

United States Courts
Southern District of Texas

Response to Objection of Duplicate Claims for Jackson Parish Ambulance Service District, Chapter 11 Case No. 25-90309 (ARP)

MAR 10 2026

Nathan Ochsner, Clerk of Court

February 19, 2026

Jackson Parish Ambulance Service District asks that claim number 1194 and claim number 1217 be reviewed and re-entered with the other surviving claims. Details of each claim are outlined below and indicated in each claim's proof attached.

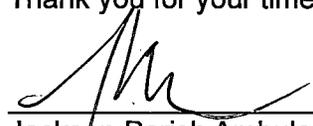
Claim numbers **1194** and 1196 were two different transports on 10/14/2022 for the same patient with each transport total \$669.50. The patient was picked up initially from the residence at 9:52:47am and arrived at Green Clinic at 10:12:00am. On the second transport, the patient was picked up from Green Clinic on the same day at 10:51:24am and arrived at residence at 11:00:00am. This information is on the bottom of the proof in the middle of both proofs for each transport.

Claim number	Date of Service	First Transport	Second Transport
1194	10/14/2022	From Residence 9:52:47am	Arrived at Green Clinic 10:12:00am
1196	10/14/2022	From Green Clinic 10:51:24am	Arrived at Residence 11:00:00am

Claim numbers **1217** and 1219 were two different transports on 9/30/2023 for the same patient with each transport total \$1,442.50. The patient was picked up initially from the Wyatt Manor or Nursing Home at 7:20:13am and arrived at Winnfield Hospital at 7:47:23am. On the second transport, the patient was picked up from Winnfield Hospital on the same day at 8:06:47am and arrived at Wyatt Manor Nursing Home at 8:27:31am. This information is on the bottom of the proof in the middle of both proofs for each transport.

Claim number	Date of Service	First Transport	Second Transport
1217	9/30/2023	From Wyatt Manor NH 7:20:13AM	Arrived at Winnfield Hosp 7:47:23am
1219	9/30/2023	From Winnfield Hosp 8:06:47am	Arrived at Wyatt Manor NH 8:27:31am

Thank you for your time in this matter.



Jackson Parish Ambulance Service District c/o Insight Billing Corporation
Scott Shurley
2640 Youree Drive
Suite 200
Shreveport, LA 71104





**IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

-----		X
In re:	:	Chapter 11
	:	
MODIVCARE INC., <i>et al.</i> ,	:	Case No. 25-90309 (ARP)
	:	
Reorganized Debtors. ¹	:	(Jointly Administered)
	:	
-----		X

**REORGANIZED DEBTORS' SECOND
OMNIBUS OBJECTION TO CERTAIN CLAIMS**

THIS IS AN OBJECTION TO YOUR CLAIM. THIS OBJECTION ASKS THE COURT TO DISALLOW THE CLAIM THAT YOU FILED IN THE BANKRUPTCY CASE. IF YOU DO NOT FILE A RESPONSE WITHIN 30 DAYS AFTER THE OBJECTION WAS SERVED ON YOU, YOUR CLAIM MAY BE DISALLOWED WITHOUT A HEARING.

TO THE CLAIMANTS WHOSE CLAIMS ARE SUBJECT TO THIS OBJECTION:

YOUR SUBSTANTIVE RIGHTS MAY BE AFFECTED BY THIS OBJECTION AND ANY FURTHER OBJECTIONS THAT MAY BE FILED IN THE CHAPTER 11 CASES.

THE RELIEF SOUGHT IN THIS OBJECTION IS WITHOUT PREJUDICE TO THE RIGHTS OF THE REORGANIZED DEBTORS AND THEIR ESTATES OR OTHER PARTIES IN INTEREST TO PURSUE FURTHER OBJECTIONS AGAINST THE CLAIMS LISTED HEREIN AND OTHER CLAIMS FILED IN THE CHAPTER 11 CASES.

¹ A complete list of each of the Reorganized Debtors in these chapter 11 cases (the "*Chapter 11 Cases*") and the last four digits of each Reorganized Debtor's taxpayer identification number (if applicable) may be obtained on the website of the Reorganized Debtors' claims and noticing agent at <https://www.veritaglobal.net/ModivCare>. Reorganized Debtor ModivCare Inc.'s principal place of business and the Reorganized Debtors' service address in these Chapter 11 Cases is 6900 E. Layton Avenue, Suite 1200, Denver, Colorado 80237.

USDOCS-66656317



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**IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

	x	
In re:	:	Chapter 11
	:	
MODIVCARE INC., <i>et al.</i> ,	:	Case No. 25-90309 (ARP)
	:	
Reorganized Debtors. ¹	:	(Jointly Administered)
	:	
	x	

**ORDER GRANTING REORGANIZED DEBTORS'
SECOND OMNIBUS OBJECTION TO CERTAIN PROOFS OF CLAIM
[Relates to Docket No.]**

Upon the objection (the "**Objection**")² of the Reorganized Debtors seeking entry of an order (this "**Order**") disallowing and expunging the Duplicative Claims set forth in **Schedule 1** hereto, all as more fully set forth in the Objection; and the Court having reviewed the Objection; and the Court having jurisdiction to consider the Objection and the relief requested therein in accordance with 28 U.S.C. § 1334; and the Court having found that this is a core proceeding pursuant to 28 U.S.C. § 157(b)(2) and that the Court may enter a final order consistent with Article III of the United States Constitution; and the Court having found that venue of this proceeding and the Objection in this district is proper pursuant to 28 U.S.C. §§ 1408 and 1409; and it appearing that proper and adequate notice of the Objection and opportunity for a hearing on the Objection were appropriate under the circumstances and that no other or further notice is necessary, except as set forth in this Order; and all responses, if any, to the Objection having been withdrawn, resolved, or overruled; and upon the record herein; and upon the record herein; and after due

¹ A complete list of each of the Reorganized Debtors in these chapter 11 cases (the "**Chapter 11 Cases**") and the last four digits of each Debtor's taxpayer identification number (if applicable) may be obtained on the website of the Reorganized Debtors' claims and noticing agent at <https://www.veritaglobal.net/ModivCare>. Debtor ModivCare Inc.'s principal place of business and the Reorganized Debtors' service address in these Chapter 11 Cases is 6900 E. Layton Avenue, Suite 1100, Denver, Colorado 80237.

