\$ _____
	<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
	<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
	<input type="checkbox"/> 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 9/13/2018
MM / DD / YYYY

/s/ Jayson Ronning

Signature

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

Name Jayson Ronning

First name Middle name Last name

Title Senior Financial Analyst – Bankruptcy

Company UHC/OPTUM360

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

Address 185 Asylum Street 03B

Number Street

Hartford, CT 06103

City State ZIP Code

Contact phone 9529796215 Email jayson_ronning@uhc.com



Optum360 Product Return Address:
 4810 Williamsburg Rd
 Warehouse #2
 Hurlock, MD 21643
 Phone # 1-800-464-3649, Option 1
Federal Tax ID Number: 46-3328307

Invoice : 80012103727

Note: You may receive your invoice prior to receiving your product as this invoice is generated immediately upon shipment of merchandise.

Customer: 0001432369

Bill To: Gilmore Memorial Hospital
 Accounts Payable
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

ShipTo: Amory Regional Medical Ctr
 Receiving Department
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

Invoice Date:	Our Order Number:	Ordered By:	Terms:
10/18/2017	13053218	Mallory Wright	Net 30 Days
Purchase Order Number:	Order Date:	Salesperson:	Shipment Tracking Number:
754-6558573	10/18/2017	417	1ZA8V1410355249716

Quantity		Item #	Description	Unit Price	Discount	Net Amount
Required	Shipped					
1	1	0053	Standard Shipping (Total Order Charge) 1563374781	12.95	0.00	12.95
1	1	ITHS18	ICD-10-CM Expert for Hospitals 2018 (Spiral) 9781622543601	114.95	45.00	63.22
1	1	ITPCS18	ICD-10-PCS Expert 2018 Spiral 9781622543861	114.95	45.00	63.22

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Optum360 60-Day Return Policy

If unsatisfied with purchase, please return within 60 days of shipment. Contact customer service to obtain authorization to return product.

FOB Optum360 warehouse. Title and risk of loss passes to buyer upon delivery to carrier.

NonTaxable Subtotal	0.00
Taxable Subtotal	139.39
Tax	9.77
Total Invoice	149.16
Payments or Credits	0.00
Invoice Balance Due	\$ 149.16

Please detach and remit with payment

Customer # 0001432369

REMITTANCE STUB

Print Date

09/13/2018

***Please make checks payable to Optum360**

****Remittance Address not for Product Returns**

Invoice 80012103727

Bill To: Gilmore Memorial Hospital
 Accounts Payable
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

Invoice \$ 149.16

Please note changes to address above

Amount Enclosed _____
Check # _____

Optum360 Remittance Address:

Optum360
 PO Box 88050
 Chicago, IL 60680-1050

Pay & check your account online at: <https://billpay.optum.com>

For product information, online ordering & credit card payments, visit www.optum360coding.com



Optum360 Product Return Address:
 4810 Williamsburg Rd
 Warehouse #2
 Hurlock, MD 21643
 Phone # 1-800-464-3649, Option 1
Federal Tax ID Number: 46-3328307

Invoice : 80012135551

Note: You may receive your invoice prior to receiving your product as this invoice is generated immediately upon shipment of merchandise.

Customer: 0001432369

Bill To: Gilmore Memorial Hospital
 Accounts Payable
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

ShipTo: Amory Regional Medical Ctr
 Receiving Department
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

Invoice Date: 12/11/2017	Our Order Number: 13053218	Ordered By: Mallory Wright	Terms: Net 30 Days
Purchase Order Number: 754-6558573	Order Date: 12/11/2017	Salesperson: 417	Shipment Tracking Number: 1ZA8V1410358589773

Quantity		Item #	Description	Unit Price	Discount	Net Amount
Required	Shipped					
1	1	CE18	Current Procedural Coding Expert 2018 (Spiral) 9781622543304	104.95	40.00	62.97

Page 1 of 1

Optum360 60-Day Return Policy

If unsatisfied with purchase, please return within 60 days of shipment.
 Contact customer service to obtain authorization to return product.

