# ADMINISTRATIVE EXPENSE CLAIM FORM
## Debtor: Fayette Memorial Hospital Association, Inc., Case No. 18-07762-JJG-11

**NOTE: This form should only be used to make a claim for an Administrative Expense arising or accruing from May 1, 2019 through August 31, 2019 ONLY.**

**Name of Creditor (The person or other entity to whom the debtor owes money or property):** Dallas A. Holmes

☐ **Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.**

**Name and address where notices should be sent:**
1809 Virginia Ave.
Connersville, IN., 47331 OR

☑ **Check box if you have never received any notices from the bankruptcy court in this case.**

**Name and address where payment should be sent (if different):**
SIHO
P.O. Box 1787
Columbus, IN., 47202
800-443-2980
800-553-6027

☐ **Check box if the address differs from the address on the envelope sent to you by the court.**

**Telephone number:** 765.825.0735 / 765.265.3286

RECEIVED
SEP 23 2019
BMC GROUP

**Last four digits of account or other number by which creditor identifies debtor:** CASE 18-07762-JJG-11 - Doc 536

**1. Basis for Administrative Claim**

- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☐ Personal injury/wrongful death
- ☐ Taxes
- ☑ Other Unpaid Medical Bills

☐ **Retiree benefits as defined in 11 U.S.C. § 1114(a)**

☐ **Wages, salaries, and compensation (fill out below)**
**Last four digits of your SS #:**
**Unpaid compensation for services performed**
**from** _____ (date) **- to** _____ (date)

**2. Date(s) debt was incurred:** 08/06/18; 08/03/18; 10/09/18; 06/23/18

**3. If court judgment, date obtained:**

**4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $** 23,503.00 + 77,000.00 = 100,503.00 TOTAL
ST. Vincent Hospital (Per SIHO)

**If all or part of your claim is secured, also complete Item 5 below.**

☐ **Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.**

**5. Please identify the property of the Debtor that secures the claim.**

**Description of Property:** _____

**Basis for Perfection:** _____

**Value of Property:** _____

**6. Offsets, Credits and Setoffs:**

☐ **All Payments made on this claim by the Debtor have been credited and deducted from the amount claimed herein**

☐ **This claim is not subject to any setoff or counterclaim.**

☐ **This claim is subject to setoff or counterclaim as follows:**

**7. This Administrative Proof of Claim:**

☐ **is the first filed proof of claim evidencing the claim asserted herein.**

☑ **amends/supplements a proof of claim** _____ **filed on** _____ **or** 06.12.2019

☐ **replaces/suspends a proof of claim filed on** _____.

**8. Assignment**

☐ **If the claimant has obtained this claim by Assignment, a copy is attached hereto.**

**9. Supporting Documentation:**

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.

**Date:** 09.13.19

**Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):**
Dallas G. Holmes, Dallas A. Holmes

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.

**UNITED STATES BANKRUPTCY COURT**
**SOUTHERN DISTRICT OF INDIANA**
**INDIANAPOLIS DIVISION**

| | | |
|---|---|---|
| IN RE: | ) | |
| | ) | Case No. 18-07762-JJG-11 |
| FAYETTE MEMORIAL HOSPITAL | ) | |
| ASSOCIATION, INC. d/b/a FAYETTE | ) | |
| REGIONAL HEALTH SYSTEMS, | ) | |
| Debtor. | ) | |
| | ) | |

**NOTICE OF DEADLINE FOR FILING ADMINISTRATIVE CLAIMS ARISING DURING THE PERIOD BETWEEN MAY 1, 2019 AND AUGUST 31, 2019**

PLEASE TAKE NOTICE. The United States Bankruptcy Court for the Southern District of Indiana, Indianapolis Division, has entered an Order Establishing Claims Bar Date (the "**Bar Date Order**") setting **October 18, 2019** (the "**Claims Bar Date**") as the deadline for all persons and entities, including individuals, partnerships, corporations, estates, trusts and governmental units (except those persons and entities described below), who have or may have any claim against Fayette Memorial Hospital Association, Inc., d/b/a Fayette Regional Health Systems (the "**Debtor**") that arose **during the period between May 1, 2019 and August 31, 2019** to file a request for allowance and/or payment of such claim pursuant to 11 U.S.C. § 503 (an "**Administrative Expense Claim**").

