FIVE POINTS HEA
6006 N MESA ST SUITE
EL PASO RECEIVED 79912

JUN 03 2024

HEALTH INSURANCE CLAIM FORM

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

Dynamic Tool- RBP-EE

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 MM DD YY 06 25 1962 SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street) SAME
CITY EL PASO STATE TX	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE 79936 TELEPHONE (Include Area Code) 915)474-1464		ZIP CODE TELEPHONE (Include Area Code) ( )
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
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES X NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME FIVE POINTS HEA
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.

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.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNATURE ON FILE
SIGNED DATE

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

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
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN AMAKIRI,ONYEMA E	17a. OTH379 17b. NPI 1811166721	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0 A. Z0000 B. Z13228 C. Z130 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24A. 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	02 09 24	02 09 24	81		83036		ABC	81 68	1		NPI	1790721538
2	02 09 24	02 09 24	81		84403		ABC	217 77	1		NPI	1790721538
3	02 09 24	02 09 24	81		80061		ABC	162 91	1		NPI	1790721538
4	02 09 24	02 09 24	81		82607		ABC	132 40	1		NPI	1790721538
5	02 09 24	02 09 24	81		36415		ABC	35 00	1		NPI	1790721538
6	02 09 24	02 09 24	81		84153		ABC	163 33	1		NPI	1790721538

25. FEDERAL TAX I.D. NUMBER SSN EIN 38-2084239 X	26. PATIENT'S ACCOUNT NO. 7229704413R	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 793 09	29. AMOUNT PAID $	30. Rsvd for NUCC Use
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.) ROBIN M. CLARK SIGNED 05/04/2024 DATE	32. SERVICE FACILITY LOCATION INFORMATION QUEST DIAGNOSTICS DALLAS 4770 REGENT BLVD IRVING TX 75063 a. 1790721538 b.	33. BILLING PROVIDER INFO & PH # 800-326-4756 QUEST DIAGNOSTIC PO BOX 822510 PHILADELPHIA PA 19182 a. 1790721538 b. 382084239			

$1349.58

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

002*7361

CLIENT # 10091407 LAB # 0000122 ACCSN # DZ065871JC DAL899 15841

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

007479 2/3

FIVE POINTS HEA
6006 N MESA ST SUITE
EL PASO TX 79912

CARRIER

HEALTH INSURANCE CLAIM FORM

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

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 [redacted] (For Program in Item 1)
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5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
CITY EL PASO STATE TX	8. RESERVED FOR NUCC USE
ZIP CODE 79936 TELEPHONE (Include Area Code) (915)474-1464	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO X PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
7. INSURED'S ADDRESS (No., Street) SAME	
CITY STATE	
ZIP CODE TELEPHONE (Include Area Code) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME FIVE POINTS HEA	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, complete items 9, 9a, and 9d.	

PATIENT AND INSURED INFORMATION

007479 3/3

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18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
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	23. PRIOR AUTHORIZATION NUMBER

1241

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 02 09 24	02 09 24	81		80050		ABC	290 47	1		NPI	1790721538
2 02 09 24	02 09 24	81		82306		ABC	266 02	1		NPI	1790721538
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 38-2084239	SSN EIN X	26. PATIENT'S ACCOUNT NO. 7229704413R	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO
28. TOTAL CHARGE $ 556 49	29. AMOUNT PAID $	30. Rsvd for NUCC Use	
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.) ROBIN M. CLARK SIGNED 05/04/2024 DATE	32. SERVICE FACILITY LOCATION INFORMATION QUEST DIAGNOSTICS DALLAS 4770 REGENT BLVD IRVING TX 75063 a. 1790721538 b.	33. BILLING PROVIDER INFO & PH # (800)326-4756 QUEST DIAGNOSTIC PO BOX 822510 PHILADELPHIA PA 19182 a. 1790721538 b. 382084239	

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

00217351

CLIENT # 10091407 LAB # 0000122 ACCSN # DZ065871JC DAL899 15842

FIVEPOINTS
BENEFIT PLANS, LLC
6006 N Mesa Street - Suite 108
El Paso, TX 79912

Explanation of Benefits (EOB)
This statement shows how we applied your coverage to claim(s) submitted to us.
This is NOT a Bill