² Capitalized terms used but not defined herein have the meanings ascribed to them in the Objection.



deliberation thereon; and the Court having determined that the legal and factual bases set forth in the Objection establish just cause for the relief granted herein; and the Court having determined that the relief requested in the Objection is in the best interests of the Reorganized Debtors, their estates, their creditors, and other parties in interest, it is hereby

ORDERED, ADJUDGED, AND DECREED THAT:

1. The Objection is GRANTED, as set forth herein.
2. Each Duplicative Claim listed on Schedule 1 is disallowed and expunged in its entirety, with the corresponding Surviving Claim remaining on the Claims Register.
3. The Claims and Noticing Agent is authorized to update the claims register maintained in the Chapter 11 Cases to reflect the relief granted in this Order.
4. Notwithstanding the relief granted in this Order and any actions taken pursuant to such relief, nothing in the Objection or this Order shall be deemed a waiver of the rights of the Reorganized Debtors to object to any Claim, and shall not constitute an admission of liability by the Reorganized Debtors with respect to any Proof of Claim or application for administrative expenses.
5. Each Duplicative Claim and the Reorganized Debtors' objections to each Duplicative Claim constitute a separate contested matter as contemplated by Bankruptcy Rule 9014. This Order shall be deemed a separate order with respect to each Duplicative Claim.
6. Nothing in the Objection or this Order shall be deemed or construed: (a) as an admission as to the validity of any Claim against the Reorganized Debtors (including any Surviving Claim); (b) as a waiver of the Reorganized Debtors' rights to dispute or otherwise object to any Claim (including any Surviving Claim) on any grounds or basis; or (c) to waive or release



any right, claim, defense, or counterclaim of the Reorganized Debtors, or to estop the Reorganized Debtors from asserting any right, claim, defense, or counterclaim (including setoff).

7. Notice of the Objection as provided therein shall be deemed good and sufficient and the requirements of the Bankruptcy Local Rules are satisfied by such notice.

8. Notwithstanding any applicable Bankruptcy Rules to the contrary, the terms and conditions of this Order are immediately effective and enforceable upon its entry.

9. The Reorganized Debtors are authorized to take all actions necessary to effectuate the relief granted in this Order in accordance with the Objection.

10. This Court retains exclusive jurisdiction with respect to all matters arising from or related to the implementation, interpretation, and enforcement of this Order.

Signed: _____, 2026

UNITED STATES BANKRUPTCY JUDGE



SCHEDULE 1

Schedule of Duplicative and Surviving Claims





FLORIDA POWER AND LIGHT	All Metro Home Care Services of Florida, Inc.	All Metro Home Care Services of Florida, Inc.	22	8/28/2025	General Unsecured Priority Secured Admin Priority Total	\$117.98 - - - \$117.98	23	8/28/2025
Jackson Parish Ambulance Service District	ModivCare Solutions, LLC	ModivCare Solutions, LLC	1194	9/30/2025	General Unsecured Priority Secured Admin Priority Total	\$670.00 - - - \$670.00	1196	9/30/2025
Jackson Parish Ambulance Service District	ModivCare Solutions, LLC	ModivCare Solutions, LLC	1217	9/30/2025	General Unsecured Priority Secured Admin Priority Total	\$1,443.00 - - - \$1,443.00	1219	9/30/2025
Jonathan Ray Linder	ModivCare Inc.	ModivCare Inc.	796	9/18/2025	General Unsecured Priority Secured Admin Priority Total	\$1,400.00 - - - \$1,400.00	814	9/18/2025



United States Bankruptcy Court for the Southern District of Texas

Indicate Debtor against which you assert a claim by checking the appropriate box below. (Check only one Debtor per claim form.)