Pursuant to 11 U.S.C. § 503, "after notice and a hearing, there shall be allowed, administrative expenses, other than claims allowed under section 502(f) of [title 11], including – the actual, necessary costs and expenses of preserving the estate. . ."

Any person or entity asserting an Administrative Expense Claim against the Debtor's bankruptcy estate shall file such claim on or before the Claims Bar Date. Each proof of claim must substantially conform to the **Administrative Proof of Claim Form attached to this Notice**. Proofs of Claim may be filed by sending them to Debtor's Claims Agent, BMC Group, Inc., either: (1) by regular mail to BMC Group, Inc., Attn: FMHA Claims Processing, PO Box 90100, Los Angeles, CA 90009 or (2) by messenger or overnight delivery to BMC Group, Inc., Attn: FMHA Claims Processing, 3732 West 120th Street, Hawthorne, CA 90250, **so as to be RECEIVED on or before October 18, 2019.** Facsimile, email or other electronic submission will not be accepted. Proofs of claim shall be deemed filed when actually received by BMC Group, Inc. Timely filed proofs of claim that are entitled to prima facie validity will be deemed allowed unless and until objected to by the Debtor or other party in interest. Should an objection be filed, you will receive notice and an opportunity to respond.

If you have previously filed an Administrative Expense Claim with the Bankruptcy Court seeking allowance and/or payment of a claim against the Debtor, or if the Bankruptcy Court has entered an order allowing or otherwise resolving your claim against the Debtor, you do NOT need to file anything further unless you have an additional or different claim.



**ANY PERSON OR ENTITY THAT IS REQUIRED TO FILE A CLAIM ON OR BEFORE THE CLAIMS BAR DATE, BUT FAILS TO DO SO, MAY BE FOREVER BARRED, ESTOPPED AND ENJOINED FROM (A) ASSERTING ANY SUCH CLAIM AGAINST THE DEBTOR AND/OR ITS BANKRUPTCY ESTATE AND (B) RECEIVING PAYMENT FROM THE DEBTOR'S ESTATE OR A DISTRIBUTION ON ACCOUNT OF SUCH CLAIM UNDER ANY PLAN CONFIRMED IN THIS CASE.**

**YOUR RIGHTS MAY BE AFFECTED BY THIS NOTICE** and you should read these papers carefully and consult with your attorney. If you do not have an attorney, you may wish to consult one.

Dated: September 6, 2019

*/s/ Wendy D. Brewer*

Wendy D. Brewer (#22669-49)
FULTZ MADDOX DICKENS PLC
333 N. Alabama Street, Ste. 350
Indianapolis, IN 46204
Tel: (317) 215-6220
E-Mail: wbrewer@fmdlegal.com

-and-

Laura M. Brymer (#30989-10)
FULTZ MADDOX DICKENS PLC
101 S. Fifth Street, Ste. 2700
Louisville, KY 40202
Tel: (502) 588-2000
E-mail: lbrymer@fmdlegal.com
*Attorneys for the Debtor*

**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

Case number: 18-7762-JJG-11

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?**

   Dallas A. Holmes
   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?**

   Dallas A. Holmes
   Name

   1809 Virginia Ave.
   Number Street

   Connersville, IN. 47331
   City State ZIP Code

   Contact phone 765.265.3286

   Contact email dallasaholmese Comcast.net

   **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? _____

**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: ____ ____ ____ ____

   TAX-ID / EIN - 35-0900741 / Case # 18-07762-JJG-11

7. **How much is the claim?** $ 23,503.00 . **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.