[redacted]
El Paso, TX 79936

Dynamic Tool Company Inc	RBP - EE	
Effective From: 6/1/2023	To:	CURRENT

Explanation of Benefits (EOB)

Patient Name: [redacted]
Issue Date: 6/5/2024

Member I.D.# [redacted]

Date of Service	Service Code	Total Charges	Allowed Charges	Savings to Member	Medicare Rate Plus 1.25%	*Co-Pay	Payment Responsibility	
							Plan	Member
2/9/2024	4	$1,349.59	$119.35	$1,349.59	$0.00	$20.00	$99.35	$20.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
						Five Points Plan Responsibility		$99.35
						Member Responsibilty		$20.00

Provider Billing Address:	Quest Diagnostic P.O. BOX 822510 Philadelphia, PA 19182

Service Codes	Description:
1 - MEDICAL	CLAIM PAID IN FULL: *The client is responsible for Co-Payment at the time of service. After repricing through the First Health Network, the client is responsible for 0% of the allowed amount and Five Points Benefit Plan is responsible for the remaining 100%.
2 - HOSPITAL	
3 - ER	
4 - LABS	
5 - IMAGING	

Please see attached repricing sheet for specific CPT Codes in Service

Member I.D. Number - your account # with our health plan
Total Charges - The total amount charged by a healthcare provider for services you received, whether or not the services are covered under your health plan.
First Health Network Allowed Charges - The amount receiving services from First Health Network provider within the network provider PPO.
Amount by Member & Five Points Health Plans, LLC - The amount paid to your health care provider.
Co-Insurance- The amount calculated using a fixed percentage you pay.
Amount not covered- The portion of the charges not covered under your health plan. Examples of Amount Not Covered include any of the following:
* Amount for services that are not medically necessary.
* Amount for services that are not covered by your health plan.
Member Responsibility - Your share for the services shown on this Explanation of Health Care Benefits (EOB). You may have already paid this amount to your health care provider.

Thank you for choosing Five Points Health Benefit Plans, LLC

Have questions?

Please email norman@fivepointsmecplan.com or iris@fivepointsmecplan.com. To find a participating provider call our customer service department at **915-803-4198** or visit our website www.fivepointshealthbenefits.com

Mail all inquiries or claims to Five Points Health Benefit Plans, LLC 6006 N Mesa Street - Suite 108 El Paso, TX 79912

If you need assistance in Spanish to understand this document, you may request it for free by calling customer service.

FIVE POINTS BENEFIT PLANS, LLC
6006 NORTH MESA STREET SUITE 108
EL PASO TX 79912
(915) 803-4198

Group:THE COMPANY STORE Rcpt Dt:06-05-2024

PATIENT INFORMATION FH INFORMATION
LAST : [redacted] TYPE: Outpatient CLIENT # :997667466
FIRST : [redacted] MI: FROM: 02-09-2024 CLIENT ID:KZU
DOB : 06-25-1962 SEX:M RL: THRU: 02-09-2024 CONTROL #:4-157-R-00216-01
INSD ID: [redacted] CLAIM #: 224-157-R-000216-001
PT SSN : PT CTRL:

PROVIDER INFORMATION NPI: FTIN:382084239
FACILITY/OFFICE: QUEST DIAGNOSTICS NM
PO BOX 822510
PHILADELPHIA PA 19182-

LINE	DATES OF SERVICE	PROCEDURE CODE	MOD	UNIT	BILLED CHARGES	NEGOTIATED RATE	SAVINGS
001	02-09-2024 02-09-2024	83036		001	81.68	8.19	73.49
002	02-09-2024 02-09-2024	84403		001	217.77	22.18	195.59
003	02-09-2024 02-09-2024	80061		001	162.91	9.60	153.31
004	02-09-2024 02-09-2024	82607		001	132.40	12.95	119.45
005	02-09-2024 02-09-2024	36415		001	35.00	0.00	35.00
006	02-09-2024 02-09-2024	84153		001	163.33	15.80	147.53
007	02-09-2024 02-09-2024	80050		001	290.47	25.20	265.27
008	02-09-2024 02-09-2024	82306		001	266.02	25.43	240.59
TOTALS:					1349.58	119.35	1230.23