- | | | |
|---|---|---|
| <input type="checkbox"/> A & B Homecare Solutions, L.L.C. (Case No. 25-90310) | <input type="checkbox"/> Auditory Response Systems, Inc. (Case No. 25-90320) | <input type="checkbox"/> Higi SH LLC (Case No. 25-90355) |
| <input type="checkbox"/> A.E. Medical Alert, Inc. (Case No. 25-90308) | <input type="checkbox"/> Barney's Medical Alert-ERS, Inc. (Case No. 25-90330) | <input type="checkbox"/> Independence Healthcare Corporation (Case No. 25-90356) |
| <input type="checkbox"/> ABC Homecare LLC (Case No. 25-90311) | <input type="checkbox"/> California MedTrans Network IPA LLC (Case No. 25-90331) | <input type="checkbox"/> Metropolitan Medical Transportation IPA, LLC (Case No. 25-90357) |
| <input type="checkbox"/> All Metro Aids Inc. (Case No. 25-90312) | <input type="checkbox"/> California MedTrans Network MSO LLC (Case No. 25-90332) | <input type="checkbox"/> MLA Sales, LLC (Case No. 25-90358) |
| <input type="checkbox"/> All Metro Associate Payroll Services Corporation (Case No. 25-90313) | <input type="checkbox"/> Care Finders Total Care LLC (Case No. 25-90333) | <input type="checkbox"/> ModivCare Inc. (Case No. 25-90309) |
| <input type="checkbox"/> All Metro CGA Payroll Services Corporation (Case No. 25-90314) | <input type="checkbox"/> CareGivers Alliance, LLC (Case No. 25-90334) | <input checked="" type="checkbox"/> ModivCare Solutions, LLC (Case No. 25-90359) |
| <input type="checkbox"/> All Metro Field Service Workers Payroll Services Corporation (Case No. 25-90315) | <input type="checkbox"/> CareGivers America Home Health Services, LLC (Case No. 25-90335) | <input type="checkbox"/> Multicultural Home Care Inc. (Case No. 25-90360) |
| <input type="checkbox"/> All Metro Health Care Services, Inc. (Case No. 25-90316) | <input type="checkbox"/> CareGivers America Medical Staffing, LLC (Case No. 25-90336) | <input type="checkbox"/> National MedTrans, LLC (Case No. 25-90361) |
| <input type="checkbox"/> All Metro Home Care Services of Florida, Inc. (Case No. 25-90317) | <input type="checkbox"/> CareGivers America Medical Supply, LLC (Case No. 25-90337) | <input type="checkbox"/> New England Emergency Response Systems, Inc. (Case No. 25-90363) |
| <input type="checkbox"/> All Metro Home Care Services of New Jersey, Inc. (Case No. 25-90318) | <input type="checkbox"/> CareGivers America Registry, LLC (Case No. 25-90338) | <input type="checkbox"/> OEP AM, Inc. (Case No. 25-90365) |
| <input type="checkbox"/> All Metro Home Care Services of New York, Inc. (Case No. 25-90319) | <input type="checkbox"/> Caregivers America, LLC. (Case No. 25-90339) | <input type="checkbox"/> Panhandle Support Services, Inc. (Case No. 25-90366) |
| <input type="checkbox"/> All Metro Home Care Services, Inc. (Case No. 25-90320) | <input type="checkbox"/> Caregivers On Call, Inc. (Case No. 25-90340) | <input type="checkbox"/> Personal In-Home Services, Inc. (Case No. 25-90368) |
| <input type="checkbox"/> All Metro Management and Payroll Services Corporation (Case No. 25-90321) | <input type="checkbox"/> CGA Holdco, Inc. (Case No. 25-90341) | <input type="checkbox"/> Philadelphia Home Care Agency, Inc. (Case No. 25-90371) |
| <input type="checkbox"/> All Metro Payroll Services Corporation (Case No. 25-90322) | <input type="checkbox"/> CGA Staffing Services, LLC (Case No. 25-90342) | <input type="checkbox"/> Provido Technologies, LLC (Case No. 25-90362) |
| <input type="checkbox"/> AM Holdco, Inc. (Case No. 25-90323) | <input type="checkbox"/> Circulation, Inc. (Case No. 25-90343) | <input type="checkbox"/> Red Top Transportation, Inc. (Case No. 25-90364) |
| <input type="checkbox"/> AM Intermediate Holdco, Inc. (Case No. 25-90324) | <input type="checkbox"/> Florida MedTrans Network LLC (Case No. 25-90344) | <input type="checkbox"/> Ride Plus, LLC (Case No. 25-90367) |
| <input type="checkbox"/> Arsenus Home Care, Inc. (Case No. 25-90325) | <input type="checkbox"/> Florida MedTrans Network MSO LLC (Case No. 25-90345) | <input type="checkbox"/> Safe Living Technologies, LLC (Case No. 25-90369) |
| <input type="checkbox"/> ARU Hospice Inc. (Case No. 25-90326) | <input type="checkbox"/> Guardian Medical Monitoring, LLC (Case No. 25-90346) | <input type="checkbox"/> Secura Home Health Holdings, Inc. (Case No. 25-90370) |
| <input type="checkbox"/> Associated Home Services, Inc. (Case No. 25-90327) | <input type="checkbox"/> Health Trans, Inc. (Case No. 25-90347) | <input type="checkbox"/> Secura Home Health, LLC (Case No. 25-90372) |
| <input type="checkbox"/> At-Home Quality Care, LLC (Case No. 25-90328) | <input type="checkbox"/> Healthcom Holdings LLC (Case No. 25-90348) | <input type="checkbox"/> Socrates Health Holdings, LLC (Case No. 25-90373) |
| | <input type="checkbox"/> Healthcom, Inc. (Case No. 25-90349) | <input type="checkbox"/> TriMed, LLC (Case No. 25-90374) |
| | <input type="checkbox"/> Helping Hand Home Health Care Agency Inc. (Case No. 25-90350) | <input type="checkbox"/> Union Home Care LLC (Case No. 25-90375) |
| | <input type="checkbox"/> Helping Hand Hospice, Inc. (Case No. 25-90351) | <input type="checkbox"/> Valued Relationships, Inc. (Case No. 25-90376) |
| | <input type="checkbox"/> Higi Care Holdings, LLC (Case No. 25-90352) | <input type="checkbox"/> Victory Health Holdings, LLC (Case No. 25-90377) |
| | <input type="checkbox"/> Higi Care, LLC (Case No. 25-90353) | <input type="checkbox"/> VRI Intermediate Holdings, LLC (Case No. 25-90378) |
| | <input type="checkbox"/> Higi SH Holdings Inc. (Case No. 25-90354) | |