   Unpaid Medical Expenses

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 $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 4/01/22 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 06 / 12 / 2019
MM / DD / YYYY

Dallas A. Holmes
Signature

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

Name: Dallas (First name) A. (Middle name) Holmes (Last name)

Title: Out Patient Therapist

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

Address: 1809 Virginia Ave
Number Street

Connersville, IN 47331
City State ZIP Code

Contact phone: 765.265.3286

Email: dallasaholmes@comcast.net
dallash@fayetteregional.org

# AmeriPath

## REQUEST FOR PAYMENT

STATEMENT



### IMPORTANT MESSAGE

Your physician chose Ameripath to diagnose and interpret the lab/pathology specimen collected at the time of your physician and /or hospital visit. Professional and Technical Services are in addition to those billed by your physician and /or hospital. Any amount not covered by your insurance is your responsibility. If the insurance information below is inaccurate or incomplete, please contact us at 800-890-6220. The CPT codes provided are based on AMA guidelines and without regard to specific payor requirements.

### PATIENT INFORMATION

| | |
|---|---|
| Patient Name | DALLAS HOLMES |
| Account Number | UM39 26947958 |

### INSURANCE INFORMATION

| | |
|---|---|
| Primary Insurance | SIHO |
| Name of Insured | DALLAS HOLMES |
| Policy Number | XXXXX2201 |
| Insured Date of Birth | 03/26/XX |
| Secondary Insurance | None on file |
| Name of Insured | |
| Policy Number | |
| Insured Date of Birth | |

### QUESTIONS

For **automated payment options** 24 hours a day please call: **800-890-6220**

Billing questions or inquiries please call: **800-890-6220**
Mon - Thurs **8:30am - 5:00pm** CST, Fri **9:00am - 4:00pm** CST

### ACCOUNT SUMMARY

| DATE | INVOICE # | DESCRIPTION | CPT-MOD | ACTIVITY | PATIENT BALANCE |
|---|---|---|---|---|---|
| | 62047936323 | REFERRING PHYSICIAN: GOODRICH MD,SARAH KAY | | | |
| 08/06/18 | | PATH CONS DURNG SU | 88331-26 x 1 | 306.00 | |
| 04/30/19 | | SIHO PAYMENT | | 0.00 | |
| | | CONTRACTUAL ADJUST | | 0.00 | |
| | | INVOICE BALANCE | | | 306.00 |
| | | EXPENSES INCURRED AFTER COVERAGE TERMINATED | | | |
| | 62047936324 | REFERRING PHYSICIAN: GOODRICH MD,SARAH KAY | | | |
| 08/06/18 | | IMHISTOCHEM/CYTCHM | 88341-26 x 3 | 363.00 | |
| 08/06/18 | | IMHISTOCHEM/CYTCHM | 88342-26 x 1 | 121.00 | |
| 04/30/19 | | SIHO PAYMENT | | 0.00 | |
| | | CONTRACTUAL ADJUST | | 0.00 | |
| | | INVOICE BALANCE | | | 484.00 |

Continued on Next Page

### ONLINE CREDIT CARD PAYMENT (Lab Code = AMP)

To pay online by credit card, visit [illegible] select [illegible] then click on [illegible]

PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

AmeriPath

P.O. BOX 619003 • EL DORADO HILLS, CA 95762-9003

Called 06.12.19 Valerie 4055 months

AB 01 000902 61843 B 3 A

DALLAS HOLMES
1809 VIRGINIA AVE
CONNERSVILLE IN 47331-2831

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

**Please write your account # on your check.**
**Make your check payable to the address below.**

| DUE DATE | STATEMENT DATE | ACCOUNT # |
|---|---|---|
| | 06/04/19 | UM39 26947958 |

AMOUNT BEING PAID

$2,021.00 $

To pay by check, please indicate the amount being paid and place check in the enclosed envelope.