SVC
LIN CODE DESCRIPTION
005 PODN REIMBURSEMENT NOT SUPPORTED BY CONTRACT

<continued>

FIVE POINTS BENEFIT PLANS, LLC
6006 NORTH MESA STREET SUITE 108
EL PASO TX 79912
(915) 803-4198

Group:THE COMPANY STORE Rcpt Dt:06-05-2024

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DOB : 06-25-1962 SEX:M RL: THRU: 02-09-2024 CONTROL #:4-157-R-00216-01
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PT SSN : PT CTRL:

PROVIDER INFORMATION NPI: FTIN:382084239
FACILITY/OFFICE: QUEST DIAGNOSTICS NM
PO BOX 822510
PHILADELPHIA PA 19182-

LINE	DATES OF SERVICE	PROCEDURE CODE	MOD	UNIT	BILLED CHARGES	NEGOTIATED RATE	SAVINGS

BILLED CHARGES	1349.58
EXCLUDED AMOUNT	0.00
NEGOTIATED RATE	119.35
TOTAL SAVINGS	1230.23

RECEIVED
MAR 1 1 2024

FIVE POINTS BEN
6006 N MESA ST STE 1
EL PASO TX 79912

HEALTH INSURANCE CLAIM FORM

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

PICA G&E Industrial RBP-EE PICA

CARRIER

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 [redacted] (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted]	11 15 1960 M X F	SAME
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
[redacted]	Self X Spouse Child Other	SAME
CITY: EL PASO	STATE: TX	8. RESERVED FOR NUCC USE	CITY	STATE
ZIP CODE: 79925	TELEPHONE (Include Area Code): (915) 252-1560		ZIP CODE	TELEPHONE (Include Area Code): ( )
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
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: FIVE POINTS BEN
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.

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14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE MM DD YY / QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN CHABRA, SANJAY	17a. I27810 / 17b. NPI 1316916125	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. M2550 B. R768 C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

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 02 14 24	02 14 24	81		85652		AB	40 83	1		NPI	1790721538
2 02 14 24	02 14 24	81		84550		AB	47 01	1		NPI	1790721538
3 02 14 24	02 14 24	81		36415		AB	35 00	1		NPI	1790721538
4 02 14 24	02 14 24	81		86140		AB	82 91	1		NPI	1790721538
5 02 14 24	02 14 24	81		80074		AB	551 86	1		NPI	1790721538
6 02 14 24	02 14 24	81		80050		AB	290 47	1		NPI	1790721538

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
38-2084239	X	6985626193R	X YES NO	$ 1048 08	$	

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 # (800) 326-4756
ROBIN M. CLARK	QUEST DIAGNOSTICS DALLAS 4770 REGENT BLVD IRVING TX 75063	QUEST DIAGNOSTIC PO BOX 822510 PHILADELPHIA PA 19182
SIGNED 03/02/2024 DATE	a. 1790721538	b. 1790721538 382084239

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

006926 8/12

7339

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0021736

CLIENT # 10400838 LAB # 0036566 ACCSN # DZ123811JC DAL899 12805

FIVE POINTS BEN
6006 N MESA ST STE 1
EL PASO TX 79912

HEALTH INSURANCE CLAIM FORM

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PICA PICA

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1 MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) X

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4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME

5. PATIENT'S ADDRESS (No., Street) [redacted]

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7. INSURED'S ADDRESS (No., Street) SAME

CITY EL PASO STATE TX

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE 79925 TELEPHONE (Include Area Code) (915) 252-1560

ZIP CODE TELEPHONE (Include Area Code) ( )

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a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

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 FIVE POINTS BEN

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN CHABRA, SANJAY

17a. I27810

17b. NPI 1316916125

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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A M2550 B R768 C D E F G H I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

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1 02 14 24	02 14 24	81		82306		AB	266 02	1		NPI	1790721538
2 02 14 24	02 14 24	81		86480		AB	369 97	1		NPI	1790721538
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 38-2084239 X