**Modified Official Form 410
 Proof of Claim**

04/25

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor? Jackson Parish Ambulance Service District
 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)

<p>Where should notices to the creditor be sent?</p> <p>Name: <u>Jackson Parish Ambulance Service</u></p> <p>Number: <u>115</u> Street: <u>Watts Street</u></p> <p>City: <u>Jonesboro, LA</u> State: <u>LA</u> ZIP Code: <u>71251-2053</u></p> <p>Country: <u>U.S.A.</u></p> <p>Contact phone: <u>318-259-2891</u></p> <p>Contact email: <u>office.manager@jpasd.com</u></p> <p>Uniform claim identifier (if you use one): _____</p>	<p>Where should payments to the creditor be sent? (if different)</p> <p>Name: <u>Jackson Parish Ambulance Service</u></p> <p>Number: <u>115</u> Street: <u>Watts Street</u></p> <p>City: <u>Jonesboro, LA</u> State: <u>LA</u> ZIP Code: <u>71251-2053</u></p> <p>Country: <u>U.S.A.</u></p> <p>Contact phone: <u>318-259-2891</u></p> <p>Contact email: <u>office.manager@jpasd.com</u></p>
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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?
 \$ 1069.50 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.
Ambulance services performed to insured.

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 amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: \$ _____

Annual Interest Rate (when case was filed) _____ %

- Fixed
- Variable

10. Is this claim based on a lease? No
 Yes. Amount necessary to cure any default as of the date of the petition. \$ _____

11. Is this claim subject to a right of setoff? No
 Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)? No
 Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,800* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> Wages, salaries, or commissions (up to \$17,150*) 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/28 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.
 \$ _____

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)(3) 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:

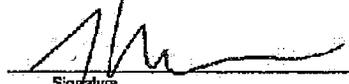
- I am the creditor.
- I am the creditor's attorney or authorized agent.
- I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this Proof of Claim serves as an acknowledgement 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 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 22 2025
MM / DD / YYYY



Signature

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

Name Scott Shurley
First name Middle name Last name

Title Billing Manager

Company Insight Billing Corporation
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 2640 Youree Dr Suite 200
Number Street

Shreveport LA 71104 U.S.A.
City State ZIP Code Country

Contact phone 888-357-9977 EXT 142 Email scott.shurley@insightbillingco
COA

United States Bankruptcy Court for the Southern District of Texas

Indicate Debtor against which you assert a claim by checking the appropriate box below. (Check only one Debtor per claim form.)

- | | | |
|---|---|---|
| <input type="checkbox"/> A & B Homecare Solutions, L.L.C. (Case No. 25-90310) | <input type="checkbox"/> Auditory Response Systems, Inc. (Case No. 25-90329) | <input type="checkbox"/> Higi SH LLC (Case No. 25-90355) |
| <input type="checkbox"/> A.E. Medical Alert, Inc. (Case No. 25-90308) | <input type="checkbox"/> Barney's Medical Alert-ERS, Inc. (Case No. 25-90330) | <input type="checkbox"/> Independence Healthcare Corporation (Case No. 25-90356) |
| <input type="checkbox"/> ABC Homecare LLC (Case No. 25-90311) | <input type="checkbox"/> California MedTrans Network IPA LLC (Case No. 25-90331) | <input type="checkbox"/> Metropolitan Medical Transportation IPA, LLC (Case No. 25-90357) |
| <input type="checkbox"/> All Metro Aids Inc. (Case No. 25-90312) | <input type="checkbox"/> California MedTrans Network MSO LLC (Case No. 25-90332) | <input type="checkbox"/> MLA Sales, LLC (Case No. 25-90358) |
| <input type="checkbox"/> All Metro Associate Payroll Services Corporation (Case No. 25-90313) | <input type="checkbox"/> Care Finders Total Care LLC (Case No. 25-90333) | <input type="checkbox"/> ModivCare Inc. (Case No. 25-90309) |
| <input type="checkbox"/> All Metro CGA Payroll Services Corporation (Case No. 25-90314) | <input type="checkbox"/> CareGivers Alliance, LLC (Case No. 25-90334) | <input checked="" type="checkbox"/> ModivCare Solutions, LLC (Case No. 25-90359) |
| <input type="checkbox"/> All Metro Field Service Workers Payroll Services Corporation (Case No. 25-90315) | <input type="checkbox"/> CareGivers America Home Health Services, LLC (Case No. 25-90335) | <input type="checkbox"/> Multicultural Home Care Inc. (Case No. 25-90360) |
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| <input type="checkbox"/> All Metro Home Care Services of Florida, Inc. (Case No. 25-90317) | <input type="checkbox"/> CareGivers America Medical Supply, LLC (Case No. 25-90337) | <input type="checkbox"/> New England Emergency Response Systems, Inc. (Case No. 25-90363) |
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| <input type="checkbox"/> All Metro Home Care Services of New York, Inc. (Case No. 25-90319) | <input type="checkbox"/> Caregivers America, LLC. (Case No. 25-90339) | <input type="checkbox"/> Panhandle Support Services, Inc. (Case No. 25-90366) |
| <input type="checkbox"/> All Metro Home Care Services, Inc. (Case No. 25-90320) | <input type="checkbox"/> Careglvers On Call, Inc. (Case No. 25-90340) | <input type="checkbox"/> Personal In-Home Services, Inc. (Case No. 25-90368) |
| <input type="checkbox"/> All Metro Management and Payroll Services Corporation (Case No. 25-90321) | <input type="checkbox"/> CGA Holdco, Inc. (Case No. 25-90341) | <input type="checkbox"/> Philadelphia Home Care Agency, Inc. (Case No. 25-90371) |
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| <input type="checkbox"/> AM Holdco, Inc. (Case No. 25-90323) | <input type="checkbox"/> Circulation, Inc. (Case No. 25-90343) | <input type="checkbox"/> Red Top Transportation, Inc. (Case No. 25-90364) |
| <input type="checkbox"/> AM Intermediate Holdco, Inc. (Case No. 25-90324) | <input type="checkbox"/> Florida MedTrans Network LLC (Case No. 25-90344) | <input type="checkbox"/> Ride Plus, LLC (Case No. 25-90367) |
| <input type="checkbox"/> Arsenis Home Care, Inc. (Case No. 25-90325) | <input type="checkbox"/> Florida MedTrans Network MSO LLC (Case No. 25-90345) | <input type="checkbox"/> Safe Living Technologies, LLC (Case No. 25-90369) |
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| | <input type="checkbox"/> Healthcom, Inc. (Case No. 25-90349) | <input type="checkbox"/> TriMed, LLC (Case No. 25-90374) |
| | <input type="checkbox"/> Helping Hand Home Health Care Agency Inc (Case No. 25-90350) | <input type="checkbox"/> Union Home Care LLC (Case No. 25-90375) |
| | <input type="checkbox"/> Helping Hand Hospice, Inc. (Case No. 25-90351) | <input type="checkbox"/> Valued Relationships, Inc. (Case No. 25-90376) |
| | <input type="checkbox"/> Higi Care Holdings, LLC (Case No. 25-90352) | <input type="checkbox"/> Victory Health Holdings, LLC (Case No. 25-90377) |
| | <input type="checkbox"/> Higi Care, LLC (Case No. 25-90353) | <input type="checkbox"/> VRI Intermediate Holdings, LLC (Case No. 25-90378) |
| | <input type="checkbox"/> Higi SH Holdings Inc. (Case No. 25-90354) | |

