Fill in this information to identify the case:

Debtor 1 [redacted] Fayette Memorial Hospital Association

Debtor 2 (Spouse, if filing) _____

United States Bankruptcy Court for the: Southern District of Indiana

Case number 18-07762-JJG

RECEIVED
SEP 23 2019
BMC GROUP

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?**
   Diana Hummel
   Name of the current creditor (the person or entity to be paid for this claim)
   Other names the creditor used with the debtor (National Jewish Health, Voice Clinic of Indiana)

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?
   Diana Hummel
   Name
   2841 Heathfield Ln
   Number Street
   Richmond IN 47374
   City State ZIP Code
   Contact phone 812-491-1749
   Contact email dh29@evansville.edu

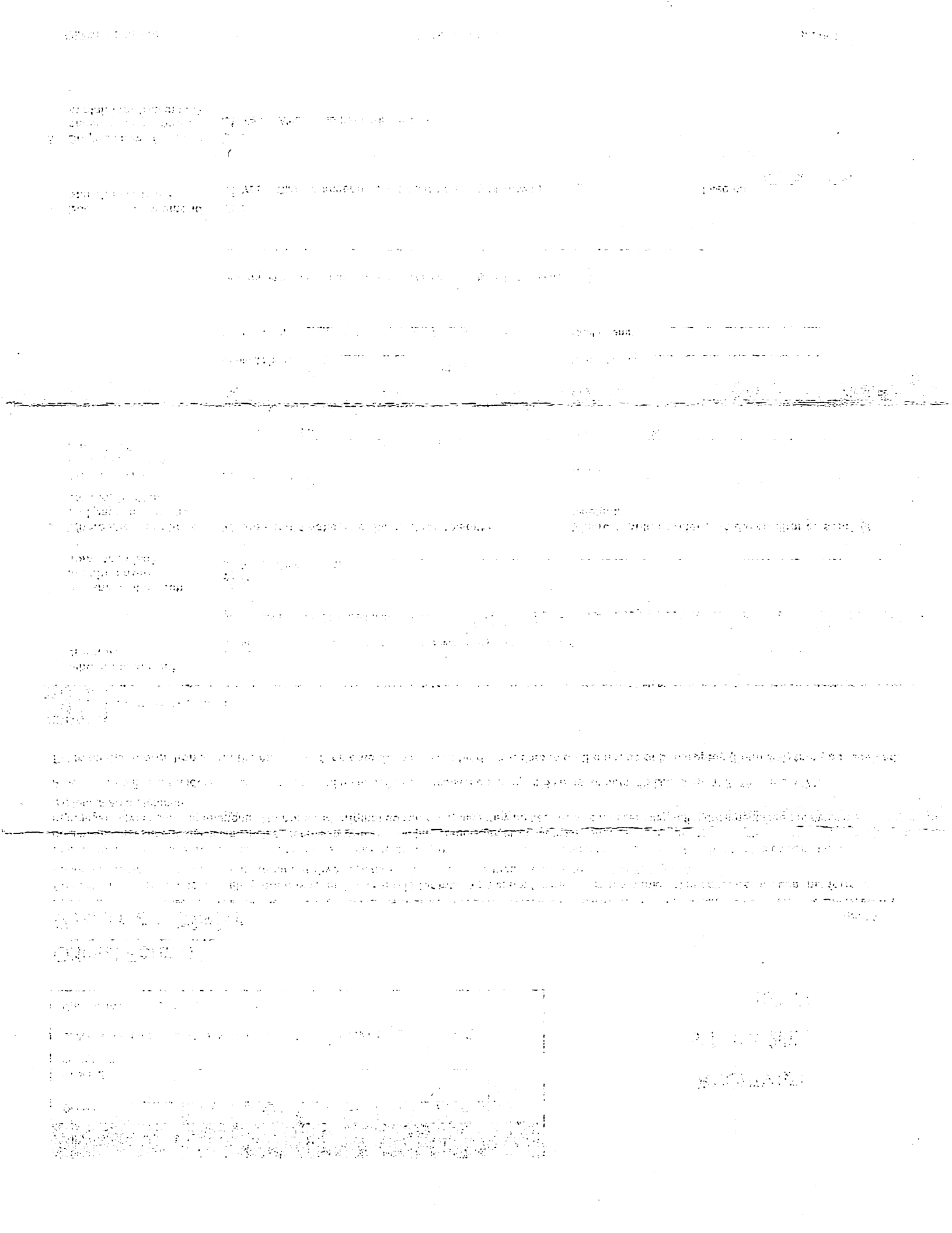
   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Contact phone _____
   Contact email _____

   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? _____

FMHA POC
00224



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: 8 9 3 4

   Name on Insurance husband - 3575

7. **How much is the claim?** $ 15,203.41 775.94. **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.