26. PATIENT'S ACCOUNT NO. 6985626193R

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 635 99

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

ROBIN M. CLARK

SIGNED 03/02/2024 DATE

32. SERVICE FACILITY LOCATION INFORMATION

QUEST DIAGNOSTICS DALLAS
4770 REGENT BLVD
IRVING TX 75063
a 1790721538

33. BILLING PROVIDER INFO & PH # (800) 326-4756

QUEST DIAGNOSTIC
PO BOX 822510
PHILADELPHIA PA 19182
a 1790721538 b 382084239

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

006928 9/12

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

00217361

CLIENT # 10400838 LAB # 0036566 ACCSN # DZ123811JC DAL899 12806

FIVE POINTS BEN
6006 N MESA ST STE 1
EL PASO TX 79912

CARRIER

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) ☐ (Medicaid#) ☐ (ID#/DoD#) ☐ (Member ID#) ☐ (ID#) ☐ (ID#) ☒ (ID#)	[redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE MM DD YY: 11 15 1960 SEX: M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street): SAME	
CITY: EL PASO	STATE: TX
8. RESERVED FOR NUCC USE	
CITY	STATE
ZIP CODE: 79925	TELEPHONE (Include Area Code): (915) 252-1560
ZIP CODE	TELEPHONE (Include Area Code): ( )
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	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒
a. INSURED'S DATE OF BIRTH MM DD YY / SEX: M ☐ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State): YES ☐ NO ☒
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ☐ NO ☒
c. INSURANCE PLAN NAME OR PROGRAM NAME: FIVE POINTS BEN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ 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.
SIGNATURE ON FILE
SIGNED DATE

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY / QUAL	15. OTHER DATE MM DD YY / QUAL	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN CHABRA, SANJAY	17a. I27810 / 17b. NPI 1316916125	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMAION (Designated by NUCC)		20. OUTSIDE LAB? YES ☒ NO ☐ / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0: A M2550 B R768 C D E F G H I J K L		22. RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

	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	02 14 24	02 14 24	81		86038		AB	92 80	1		NPI	1780620526
2	02 14 24	02 14 24	81		86160		AB	232 64	2		NPI	1780620526
3	02 14 24	02 14 24	81		86147		AB	107 53	1		NPI	1780620526
4	02 14 24	02 14 24	81		86147	59	AB	107 53	1		NPI	1780620526
5	02 14 24	02 14 24	81		86147	59	AB	107 53	1		NPI	1780620526
6	02 14 24	02 14 24	81		86376		AB	137 35	1		NPI	1780620526

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
38-2084239	☐	☒	6985626193R	☒ YES ☐ NO	$ 785 38	$	

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 # (800)326-4756
ROBIN M. CLARK	QUEST DIAGNOSTICS/NICHOLS 33608 ORTEGA HWY SAN JUAN CAPIST CA 92675	QUEST DIAGNOSTIC PO BOX 822510 PHILADELPHIA PA 19182
SIGNED 03/02/2024 DATE	a 1780620526	a 1790721538 b 382084239

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

006928 10/12

7340

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

00217351

CLIENT # 10400838 LAB # 0036566 ACCSN # DZ123811JC DAL899 12807

FIVE POINTS BEN
6006 N MESA ST STE 1
EL PASO TX 79912

HEALTH INSURANCE CLAIM FORM

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

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 [redacted] (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE 11 15 1960 SEX M X F
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
CITY EL PASO STATE TX	8. RESERVED FOR NUCC USE
ZIP CODE 79925 TELEPHONE (Include Area Code) (915) 252-1560	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)

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.
SIGNATURE ON FILE
SIGNED DATE

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
7. INSURED'S ADDRESS (No., Street) SAME	
CITY STATE	
ZIP CODE TELEPHONE (Include Area Code) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME FIVE POINTS BEN	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.	