**Modified Official Form 410
Proof of Claim**

04/25

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

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.

ModivCare

798 Park Ave NW
4th Floor
Norton, VA 24273

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																																																																																																																																																							
1. MEDICARE <input type="checkbox"/> (Medicare#)										MEDICAID <input checked="" type="checkbox"/> (Medicaid#)										TRICARE <input type="checkbox"/> (ID#/DoD#)										CHAMPVA <input type="checkbox"/> (Member ID#)										GROUP HEALTH PLAN <input type="checkbox"/> (ID#)										FECA BLK LUNG <input type="checkbox"/> (ID#)										OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER 9309436859352 (For Program in Item 1)																																																																																																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Proctor Tina															3. PATIENT'S BIRTH DATE MM DD YY 1962 M <input type="checkbox"/> F <input checked="" type="checkbox"/>															4. INSURED'S NAME (Last Name, First Name, Middle Initial) Proctor Tina																																																																																																																																																																																			
5. PATIENT'S ADDRESS (No., Street) [REDACTED]															6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>															7. INSURED'S ADDRESS (No., Street) [REDACTED]																																																																																																																																																																																			
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Proctor Tina															10. IS PATIENT'S CONDITION RELATED TO:															11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER 9309436859352															a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															a. INSURED'S DATE OF BIRTH MM DD YY 09 15 1962 M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																			
b. RESERVED FOR NUCC USE															b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															b. OTHER CLAIM ID (Designated by NUCC)																																																																																																																																																																																			
c. RESERVED FOR NUCC USE															c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																			
d. INSURANCE PLAN NAME OR PROGRAM NAME UHC of LA															10d. CLAIM CODES (Designated by NUCC)															d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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. Signature on File SIGNED _____ DATE 10 14 2022																														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 10 14 22 QUAL 431															15. OTHER DATE MM DD YY															16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE															17a. _____															17b. NPI _____															18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY																																																																																																																																																																				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																														20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															22. RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0																														23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																			
A. R531															B. Z743															C. _____															D. _____															E. _____															F. _____															G. _____															H. _____															I. _____															J. _____																																																																										
24. A. DATE(S) OF SERVICE From To MM DD YY 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. EPSTD Family Plan															I. ID. QUAL.															J. RENDERING PROVIDER ID. #																																																																										
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25. FEDERAL TAX I.D. NUMBER 72-1433510															SSN EIN <input type="checkbox"/>															26. PATIENT'S ACCOUNT NO. 025-20221014005:1															27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO															28. TOTAL CHARGE \$ 669.50															29. AMOUNT PAID \$ 0.00															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.) Aaron Johnson 2/19/2026															32. SERVICE FACILITY LOCATION INFORMATION Green Clinic Residence 4707 Quitman Hwy 149 Ohio St Jonesboro, LA 71251 East Hodge, LA 71247 10:51:24 AM 11:00:00 AM															33. BILLING PROVIDER INFO & PH # (888) 357 9977 Jackson Parish Amb Service Dist 115 Watts St Jonesboro, LA 71251																																																																																																																																																																																			
SIGNED															DATE															a. 1124021092															b. ZZ34160000X																																																																																																																																																																				

Part 1: Identify the Claim

1. Who is the current creditor? Jackson Parish Ambulance Service District
 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? Name <u>Jackson Parish Ambulance Service</u> Number <u>115</u> Street <u>Watts Street</u> City <u>Jonesboro</u> State <u>LA</u> ZIP Code <u>71251-2053</u> Country <u>U.S.A.</u> Contact phone <u>318-259-2891</u> Contact email <u>office.manager@jpasd.com</u> Uniform claim identifier (if you use one): _____	Where should payments to the creditor be sent? (if different) Name <u>Jackson Parish Ambulance Service</u> Number <u>115</u> Street <u>Watts Street</u> City <u>Jonesboro</u> State <u>LA</u> ZIP Code <u>71251-2053</u> Country <u>U.S.A.</u> Contact phone <u>318-259-2891</u> Contact email <u>office.manager@jpasd.com</u>
--	--

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?
 \$ 6609.50 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.
Ambulance services performed to insured.