   Medical expenses that should have been paid by hospital with insurance that they neglected to pay

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)?**

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).	$_____
☐ 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 09 / 17 / 2019
MM / DD / YYYY

Diana Hummel
Signature

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

Name: Diana (First name) Marie (Middle name) Hummel (Last name)

Title:

Company:
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 2841 Heathfield Ln
Number Street
Richmond IN 47374
City State ZIP Code

Contact phone: 812-491-1749 Email: dh29@evansville.edu

Print | Save As... | Add Attachment | Reset

PROOF OF CLAIM FILING INFORMATION FOR

FAYETTE MEMORIAL HOSPITAL ASSOCIATION, INC.

CASE NO. 18-07762-JJG

US BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF INDIANA

Debtor Name	Case Number
Fayette Memorial Hospital Association	18-07762-JJG

General Bar Date: June 12, 2019

General Administrative Bar Date: June 12, 2019

Governmental Bar Date: June 12, 2019

You may file your claim online at: www.bmcgroup.com/fmha (click on File A Claim tab) or send completed Proof of Claim to:

If by regular mail:

BMC Group, Inc.
Attn: FMHA Claims Processing
PO Box 90100
Los Angeles, CA 90009

If by messenger or overnight delivery

BMC Group, Inc.
Attn: FMHA Claims Processing
3732 West 120th Street
Hawthorne, CA 90250

Our hospital (employer) told us to wait to submit these claims. I am hoping it is not too late. I had met major medical last year and these should have been paid. I have been making payments to keep things okay, but would like it settled. Thanks.

Diana Hummel

National Jewish Health
PO BOX 17379
DENVER, CO 80217-0379

SUMMARY OF SERVICES

DATE	01/16/2019
PATIENT	DIANA M HUMMEL
MEDICAL RECORD	107-95-09

SERVICE CHARGES
$15,568.41

INSURANCE PAYMENTS/ADJ.
$305.00

PATIENT PAYMENTS
$0.00

0-30 Days	31-60 Days	60+ Days
$15,263.41	$0.00	$0.00

PAY ONLINE
www.nationaljewish.org/mychart

For QUESTIONS or to arrange financial assistance call
855-715-1792 or 303-532-3735

AMOUNT DUE NOW
$15,263.41

WAYS TO PAY ...

www.nationaljewish.org/paymybill
855-715-1792 or 303-532-3735
By mail, return stub below

www.nationaljewish.org/healthinfo

Please be aware:

- You may have received services from a National Jewish Health physician while at another facility or location.
- National Jewish Health is a hospital facility and the physicians are employees of the hospital. Therefore, in adition to a specialty physician co-payment, a hospital co-payment, deductible, and/or co-insurance may apply. If you have any questions about your financial responsibility, please contact your insurance carrier.

Thank you for choosing National Jewish for your healthcare needs.

If you need assistance, we offer Payment Plans and a Financial Assistance Program to eligible patients.

If you would like to discuss these options or have questions about your account, please call Patient Accounts at 855-715-1792 or 303-532-3735.

Gracias por haber escogido National Jewish para sus necesidades al cuidado de su salud.

Si necesita ayuda, le ofrecemos Planes de Pago y Programa de Asistencia Financiera a pacientes elegibles.

Si quisiera discutir estas opciones ó si tiene preguntas respecto a su cuenta, por favor de llamar a la Cuenta de Pacientes al 855-715-1792 o al 303-532-3735.

6687607569

PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION

DATE 01/16/2019
PATIENT DIANA M HUMMEL
MEDICAL RECORD # 107-95-09

ACCOUNT DETAILS

Accounts: 0 - 30 Days

ACCOUNT NUMBER	SERVICE DESCRIPTION	AMOUNT
1003141892	For Your Medical Services: 08/08/2018-08/15/2018	
	Facility: NJH Campus	
	Primary Insurance: SELF PAY	
	ALLERGY TESTING	$910.00
	CARDIOLOGY TESTING	$2,050.00
	FACILITY AND NURSING SERVICES	$750.00
	LAB SERVICES	$1,833.41
	MEDICAL SUPPLIES	$330.00
	OTHER DIAGNOSTIC SERVICES	$60.00
	OTHER DIAGNOSTIC/TREATMENT SERVICES	$1,585.00
	PHARMACY AND INFUSION SERVICES	$50.00
	PHYSICIAN SERVICES	$2,040.00
	PULMONARY FUNCTION TESTING	$1,445.00
	RADIOLOGY	$3,700.00
	REHABILITATION SERVICES	$720.00
	RESPIRATORY SERVICES	$95.00
	Total Medical Charges	$15,568.41
	Insurance Payments and Adjustments	$305.00
	Patient Payments	$0.00
	Amount Due	**$15,263.41**

THE VOICE CLINIC LLC
PO BOX 790126 DEPT. 8008
ST. LOUIS, MO 63179-0126
PERSONAL & CONFIDENTIAL

ADDRESS SERVICE REQUESTED

005578
0102

10066689.co1 1003 2210066689
Stmt Date: 06/25/2019

DIANA HUMMEL
2841 HEATHFIELD LN
RICHMOND, IN 47374-6695

IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NUMBER | VERIFICATION #

CARDHOLDER NAME | EXP. DATE

SIGNATURE

ACCOUNT NUMBER	DUE DATE	Amount Due	AMOUNT PAID
71970	07/10/2019	$775.94	

THE VOICE CLINIC LLC
PO BOX 790126 DEPT. 8008
ST. LOUIS, MO 63179-0126

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

TO ENSURE PROPER CREDIT, DETACH AND RETURN TOP PORTION IN THE ENCLOSED ENVELOPE.