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE MM DD YY QUAL.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN CHABRA,SANJAY	17a. I27810 17b. NPI 1316916125
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M2550 B. R768 C. D. E. F. G. H. I. J. K. L.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
	20. OUTSIDE LAB? YES X NO $ CHARGES
	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	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	02 14 24	02 14 24	81		86200		AB	150 96	1		NPI	1780620526
2	MUTATED CITRULLINATE 02 14 24	02 14 24	81		83520		AB	146 34	1		NPI	1780620526
3	RHEUMATOID FACTOR (I 02 14 24	02 14 24	81		83520	59	AB	71 76	1		NPI	1780620526
4	RHEUMATOID FACTOR (I 02 14 24	02 14 24	81		83520	59	AB	71 76	1		NPI	1780620526
5	RHEUMATOID FACTOR (I 02 14 24	02 14 24	81		83520	59	AB	71 76	1		NPI	1780620526
6	02 14 24	02 14 24	81		86146		AB	147 66	1		NPI	1780620526

25. FEDERAL TAX I.D. NUMBER 38-2084239	SSN EIN X	26. PATIENT'S ACCOUNT NO. 6985626193R	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE $ 660 24	29. AMOUNT PAID $	30. Rsvd for NUCC Use

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.) ROBIN M. CLARK SIGNED 03/02/2024 DATE	32. SERVICE FACILITY LOCATION INFORMATION QUEST DIAGNOSTICS/NICHOLS 33608 ORTEGA HWY SAN JUAN CAPIST CA 92675 a. 1780620526 b. 1790721538	33. BILLING PROVIDER INFO & PH # (800) 326-4756 QUEST DIAGNOSTIC PO BOX 822510 PHILADELPHIA PA 19182 a. b. 382084239

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

0021735

CARRIER

PATIENT AND INSURED INFORMATION

006928 11/12

PHYSICIAN OR SUPPLIER INFORMATION

CLIENT # 10400838 LAB # 0036566 ACCSN # DZ123811JC DAL899 12808

FIVE POINTS BEN
6006 N MESA ST STE 1
EL PASO TX 79912

HEALTH INSURANCE CLAIM FORM

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

PICA

1 MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X		1a. INSURED'S I.D. NUMBER [redacted] (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]	3. PATIENT'S BIRTH DATE MM DD YY 11 15 1960 SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME	
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street) SAME	
CITY EL PASO STATE TX	8. RESERVED FOR NUCC USE	CITY STATE	
ZIP CODE 79925 TELEPHONE (Include Area Code) (915)252-1560		ZIP CODE TELEPHONE (Include Area Code) ( )	
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	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES X NO	b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME FIVE POINTS BEN	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO 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.
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SIGNED DATE

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

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 DN CHABRA,SANJAY	17a. I27810 17b. NPI 1316916125	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMAION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M2550 B. R768 C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO 23. PRIOR AUTHORIZATION NUMBER

	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	02 14 24	02 14 24	81		86146	59	AB	147 66	1		NPI	1780620526
2	02 14 24	02 14 24	81		86146	59	AB	147 65	1		NPI	1780620526
3	FLUORESCENT AB 02 14 24	02 14 24	81		86255		AB	142 30	1		NPI	1780620526
4	SJOGREN'S ANTIBODY (02 14 24	02 14 24	81		86235		AB	1095 93	9		NPI	1780620526
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 38-2084239 X	26. PATIENT'S ACCOUNT NO. 6985626193R	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 1533 54	29. AMOUNT PAID $ 1463.23
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.) ROBIN M. CLARK SIGNED 03/02/2024 DATE	32. SERVICE FACILITY LOCATION INFORMATION QUEST DIAGNOSTICS/NICHOLS 33608 ORTEGA HWY SAN JUAN CAPIST CA 92675 a. 1780620526 b.	33. BILLING PROVIDER INFO & PH # (800)326-4756 QUEST DIAGNOSTIC PO BOX 822510 PHILADELPHIA PA 19182 a. 1790721538 b. 382084239		

CARRIER

PATIENT AND INSURED INFORMATION

006928 12/12

PHYSICIAN OR SUPPLIER INFORMATION

7341

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

00217351

CLIENT # 10400838 LAB # 0036566 ACCSN # DZ123811JC DAL899 12809

FIVEPOINTS
BENEFIT PLANS, LLC
6006 N Mesa Street - Suite 108
El Paso, TX 79912

Explanation of Benefits (EOB)
This statement shows how we applied your coverage to claim(s) submitted to us.
This is **NOT** a Bill