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 amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: \$ _____

Annual Interest Rate (when case was filed) _____ %

- Fixed
- Variable

10. Is this claim based on a lease? No
 Yes. Amount necessary to cure any default as of the date of the petition. \$ _____

11. Is this claim subject to a right of setoff? No
 Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)? No
 Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,800* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> Wages, salaries, or commissions (up to \$17,150*) 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/28 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.
 \$ _____

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)(3) 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:

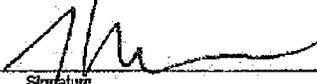
- I am the creditor.
- I am the creditor's attorney or authorized agent.
- I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this Proof of Claim serves as an acknowledgement 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 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 22 2025
MM / DD / YYYY


Signature

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

Name: Scott Shurley
First name Middle name Last name

Title: Billing Manager

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

Address: 2640 Youree Dr Suite 200
Number Street

Shreveport LA 71104 U.S.A.
City State ZIP Code Country

Contact phone: 888-357-9977 EXT 142 Email: scott.shurley@insightbillingco

COA

United States Bankruptcy Court for the Southern District of Texas

Indicate Debtor against which you assert a claim by checking the appropriate box below. (Check only one Debtor per claim form.)

- | | | |
|--|---|---|
| <input type="checkbox"/> A & B Homecare Solutions, L.L.C. (Case No. 25-90310) | <input type="checkbox"/> Auditory Response Systems, Inc. (Case No. 25-90329) | <input type="checkbox"/> Higi SH LLC (Case No. 25-90355) |
| <input type="checkbox"/> A.E. Medical Alert, Inc. (Case No. 25-90308) | <input type="checkbox"/> Baney's Medical Alert-ERS, Inc. (Case No. 25-90330) | <input type="checkbox"/> Independence Healthcare Corporation (Case No. 25-90356) |
| <input type="checkbox"/> ABC Homecare LLC (Case No. 25-90311) | <input type="checkbox"/> California MedTrans Network IPA LLC (Case No. 25-90331) | <input type="checkbox"/> Metropolitan Medical Transportation IPA, LLC (Case No. 25-90357) |
| <input type="checkbox"/> All Metro Aids Inc. (Case No. 25-90312) | <input type="checkbox"/> California MedTrans Network MSO LLC (Case No. 25-90332) | <input type="checkbox"/> MLA Sales, LLC (Case No. 25-90358) |
| <input type="checkbox"/> All Metro Associate Payroll Services Corporation (Case No. 25-90313) | <input type="checkbox"/> Care Finders Total Care LLC (Case No. 25-90333) | <input type="checkbox"/> ModivCare Inc. (Case No. 25-90309) |
| <input type="checkbox"/> All Metro CGA Payroll Services Corporation (Case No. 25-90314) | <input type="checkbox"/> CareGivers Alliance, LLC (Case No. 25-90334) | <input checked="" type="checkbox"/> ModivCare Solutions, LLC (Case No. 25-90359) |
| <input type="checkbox"/> All Metro Field Services Workers Payroll Services Corporation (Case No. 25-90315) | <input type="checkbox"/> CareGivers America Home Health Services, LLC (Case No. 25-90335) | <input type="checkbox"/> Multicultural Home Care Inc. (Case No. 25-90360) |
| <input type="checkbox"/> All Metro Health Care Services, Inc. (Case No. 25-90316) | <input type="checkbox"/> CareGivers America Medical Staffing, LLC (Case No. 25-90336) | <input type="checkbox"/> National MedTrans, LLC (Case No. 25-90361) |
| <input type="checkbox"/> All Metro Home Care Services of Florida, Inc. (Case No. 25-90317) | <input type="checkbox"/> CareGivers America Medical Supply, LLC (Case No. 25-90337) | <input type="checkbox"/> New England Emergency Response Systems, Inc. (Case No. 25-90363) |
| <input type="checkbox"/> All Metro Home Care Services of New Jersey, Inc. (Case No. 25-90318) | <input type="checkbox"/> CareGivers America Registry, LLC (Case No. 25-90338) | <input type="checkbox"/> OEP AM, Inc. (Case No. 25-90365) |
| <input type="checkbox"/> All Metro Home Care Services of New York, Inc. (Case No. 25-90319) | <input type="checkbox"/> Caregivers America, LLC. (Case No. 25-90339) | <input type="checkbox"/> Panhandle Support Services, Inc. (Case No. 25-90366) |
| <input type="checkbox"/> All Metro Home Care Services, Inc. (Case No. 25-90320) | <input type="checkbox"/> Caregivers On Call, Inc. (Case No. 25-90340) | <input type="checkbox"/> Personal In-Home Services, Inc. (Case No. 25-90368) |
| <input type="checkbox"/> All Metro Management and Payroll Services Corporation (Case No. 25-90321) | <input type="checkbox"/> CGA Holdco, Inc. (Case No. 25-90341) | <input type="checkbox"/> Philadelphia Home Care Agency, Inc. (Case No. 25-90371) |
| <input type="checkbox"/> All Metro Payroll Services Corporation (Case No. 25-90322) | <input type="checkbox"/> CGA Staffing Services, LLC (Case No. 25-90342) | <input type="checkbox"/> Provado Technologies, LLC (Case No. 25-90362) |
| <input type="checkbox"/> AM Holdco, Inc. (Case No. 25-90323) | <input type="checkbox"/> Circulation, Inc. (Case No. 25-90343) | <input type="checkbox"/> Red Top Transportation, Inc. (Case No. 25-90364) |
| <input type="checkbox"/> AM Intermediate Holdco, Inc. (Case No. 25-90324) | <input type="checkbox"/> Florida MedTrans Network LLC (Case No. 25-90344) | <input type="checkbox"/> Ride Plus, LLC (Case No. 25-90367) |
| <input type="checkbox"/> Arsens-Home-Care, Inc. (Case No. 25-90325) | <input type="checkbox"/> Florida MedTrans Network MSO LLC (Case No. 25-90345) | <input type="checkbox"/> Safe Living Technologies, LLC (Case No. 25-90369) |
| <input type="checkbox"/> ARU Hospice Inc. (Case No. 25-90326) | <input type="checkbox"/> Guardian Medical Monitoring, LLC (Case No. 25-90346) | <input type="checkbox"/> Secura Home Health Holdings, Inc. (Case No. 25-90370) |
| <input type="checkbox"/> Associated Home Services, Inc. (Case No. 25-90327) | <input type="checkbox"/> Health Trans, Inc. (Case No. 25-90347) | <input type="checkbox"/> Secura Home Health, LLC (Case No. 25-90372) |
| <input type="checkbox"/> At-Home Quality Care, LLC (Case No. 25-90328) | <input type="checkbox"/> Healthcom Holdings LLC (Case No. 25-90348) | <input type="checkbox"/> Socrates Health Holdings, LLC (Case No. 25-90373) |
| | <input type="checkbox"/> Healthcom, Inc. (Case No. 25-90349) | <input type="checkbox"/> TriMed, LLC (Case No. 25-90374) |
| | <input type="checkbox"/> Helping Hand Home Health Care Agency/Inc (Case No. 25-90350) | <input type="checkbox"/> Union Home Care LLC (Case No. 25-90375) |
| | <input type="checkbox"/> Helping Hand Hospice, Inc. (Case No. 25-90351) | <input type="checkbox"/> Valued Relationships, Inc. (Case No. 25-90376) |
| | <input type="checkbox"/> Higi Care Holdings, LLC (Case No. 25-90352) | <input type="checkbox"/> Victory Health Holdings, LLC (Case No. 25-90377) |
| | <input type="checkbox"/> Higi Care, LLC (Case No. 25-90353) | <input type="checkbox"/> VRI Intermediate Holdings, LLC (Case No. 25-90378) |
| | <input type="checkbox"/> Higi SH Holdings Inc. (Case No. 25-90354) | |

