Fill in this information to identify the case:

Debtor 1: Fayette Memorial Hospital Association, Inc.

Debtor 2 (Spouse, if filing):

United States Bankruptcy Court for the: Southern District of Indiana, Indianapolis Division

Case number: 18-07762-JJG-11

E-Filed on 06/20/2019
Claim # 204

Modified 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?**

Franciscan Physician Network
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)
Hospital Reimbursement Services: Donna Name	Franciscan Physician Network Name
250 Parkway Drive Ste 160 Number Street	PO Box 781076 Number Street
Lincolnshire IL 60069 City State ZIP Code	Detroit IN 48278 City State ZIP Code
Contact phone (847) 403-5862	Contact phone (847) 403-5862
Contact email Donna.Schlenker@franciscanalliance.o	Contact email Donna.Schlenker@franciscanalliance.o

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: ____ ____ ____ ____

7. **How much is the claim?** $ 603.00 . **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 health care information.

_____

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.** $ 0.00

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)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check one:*

	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).	$ 0.00
☐ 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).	$ 0.00
☐ 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).	$ 0.00
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$ 0.00
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$ 0.00
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$ 0.00

* 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.

13. **Is all or part of the claim entitled to administrative priority pursuant to 11 U.S.C. § 503(b)(9)?**

☑ No

☐ Yes. **Indicate the amount of your claim arising from the value of any goods received by the Debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.** $ 0.00

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 06/20/2019
MM / DD / YYYY

Donna Schlenker
Signature

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

Name: Donna Schlenker
First name | Middle name | Last name

Title: Account Manager

Company: Hospital Reimbursement Services for Franciscan Physicians Netwk
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address
Number Street

City | State | ZIP Code

Contact phone | Email

Attachment 1 - Franciscan Physician Network JS HRS 18-229073 PHI REDACTED.pdf
Description - Unpaid Medical bill for physician all patient data redacted per HIPAA

18-229073

SIHO
PO BOX 1787

COLUMBUS, IN 47202

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE [redacted] SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [X] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street) [redacted]
CITY [redacted] STATE [redacted]	8. RESERVED FOR NUCC USE	CITY [redacted] STATE [redacted]
ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]		ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]
9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER FAYHSP
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH [redacted] SEX M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State) [ ]	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME MANAGED CARE-SIHO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06 20 2019

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DNRUXANDRA C IONESCU	17a. 17b. NPI 1093905408	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 11 28 2017 TO 12 01 2017
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 000
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. J9601 B. C3490 C. Z66 D. Z7189 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 180704

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 28 17	21		99223	25	ABCD	353.00	1		ZZ	363LF0000X
									NPI	1497276257
2 11 28 17	21		99356		ABCD	250.00	1		ZZ	363LF0000X
									NPI	1497276257
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC use
[redacted] [X]	E277675032	[X] YES [ ] NO	$ 603.00	$ 0.00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (866) 903-0436
STEPHANIE M STIERS NP	ST FRANCIS HOSPITAL INDPLS	FRANCISCAN PHYSICIAN NETWORK
	8111 S EMERSON	PO BOX 781076
	INDIANAPOLIS IN 46237-8106	DETROIT MI 48278-1076
SIGNED 06 20 DATE 2019	a. 1225327984 b.	a. 1225327984 b. 611630276

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FRANCISCAN ALLIANCE
28044 NETWORK PLACE

CHICAGO, IL 60673-1280
Ph:(866)903-0436

Account ID
1888766

Guarantor Name & Address
[redacted]

Visit ID
24504886

Detailed Bill For

Patient Name: [redacted]
Account Class: Inpatient
Attending Physician:
Location: FRANCISCAN HEALTH INDIANAPOLIS

Total Charges: 2,331.00
Service Date From: 11/28/2017
Service Date To: 12/01/2017

Charges

Service Date	Cost Ctr.	Rev. Code	Proc. Code	Description	Qty.	Amount
Professional Charges						
11/28/17			99223	INITIAL HOSPITAL CARE/DA	1	353.00
11/28/17			99356	PROLONGED SERVICE I/P RE	1	250.00
11/29/17			99233	SBSQ HOSPITAL CARE/DAY	1	182.00
11/30/17			99233	SBSQ HOSPITAL CARE/DAY	1	182.00
11/30/17			99356	PROLONGED SERVICE I/P RE	1	250.00
11/30/17			99357	PROLONGED SVC I/P REQ UN	3	750.00
12/01/17			99233	SBSQ HOSPITAL CARE/DAY	1	182.00
11/29/17			99233	SBSQ HOSPITAL CARE/DAY	1	182.00
Total professional charges:						2,331.00

Payments

Post Date	Recd. From	Amount
Professional Payments		
04/25/18	MANAGED CARE	-147.72
04/25/18	MANAGED CARE	-666.85
04/25/18	MANAGED CARE	0.00
04/25/18	MANAGED CARE	-147.72
Total professional payments:	these charges were not paid	-962.29

Adjustments

Post Date	Adj. For	Amount
Professional Adjustments		
04/25/18	MANAGED CARE	-34.28
04/25/18	MANAGED CARE	-361.38
04/25/18	MANAGED CARE	-119.49

04/25/18	MANAGED CARE	-34.28
04/25/18	MANAGED CARE	-34.28
Total professional adjustments:		-583.71
Total balance:		785.00