[redacted]
El Paso, TX 79925

G & E Industrial Supplies Inc	RBP - EE	
Effective From: 1/1/2023	**To:**	CURRENT

Explanation of Benefits (EOB)

Patient Name: [redacted]
Issue Date: 4/23/2024

Member I.D.# [redacted]

Date of Service	Service Code	Total Charges	Allowed Charges	Savings to Member	Medicare Rate Plus 1.25%	*Co-Pay	Payment Responsibility	
							Plan	Member
2/14/2024	4	$4,663.23	$539.58	$4,643.23	$0.00	$20.00	$519.58	$20.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
				$0.00			$0.00	$0.00
						Five Points Plan Responsibility		**$519.58**
						Member Responsibilty		**$20.00**

Provider Billing Address:	Quest Diagnostic P.O. BOX 822510 Philadelphia, PA 19182

Service Codes	Description:
1 - MEDICAL	This Claim was Repriced using Referenced Based Pricing, providers who provide services to this member agree to 1.25% over the Medicare Rate with no balance billing.
2 - HOSPITAL	
3 - ER	
4 - LABS	
5 - IMAGING	

Please see attached repricing sheet for specific CPT Codes in Service

Member I.D. Number - your account # with our health plan
Total Charges - The total amount charged by a healthcare provider for services you received, whether or not the services are covered under your health plan.
First Health Network Allowed Charges - The amount receiving services from First Health Network provider within the network provider PPO.
Amount by Member & Five Points Health Plans, LLC - The amount paid to your health care provider.
Co-Insurance- The amount calculated using a fixed percentage you pay.
Amount not covered- The portion of the charges not covered under your health plan. Examples of Amount Not Covered include any of the following:
* Amount for services that are not medically necessary.
* Amount for services that are not covered by your health plan.
Member Responsibility - Your share for the services shown on this Explanation of Health Care Benefits (EOB). You may have already paid this amount to your health care provider.

Thank you for choosing Five Points Health Benefit Plans, LLC

Have questions?

Please email norman@fivepointsmecplan.com or elena@fivepointsmecplan.com. To find a participating provider call our customer service department at **1-800-785-1830 / 915-803-4198** or visit our website www.fivepointshealthbenefits.com

Mail all inquiries or claims to Five Points Health Benefit Plans, LLC 6006 N Mesa Street - Suite 108 El Paso, TX 79912

If you need assistance in Spanish to understand this document, you may request it for free by calling customer service.

FIVE POINTS BENEFIT PLANS, LLC
6006 NORTH MESA STREET SUITE 108
EL PASO TX 79912
(915) 803-4198

Group:THE COMPANY STORE Rept Dt:04-23-2024

PATIENT INFORMATION FH INFORMATION

LAST : [redacted] TYPE: Outpatient CLIENT # :997667466
FIRST : [redacted] MI: FROM: 02-14-2024 CLIENT ID:KZU
DOB : 11-15-1960 SEX:M RL: THRU: 02-14-2024 CONTROL #:4-114-R-00245-05
INSD ID: [redacted] CLAIM #: 224-114-R-000245-005
PT SSN : PT CTRL:

PROVIDER INFORMATION NPI: FTIN:382084239
FACILITY/OFFICE: QUEST DIAGNOSTICS TX
PO BOX 822510
PHILADELPHIA PA 19182-

LINE	DATES OF SERVICE	PROCEDURE CODE	MOD	UNIT	BILLED CHARGES	NEGOTIATED RATE	SAVINGS
001	02-14-2024 02-14-2024	85652		001	40.83	2.33	38.50
002	02-14-2024 02-14-2024	84550		001	47.01	3.87	43.14
003	02-14-2024 02-14-2024	36415		001	35.00	0.00	35.00
004	02-14-2024 02-14-2024	86140		001	82.91	4.45	78.46
005	02-14-2024 02-14-2024	80074		001	551.86	37.40	514.46
006	02-14-2024 02-14-2024	80050		001	290.47	25.20	265.27
007	02-14-2024 02-14-2024	82306		001	266.02	25.43	240.59
008	02-14-2024 02-14-2024	86480		001	369.97	51.36	318.61
009	02-14-2024 02-14-2024	86038		001	92.80	10.38	82.42
010	02-14-2024 02-14-2024	86160		002	232.64	20.64	212.00