**TO PAY ONLINE, WE ACCEPT THE FOLLOWING CREDIT CARDS:**

VISA DISCOVER

Website: AmeriPath.com/PayMyBill Phone: [illegible]

AMERIPATH INDIANAPOLIS
AMERIPATH INDIANAPOLIS PO
PO BOX 740975
CINCINNATI OH 45274-0975

01UM39000026947958002021000604 19DALLASOHOLMES0000000000008

ST VINCENT HEALTH

# Your Account Status

Southeastern IN Health Org notified us that you were not covered under their plan. This balance is your responsibility. If this is incorrect, contact your insurer.

| | |
|---|---|
| Charges | $17,157.00 |
| Previous Payments & Credits | $0.00 |
| **Payment Due Upon Receipt** | **$17,157.00** |

## PROFESSIONAL FEES

Charges for services rendered by a provider, such as an examination or explanation of results.

Patient Name: Dallas Holmes | Provider Name: Janet Rippy, MD | Service Location: ST VINCENT HOSPITAL

- 11.58

| Date | Description | Charge Status | Charges | Payments/ Credits | Patient Balance |
|---|---|---|---|---|---|
| 08/03/2018 | ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS: INTERPRETATION AND R | | $48.00 | | |
| 02/02/2019 | Insurance Company: Southeastern IN Health Org | Not Elig | | $0.00 | |
| | *Patient Balance - Misc.* | | | | $48.00 |

Patient Name: Dallas Holmes | Provider Name: Sarah Goodrich, MD | Service Location: ST VINCENT HOSPITAL

- 1,4079.91

| Date | Description | Charge Status | Charges | Payments/ Credits | Patient Balance |
|---|---|---|---|---|---|
| 08/06/2018 | TLH WITHOUT 250G OR LESS | | $4,608.00 | | |
| 02/02/2019 | Insurance Company: Southeastern IN Health Org | Not Elig | | $0.00 | |
| | *Patient Balance - Misc.* | | | | $4,608.00 |
| 08/06/2018 | LAPAROSCOPY BILATERAL TOTAL PELVIC LYMPHADENECTOMY | | $3,651.00 | | |
| 02/02/2019 | Insurance Company: Southeastern IN Health Org | Not Elig | | $0.00 | |
| | *Patient Balance - Misc.* | | | | $3,651.00 |
| 08/06/2018 | CYSTOURETHROSCOPY | | $591.00 | | |
| 02/02/2019 | Insurance Company: Southeastern IN Health Org | Not Elig | | $0.00 | |
| | *Patient Balance - Misc.* | | | | $591.00 |

Patient Name: Dallas Holmes | Provider Name: Wendy M Fodstad PA-C | Service Location: ST VINCENT HOSPITAL

- 210.04

| Date | Description | Charge Status | Charges | Payments/ Credits | Patient Balance |
|---|---|---|---|---|---|
| 08/06/2018 | TLH WITHOUT 250G OR LESS | | $4,608.00 | | |
| 02/02/2019 | Insurance Company: Southeastern IN Health Org | Not Elig | | $0.00 | |
| | *Patient Balance - Misc.* | | | | $4,608.00 |
| 08/06/2018 | LAPAROSCOPY BILATERAL TOTAL PELVIC LYMPHADENECTOMY | | $3,651.00 | | |
| 02/02/2019 | Insurance Company: Southeastern IN Health Org | Not Elig | | $0.00 | |
| | *Patient Balance - Misc.* | | | | $3,651.00 |

$8,259

Any dispute regarding this statement or any amounts due must be submitted in writing to:
P.O. Box 19000, Belfast, ME 04915-4085
Submitting payment in an amount less than the total on this statement shall not constitute an offer to settle any dispute regardless of any action, duty, or communication

## >IMPORTANT INFORMATION

THANK YOU FOR YOUR BUSINESS. PLEASE SEND YOUR PAYMENT WITHIN 10 DAYS.

IF YOU'VE SENT PAYMENT IN FULL, PLEASE ACCEPT OUR THANKS

FOR PROFESSIONAL PATHOLOGY SERVICES RENDERED AT CYTOMETRY SPECIALISTS INC.



