EXHIBIT B

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
5/1/2019
TERESA C. AZAN, Acting 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?**
   UnitedHealthcare Insurance Company
   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)
UnitedHealthcare Insurance Company	
Name	Name
ATTN: CDM/Bankruptcy 185 Asylum Street − 03B Hartford, CT 06103	
Contact phone 952−979−6215	Contact phone
Contact email jayson_ronning@uhc.com	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) 15 Filed on 09/05/2018
   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: 4755

7. **How much is the claim?** $ 7122.95

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.

Claims overpayments that have not been properly reimbursed.

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 $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).	$
	☐ 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).	$
	☐ 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 4/1/22 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 5/1/2019
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: UnitedHealthcare Insurance Company
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

May 1, 2019

Clarksdale Regional Medical Center, Inc.

Chpt. 11 Bankruptcy
Filed: 8/24/18 | Case No. 18-05678

Reservation of Rights:
UnitedHealthcare Insurance Company ("United") reserves its right to amend this claim to further liquidate the amount of overpayment owed by the Debtor to United based on the results of United's ongoing audit of claims submitted by the Debtor.

Provider Tin	Provider Name	State	Date of Service	Amount of Claim Paid by UHC	Claim Audit Amount	Balance Due	Collection Description
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	GA	2018	$3,217.60	$1,256.74	$1,256.74	Claim should have allowed $1256.74 for observation services. Total claim allowable for outpatient services = $1960.86.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	GA	2018	$3,400.72	$3,400.72	$3,400.72	Member had primary coverage through Medicare for this date of service. Please submit claim to Medicare for reimbursement.
815064755	NORTHWEST MISSISSIPPI MEDICAL	GA	2018	$6,095.00	$2.75	$2.75	Please refund -Corrected bill submitted
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	GA	2018	$2,122.60	$235.64	$235.64	Claim should have allowed $1256.74 for observation services. Total claim allowable for outpatient services = $1886.96.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	GA	2018	$252.11	$252.11	$252.11	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	GA	2018	$276.18	$276.18	$276.18	Services provided after Member Coverage End Date.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	GA	2018	$48.56	$48.56	$48.56	Services provided after Member Coverage End Date.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2018	$574.06	$20.65	$20.65	Incorrect contract rate applied. Claim should have allowed $553.41 for all services.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2018	$328.75	$328.75	$328.75	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2018	$283.36	$283.36	$283.36	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2017	$266.32	$266.32	$266.32	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2018	$229.02	$229.02	$229.02	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2018	$221.20	$221.20	$221.20	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2018	$92.41	$92.41	$92.41	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.

815064755	NORTHWEST MISSISSIPPI MEDICAL CE	MS	2018	$208.54	$208.54	$208.54	Member had primary coverage through Medicare for this date of service. Please submit claim to Medicare for reimbursement.

Total Balance Due UHC	**$7,122.95**