FOB Optum360 warehouse. Title and risk of loss passes to buyer upon delivery to carrier.

NonTaxable Subtotal	0.00
Taxable Subtotal	62.97
Tax	4.41
Total Invoice	67.38
Payments or Credits	0.00
Invoice Balance Due	\$ 67.38

Please detach and remit with payment

Customer # 0001432369

REMITTANCE STUB

Print Date

09/13/2018

***Please make checks payable to Optum360**

****Remittance Address not for Product Returns**

Invoice 80012135551

Bill To: Gilmore Memorial Hospital
 Accounts Payable
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

Invoice \$ 67.38

Please note changes to address above

Amount Enclosed _____
Check # _____

Optum360 Remittance Address:

Optum360
 PO Box 88050
 Chicago, IL 60680-1050

Pay & check your account online at: <https://billpay.optum.com>

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Optum360 Product Return Address:
 4810 Williamsburg Rd
 Warehouse #2
 Hurlock, MD 21643
 Phone # 1-800-464-3649, Option 1
Federal Tax ID Number: 46-3328307

Invoice : 80012160391

Note: You may receive your invoice prior to receiving your product as this invoice is generated immediately upon shipment of merchandise.

Customer: 0001432369

Bill To: Gilmore Memorial Hospital
 Accounts Payable
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

ShipTo: Amory Regional Medical Ctr
 Receiving Department
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

Invoice Date: 12/21/2017	Our Order Number: 13053218	Ordered By: Mallory Wright	Terms: Net 30 Days
Purchase Order Number: 754-6558573	Order Date: 12/21/2017	Salesperson: 417	Shipment Tracking Number: 1ZA8V1410356791511

Quantity		Item #	Description	Unit Price	Discount	Net Amount
Required	Shipped					
1	1	HS18	HCPCS Level II Expert 2018 (Spiral) 9781622543762	104.95	55.00	47.23

Page 1 of 1

Optum360 60-Day Return Policy

If unsatisfied with purchase, please return within 60 days of shipment.
 Contact customer service to obtain authorization to return product.

FOB Optum360 warehouse. Title and risk of loss passes to buyer upon delivery to carrier.

NonTaxable Subtotal	0.00
Taxable Subtotal	47.23
Tax	3.31
Total Invoice	50.54
Payments or Credits	0.00
Invoice Balance Due	\$ 50.54

Please detach and remit with payment

Customer # 0001432369

REMITTANCE STUB

Print Date

09/13/2018

***Please make checks payable to Optum360**

****Remittance Address not for Product Returns**

Invoice 80012160391

Bill To: Gilmore Memorial Hospital
 Accounts Payable
 1105 Earl Frye Blvd
 Amory, MS 38821-5500
 US

Invoice \$ 50.54

Please note changes to address above

Optum360 Remittance Address:

Optum360
 PO Box 88050
 Chicago, IL 60680-1050

Pay & check your account online at: <https://billpay.optum.com>

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Amount Enclosed	_____
Check #	_____

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):	
<i>Creditor:</i> (6738396)	Claim No: 29	<i>Status:</i>
Optum360	<i>Original Filed</i>	<i>Filed by:</i> CR
CDM-ATTN: Bankruptcy	<i>Date:</i> 09/13/2018	<i>Entered by:</i> admin
185 Asylum Street	<i>Original Entered</i>	<i>Modified:</i>
03B	<i>Date:</i> 09/13/2018	
Hartford, CT 06103		
Amount claimed: \$267.08		

History:

[Details](#) [29-1](#) 09/13/2018 Claim #29 filed by Optum360, Amount claimed: \$267.08 (admin)

Description:

Remarks: (29-1) Account Number (last 4 digits):2640

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*	\$267.08
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		