

Fill in this information to identify the case:

Debtor 1 <u>Clarksdale Regional Medical Center Inc.</u>
Debtor 2 (Spouse, if filing)
United States Bankruptcy Court MIDDLE DISTRICT OF TENNESSEE
Case number: 18-05678

FILED
 U.S. Bankruptcy Court
 MIDDLE DISTRICT OF TENNESSEE
 2/3/2020
 TERESA C. AZAN, Clerk

**Official Form 410
Proof of Claim**

04/19

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>CURAE HEALTH, INC.</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? 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)
	<u>CURAE HEALTH, INC.</u>	_____
	Name	Name
	<u>1721 MIDPARK ROAD, SUITE B200 KNOXVILLE, TN 37921</u>	_____
	Contact phone <u>6626451391</u>	Contact phone _____
	Contact email <u>meri_lindsey@yahoo.com</u>	Contact email _____
	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

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: _____

7. How much is the claim? \$ 357.27
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.
Outpatient medical services

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)?	<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 \$3,025* 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 \$13,650*) 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 4/1/22 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 2/3/2020

MM / DD / YYYY

/s/ Meri Lindsey Hill

Signature

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

Name Meri Lindsey Hill

First name Middle name Last name

Title _____

Company _____

Address PO BOX 471

Number Street

Lyon, MS 38645

City State ZIP Code

Contact phone 6626451391 Email meri_lindsey@yahoo.com

Meri Lindsey Hill

02/03/2020

Po Box 471 Lyon MS 38645

To whom it may concern:

I was billed for outpatient medical services rendered 09/12/2018 at NW MS Medical Center for my daughter (Everly A. Hill). I was an employee of NW MS Medical Center at that time and had health insurance through the hospital for myself and my daughter. I received a bill for said services and began making payments. A total of \$357.27 was paid towards the bill before being notified by the business office at the hospital that I should not have been billed for these services due to being an employee at that time.

Sincerely,

Meri Lindsey Hill

DEMAND BILL

NW MISSISSIPPI MED CTR
 1970 HOSPITAL DRIVE
 CLARKSDALE MS
 38614-0001
 662-627-3211

PATIENT NAME
 HILL EVERLY A

ACCOUNT NO.
 2200219

ADMIT DATE 9/12/18
 DIS. DATE 9/12/18

PAGE
 1

110420 GUARANTOR NAME/ADDR.
 HILL MERI LINDSEY
 P O BOX 471
 154 SIMS COVE
 LYON MS 38645

F/C INS. CO/PLANS
 EI BCBS TN CURAE

POLICY #
 TNC 907451151

CHRG CODE	DESCRIPTION	QTY	UNIT PRICE	AMOUNT	CPT CODE
11/26/18	0000000			624.53CR	
11/26/18	0000001			1177.21CR	
4/03/19	0000000			40.00CR	
4/11/19	0000000			40.00CR	
5/10/19	0000000			77.27CR	
6/10/19	0000000			40.00CR	
6/18/19	0000000			40.00CR	
7/03/19	0000000			40.00CR	
8/05/19	0000000			40.00CR	
9/06/19	0000000			40.00CR	
10/15/19	0000001			397.27	
11/12/19	0000001			397.27CR	
11/12/19	0000001			397.27CR	
9/12/18	4360970	1	1801.74	1801.74	87633
9/12/18	4360982	1	397.27	397.27	87420

** SUMMARY OF CHARGES **
 ** TOTAL CHARGES ** 2199.01
 ** TOTAL PAYMENTS ** 981.80CR
 ** TOTAL ADJUSTMENTS ** 1574.48CR
 ** TOTAL AMOUNT DUE ** 357.27CR

MIDDLE DISTRICT OF TENNESSEE Claims Register

[3:18-bk-05678 Clarksdale Regional Medical Center Inc.](#)

Judge: Charles M Walker **Chapter:** 11
Office: Nashville **Last Date to file claims:**
Trustee: **Last Date to file (Govt):**
Creditor: (6729245) **Claim No: 58** *Status:*
CURAE HEALTH, INC. *Original Filed* *Filed by:* CR
1721 MIDPARK ROAD, SUITE *Date:* 02/03/2020 *Entered by:* admin
B200 *Original Entered* *Modified:*
KNOXVILLE, TN 37921 *Date:* 02/03/2020

Amount claimed: \$357.27

History:

[Details](#) [58-1](#) 02/03/2020 Claim #58 filed by CURAE HEALTH, INC., Amount claimed: \$357.27 (admin)

Description:

Remarks:

Claims Register Summary

Case Name: Clarksdale Regional Medical Center Inc.
Case Number: 3:18-bk-05678
Chapter: 11
Date Filed: 08/24/2018
Total Number Of Claims: 1

Total Amount Claimed*	\$357.27
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		