## >PATIENT INFORMATION

| | |
|---|---|
| Patient Name | HOLMES,DALLAS A |
| Your Physician | TOLNAY,GABOR L |
| Account Number | 063258749 |
| Original account# | 378279/CSIG |

## >INSURANCE INFORMATION

| | |
|---|---|
| PRIMARY | |
| Insurance Name | SIHO |
| Name of Insured | HOLMES,DALLAS A |
| Policy Number | 00069482201 |
| SECONDARY | |
| Insurance Name | None on file |
| Policy Number | |

## >QUESTIONS?

Billing questions or changes to insurance coverage? Please contact Patient Accounts at 1-800-274-2158
Monday - Friday 9:00AM-7:00PM

## >CREDIT CARD

TO PAY YOUR BILL ONLINE, PLEASE VISIT HTTPS://PAYYOURBILL.APSMEDBILL.COM

## >ACCOUNT SUMMARY

| | | | |
|---|---|---|---|
| 06/23/18 | IMMUNOHISTO ANTB ADDL SLIDE | 88341-59x10 | 2300.00 |
| 06/23/18 | IMMUNOHISTO ANTB 1ST STAIN | 88342-59x2 | 540.00 |
| 06/23/18 | TUMOR IMMUNOHISTOCHEM/MANUAL | 88360-59x2 | 700.00 |
| 06/27/18 | MICROSLIDE CONSULTATION | 88323 | 320.00 |
| | Balance Due | | 3860.00 |

Called -
ON 04.02.19
- Said Coding
Issue

**THIS IS YOUR BALANCE: $3860.00 -**

THANK YOU FOR YOUR PROMPT PAYMENT!

- 1,248.00
6.23.18
- Next Bill -
$2,440.00 -
1,136.00 -
NO DEDUCTIBLE

MAKE CHECKS PAYABLE TO

CYTOMETRY SPECIALISTS INC.
5700 SOUTHWYCK BLVD
TOLEDO,OH 43614-1509

| STATEMENT DATE | PAY THIS AMOUNT | ACCOUNT NUMBER |
|---|---|---|
| 03/26/19 | 3860.00 | 063258749 |
| SHOW AMOUNT PAID HERE $ | PASS CODE | CSIG |

* FORWARDING SERVICE REQUESTED
ADDRESSEE

DALLAS A HOLMES
1809 VIRGINIA AVE
CONNERSVILLE IN 47331-2831

REMIT TO

CYTOMETRY SPECIALISTS INC.
5700 SOUTHWYCK BLVD
TOLEDO,OH 43614-1509

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

Please detach and return this portion with payment.

6100 W 96TH ST
STE 125
INDIANAPOLIS, IN 46278

1 / 2

| | |
|---|---|
| **Statement Date** | 02/12/19 |
| **Account Number** | 46978 |
| **Payment Due Date** | 02/26/19 |
| **Pay This Amount** | **$5667.00** |

Billing Questions? Call (866) 771-5257 or (317) 715-1800

Dallas A Holmes
1809 VIRGINIA AVE
CONNERSVILLE, IN 47331-2831

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Language assistance available: Español, Kreyol Ayisien, Tiếng Việt, Português, 中文, français, Tagalog, русский, عربي, Italiano, Deutsche , 한국어, Polskie, Gujarati, ኣማ, 日本語, سرائی