655086B (PC1)

Page	Statement Date	Due Date	Office Phone Number	Account #	Patient Balance
2 of 2	06/25/2019	07/10/2019	(317) 744-2855	71970	$775.94

Date	Visit Detail	Explanation of Activity	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
		Visit Total				**$180.00**
Voucher: 571540						
10/11/2018	92507	Individual Speech Thera	$195.00			
10/11/2018	31579	Laryngoscopy Flx/Rgd Fi	$575.00			
02/21/2019	000004264	Commercial Insurance Pa			-$282.06	
02/21/2019	000004264	Commercial Insurance Ad			-$292.94	
06/25/2019	billing pt	Commercial Insurance Pa			$0.00	
06/25/2019	billing pt	Commercial Insurance Ad			-$134.53	
06/25/2019	billing pt	Commercial Insurance Tr				
		Visit Total				**$60.47**

MESSAGE

You can now PAY ONLINE.Go to www.voiceindy.com. Click Click Here to Pay Now"

THE VOICE CLINIC LLC
PO BOX 790126 DEPT. 8008
ST. LOUIS, MO 63179-0126

Account Number 71970
Billing Inquiries (317) 744-2855

Amount Due **$775.94**

2738-ALLST7-245089-1311673945-P. 6537235-1-3. 30821819-2. 2

THE VOICE CLINIC LLC
PO BOX 790126 DEPT. 8008
ST. LOUIS, MO 63179-0126
PERSONAL & CONFIDENTIAL

ADDRESS SERVICE REQUESTED

005578
0202

10066689.co1 1003 2210066689
Stmt Date: 06/25/2019

DIANA HUMMEL
2841 HEATHFIELD LN
RICHMOND, IN 47374-6695

IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NUMBER | VERIFICATION #

CARDHOLDER NAME | EXP. DATE

SIGNATURE

ACCOUNT NUMBER	DUE DATE	Amount Due	AMOUNT PAID
71970	07/10/2019	Continued	

THE VOICE CLINIC LLC
PO BOX 790126 DEPT. 8008
ST. LOUIS, MO 63179-0126

$37 1946

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

TO ENSURE PROPER CREDIT, DETACH AND RETURN TOP PORTION IN THE ENCLOSED ENVELOPE.

655086B (PC1)

Page	Statement Date	Due Date	Office Phone Number	Account #	Patient Balance
1 of 2	06/25/2019	07/10/2019	(317) 744-2855	71970	$775.94

Date	Visit Detail	Explanation of Activity	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
Patient: Diana Hummel						
Voucher: 557050						
09/13/2018	99204	Office Outpt New Level	$315.00			
09/13/2018	31579	Laryngoscopy Flx/Rgd Fi	$575.00			
09/27/2018	V025519	Co-pay credit card			-$30.00	
06/25/2019	reduced to	Commercial Insurance Ad			-$373.00	
06/25/2019	reduced to	Commercial Insurance Ad			-$158.00	
06/25/2019	reduced to	Commercial Insurance Tr				
		Visit Total				**$329.00**
Voucher: 571520						
09/27/2018	92524	Non-Instrumental Evalua	$235.00			
09/27/2018	92507	Individual Speech Thera	$195.00			
06/25/2019	reduced to	Commercial Insurance Ad			-$284.00	
06/25/2019	reduced to	Commercial Insurance Tr				
		Visit Total				**$146.00**
Voucher: 571530						
10/04/2018	92507	Individual Speech Thera	$195.00			
02/21/2019	000004264	Commercial Insurance Pa			$0.00	
06/25/2019	reduced to	Commercial Insurance Ad			-$134.53	
06/25/2019	reduced to	Commercial Insurance Tr				
		Visit Total				**$60.47**
Voucher: 571500						
10/05/2018	91034	Esoph G-Esop Rflx Ncath	$445.00			
10/05/2018	A4557	Lead Wires	$295.00			
06/25/2019	reduced to	Commercial Insurance Ad			-$295.00	
06/25/2019	reduced to	Commercial Insurance Pa			$0.00	
06/25/2019	reduced to	Commercial Insurance Ad			-$265.00	
06/25/2019	reduced to	Commercial Insurance Tr				

MESSAGE

You can now PAY ONLINE.Go to www.voiceindy.com. Click Click Here to Pay Now"

THE VOICE CLINIC LLC
PO BOX 790126 DEPT. 8008
ST. LOUIS, MO 63179-0126

Account Number 71970
Billing Inquiries (317) 744-2855

Amount Due Continued

2738-ALLST7-245089-1311673945-P. 6537235-1-3; 30821819-2: 1