<continued>

FIVE POINTS BENEFIT PLANS, LLC
6006 NORTH MESA STREET SUITE 108
EL PASO TX 79912
(915) 803-4198

Group:THE COMPANY STORE Rcpt Dt:04-23-2024

PATIENT INFORMATION FH INFORMATION

LAST : [redacted] TYPE: Outpatient CLIENT # :997667466
FIRST : [redacted] MI: FROM: 02-14-2024 CLIENT ID:KZU
DOB : 11-15-1960 SEX:M RL: THRU: 02-14-2024 CONTROL #:4-114-R-00245-05
INSD ID: [redacted] CLAIM #: 224-114-R-000245-005
PT SSN : PT CTRL:

PROVIDER INFORMATION NPI: FTIN:382084239
FACILITY/OFFICE: QUEST DIAGNOSTICS TX
PO BOX 822510
PHILADELPHIA PA 19182-

LINE	DATES OF SERVICE	PROCEDURE CODE	MOD	UNIT	BILLED CHARGES	NEGOTIATED RATE	SAVINGS
011	02-14-2024 02-14-2024	86147		001	107.53	22.72	84.81
012	02-14-2024 02-14-2024	86147	59	001	107.53	22.72	84.81
013	02-14-2024 02-14-2024	86147	59	001	107.53	22.72	84.81
014	02-14-2024 02-14-2024	86376		001	137.35	12.49	124.86
015	02-14-2024 02-14-2024	86200		001	150.96	11.12	139.84
016	02-14-2024 02-14-2024	83520		001	146.34	12.39	133.95
017	02-14-2024 02-14-2024	83520	59	001	71.76	12.39	59.37
018	02-14-2024 02-14-2024	83520	59	001	71.76	12.39	59.37
019	02-14-2024 02-14-2024	83520	59	001	71.76	12.39	59.37
020	02-14-2024 02-14-2024	86146		001	147.66	22.72	124.94

<continued>

FIVE POINTS BENEFIT PLANS, LLC
6006 NORTH MESA STREET SUITE 108
EL PASO TX 79912
(915) 903-4198

Group:THE COMPANY STORE Rcpt Dt:04-23-2024

PATIENT INFORMATION FH INFORMATION

LAST : [redacted]
FIRST : [redacted] MI: TYPE: Outpatient CLIENT # :997667466
DOB : 11-15-1960 SEX:M RL: FROM: 02-14-2024 CLIENT ID:KZU
INSD ID: [redacted] THRU: 02-14-2024 CONTROL #:4-114-R-00245-05
PT SSN : CLAIM #: 224-114-R-000245-005
PT CTRL:

PROVIDER INFORMATION NPI: FTIN:382084239
FACILITY/OFFICE: QUEST DIAGNOSTICS TX
PO BOX 922510
PHILADELPHIA PA 19182-

LINE	DATES OF SERVICE	PROCEDURE CODE	MOD	UNIT	BILLED CHARGES	NEGOTIATED RATE	SAVINGS
021	02-14-2024 02-14-2024	86146	59	001	147.66	22.72	124.94
022	02-14-2024 02-14-2024	86146	59	001	147.65	22.72	124.93
023	02-14-2024 02-14-2024	86255		001	142.30	10.34	131.96
024	02-14-2024 02-14-2024	86235		009	1095.93	138.69	957.24
TOTALS:					4663.23	539.58	4123.65

SVC
LIN CODE DESCRIPTION
003 PODN REIMBURSEMENT NOT SUPPORTED BY CONTRACT

BILLED CHARGES	4663.23
EXCLUDED AMOUNT	0.00
NEGOTIATED RATE	539.58
TOTAL SAVINGS	4123.65