**Modified Official Form 410
Proof of Claim**

04/25

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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 357f.

Fill in all the information about the claim as of the date the case was filed.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL LATENT CLAIM COMMITTEE (NUCC)-02/12

ModivCare

798 Park Ave NW
4th Floor
Norton, VA 24273

1. MEDICARE <input type="checkbox"/> (Medicare)		MEDICAID <input checked="" type="checkbox"/> (Medicaid)		TRICARE <input type="checkbox"/> (TRICARE)		CHAMPVA <input type="checkbox"/> (ChAMPVA)		SPECIAL HEALTH PLAN <input type="checkbox"/> (SHIP)		FECA BLK LINE <input type="checkbox"/> (FECA)		OT-PR <input type="checkbox"/> (OT-PR)		10. INSUREE'S ID NUMBER 0804001965601		(For Filing in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARPER DARYL A				3. PATIENT'S BIRTH DATE 09 30 1971				SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSUREE'S NAME (Last Name, First Name, Middle Initial) HARPER DARYL A													
5. PATIENT'S ADDRESS (No. Street) [REDACTED]				6. PATIENT RELATIONSHIP TO INSURED: Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSUREE'S ADDRESS (No. Street) [REDACTED]															
CITY [REDACTED]				STATE [REDACTED]				8. RESERVED FOR NUCC USE				CITY [REDACTED]				STATE [REDACTED]							
ZIP CODE [REDACTED]				TP, FP, ONF (Include Area Code) () ()				9. RESERVED FOR NUCC USE				ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) () ()							
9. OTHER INSUREE'S NAME (Last Name, First Name, Middle Initial) HARPER DARYL A				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? (Place State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSUREE'S POLICY GROUP OR FECA NUMBER 0804001965601								12. INSUREE'S DATE OF BIRTH 09 30 1971				SEX <input type="checkbox"/> M <input type="checkbox"/> F			
13. RESERVED FOR NUCC USE				14. RESERVED FOR NUCC USE				15. RESERVED FOR NUCC USE				16. INSUREE'S POLICY GROUP OR FECA NUMBER				17. OTHER CLAIM ID (Designated by NUCC)							
18. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid Louisiana				19. CLAIM CODES (Designated by NUCC)				20. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If yes, complete items 21, 22, and 23.)								21. INSUREE'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 DATE: 09 30 2023							
22. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) QUAL 09 30 23 431				23. OTHER DATE (MM/DD/YY) QUAL [REDACTED]				24. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY) [REDACTED]								25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY) [REDACTED]							
26. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [REDACTED]				27. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				28. ICD-9 CODE 0				29. SUBMISSION CODE [REDACTED]				30. ORIGINAL ICD-9 CODE [REDACTED]							
28. A. Z7401				B. K9423				C. Z743-				D. [REDACTED]				E. [REDACTED]							
29. A. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY) 09 30 23 09 30 23				B. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Specify Unusual Circumstances) A0428 NH				C. DIAGNOSIS POINTER AB				D. CHARGES 1 000.00				E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. ZZ 34160000X							
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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