## STATEMENT - CANCER CARE GROUP PC

| Date | Description | Amount | Insurance Balance | Patient Balance | Balance |
|---|---|---|---|---|---|
| **10/09/18** | **ENCOUNTER 459234 FOR DALLAS WITH LIEBROSS MD, ROBERT** | | | | |
| 10/05/18 | 99205 - OFFICE/OUTPATIENT VISIT, NEW | 465.00 | | 465.00 | |
| | **ENCOUNTER TOTAL** | **465.00** | | **465.00** | **465.00** |
| **10/17/18** | **ENCOUNTER 460196 FOR DALLAS WITH DUGAN MD, THOMAS** | | | | |
| 10/12/18 | 57156 - INSERTION OF VAGINAL RAD AFTERLOAD APP FOR BRACHY | 320.00 | | 320.00 | $ 181.87 |
| 10/12/18 | 7777026 - HDR INTERSTITIAL INTRACAVITARY 1 CHANNEL | 425.00 | | 425.00 | |
| | **ENCOUNTER TOTAL** | **745.00** | | **745.00** | ***745.00*** |
| **10/17/18** | **ENCOUNTER 460197 FOR DALLAS WITH TUMATI MD, VASU** | | | | |
| 10/10/18 | 77263 - RADIATION THERAPY PLANNING | 496.00 | | 496.00 | |
| 10/10/18 | 7747026 - PROF SPECIAL RADIATION TREATMENT | 395.00 | | 395.00 | |
| 10/10/18 | 57156 - INSERTION OF VAGINAL RAD AFTERLOAD APP FOR BRACHY | 320.00 | | 320.00 | |
| 10/10/18 | 7777026 - HDR INTERSTITIAL INTRACAVITARY 1 CHANNEL | 425.00 | | 425.00 | |
| 10/10/18 | 7731626 - PROF BRACHY ISODOSE PLAN SIMPLE | 445.00 | | 445.00 | |
| | **ENCOUNTER TOTAL** | **2081.00** | | **2081.00** | **2081.00** |
| **10/23/18** | **ENCOUNTER 460764 FOR DALLAS WITH DUGAN MD, THOMAS** | | | | |
| 10/17/18 | 57156 - INSERTION OF VAGINAL RAD AFTERLOAD APP FOR BRACHY | 320.00 | | 320.00 | |
| 10/17/18 | 7777026 - HDR INTERSTITIAL INTRACAVITARY 1 CHANNEL | 425.00 | | 425.00 | |

Please pay your balance as indicated at the bottom of this statement. Thank you for your prompt payment
Mon-Thur 8am-5:00pm Friday 8am-4:30pm

PLEASE DETACH AT THE PERFORATION AND MAIL THIS PORTION WITH YOUR PAYMENT

Please check box if above address is incorrect or if insurance information is on back and indicate changes or reverse.

VISA ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

CARD NUMBER | CID CODE | AMOUNT PAID

SIGNATURE | EXP DATE

NAME: Dallas A Holmes

STATEMENT ID: 69547835

| AMOUNT DUE | ACCOUNT NUMBER | PAYMENT DUE DATE |
|---|---|---|
| $5667.00 | 46978 | 02/26/19 |

**Cancer Care Group is pleased to announce Bill Payment online; please go to:**

**https://patients.availity.com/**

**Statement ID: 69547835**
**Access Code: 2E2160**

Please remit payments to:
CANCER CARE GROUP
DEPT 78725
PO BOX 78000
DETROIT, MI 48278-0725

DIDN'T PAY
Robert -
LIEBROSS -
MD

SIHO INSURANCE SERVICES

**Fayette Regional Health**
**Group #: FAYHSP**
**ID#: 00069482201**
**DALLAS A HOLMES**

RXBIN 017274
RXPCN PDMI
RXGRP 99993054

TrueScripts
Rx Help Desk 855-326-2159
Mbr Scv 844-257-1955

Copays: Deductible then Gen $10/ Pref $30/ Non-Pref 30% Coinsurance

**Benefit Networks**

Fayette Regional

SIHO INSURANCE SERVICES

800 443 2980
www.siho.org

Copays: HSA - 0% After Deductible

**Claims Submission**

EDI Route #: 77153
EDI Contact: 888.372.2808

Mail: SIHO
PO Box 1787
Columbus, IN 47202

**Out of Area**

To locate a participating PHCS network provider when out-of-area please call 888.779.7427 or visit www.multiplan.com

PHCS

Member/Provider Services:
Toll Free : 800.443.2680
Local : 812.378.7070
Website : www.siho.org
Email : MemberServices@siho.org

Precertification is required for certain inpatient, outpatient and pharmacy services. Call SIHO to precertify.

Possession of this card confers no rights to benefits except as described in the Health Plan under which it was issued.