Part 1: Identify the Claim

1. Who is the current creditor? Jackson Parish Ambulance Service District
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)

<p>Where should notices to the creditor be sent?</p> <p><u>Jackson Parish Ambulance Service</u> <small>Name</small> <u>115 Watts Street</u> <small>Number Street</small> <u>Jonesboro, LA 71251-2053</u> <small>City State ZIP Code</small> <u>U.S.A.</u> <small>Country</small> Contact phone <u>318-259-2891</u> Contact email <u>office.manager@jpasd.com</u></p> <p>Uniform claim identifier (if you use one): _____</p>	<p>Where should payments to the creditor be sent? (if different)</p> <p><u>Jackson Parish Ambulance Service</u> <small>Name</small> <u>115 Watts Street</u> <small>Number Street</small> <u>Jonesboro, LA 71251-2053</u> <small>City State ZIP Code</small> <u>U.S.A.</u> <small>Country</small> Contact phone <u>318-259-2891</u> Contact email <u>office.manager@jpasd.com</u></p>
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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?
 \$ 1,442.50 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.
Ambulance services performed to insured.

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 amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: \$ _____

Annual Interest Rate (when case was filed) _____ %

- Fixed
- Variable

10. Is this claim based on a lease? No
 Yes. Amount necessary to cure any default as of the date of the petition. \$ _____

11. Is this claim subject to a right of setoff? No
 Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)? No
 Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,800* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> Wages, salaries, or commissions (up to \$17,150* 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(6).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/28 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.
 \$ _____

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)(3) 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 acknowledgement 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 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 22 2025
MM / DD / YYYY


Signature

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

Name Scott Shurley
First name Middle name Last name

Title Billing Manager

Company Insight Billing Corporation
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 2640 Youree Dr Suite 200
Number Street

Shreveport LA 71104 U.S.A.
City State ZIP Code Country

Contact phone 888-357-9977 EXT 142 Email scott.shurley@insightbillingco
COR

United States Bankruptcy Court for the Southern District of Texas

Indicate Debtor against which you assert a claim by checking the appropriate box below. (Check only one Debtor per claim form.)

- | | | |
|---|---|---|
| <input type="checkbox"/> A & B Homecare Solutions, L.L.C. (Case No. 25-90310) | <input type="checkbox"/> Auditory Response Systems, Inc. (Case No. 25-90329) | <input type="checkbox"/> Higi SH LLC (Case No. 25-90355) |
| <input type="checkbox"/> A.E. Medical Alert, Inc. (Case No. 25-90308) | <input type="checkbox"/> Barney's Medical Alert-ERS, Inc. (Case No. 25-90330) | <input type="checkbox"/> Independence Healthcare Corporation (Case No. 25-90356) |
| <input type="checkbox"/> ABC Homecare LLC (Case No. 25-90311) | <input type="checkbox"/> California MedTrans Network IPA LLC (Case No. 25-90331) | <input type="checkbox"/> Metropolitan Medical Transportation IPA, LLC (Case No. 25-90357) |
| <input type="checkbox"/> All Metro Aids Inc. (Case No. 25-90312) | <input type="checkbox"/> California MedTrans Network MSO LLC (Case No. 25-90332) | <input type="checkbox"/> MLA Sales, LLC (Case No. 25-90358) |
| <input type="checkbox"/> All Metro Associate Payroll Services Corporation (Case No. 25-90313) | <input type="checkbox"/> Care Finders Total Care LLC (Case No. 25-90333) | <input type="checkbox"/> ModivCare Inc. (Case No. 25-90309) |
| <input type="checkbox"/> All Metro CGA Payroll Services Corporation (Case No. 25-90314) | <input type="checkbox"/> CareGivers Alliance, LLC (Case No. 25-90334) | <input checked="" type="checkbox"/> ModivCare Solutions, LLC (Case No. 25-90359) |
| <input type="checkbox"/> All Metro Field Service Workers Payroll Services Corporation (Case No. 25-90315) | <input type="checkbox"/> CareGivers America Home Health Services, LLC (Case No. 25-90335) | <input type="checkbox"/> Multicultural Home Care Inc. (Case No. 25-90360) |
| <input type="checkbox"/> All Metro Health Care Services, Inc. (Case No. 25-90316) | <input type="checkbox"/> CareGivers America Medical Staffing, LLC (Case No. 25-90336) | <input type="checkbox"/> National MedTrans, LLC (Case No. 25-90361) |
| <input type="checkbox"/> All Metro Home Care Services of Florida, Inc. (Case No. 25-90317) | <input type="checkbox"/> CareGivers America Medical Supply, LLC (Case No. 25-90337) | <input type="checkbox"/> New England Emergency Response Systems, Inc. (Case No. 25-90363) |
| <input type="checkbox"/> All Metro Home Care Services of New Jersey, Inc. (Case No. 25-90318) | <input type="checkbox"/> CareGivers America Registry, LLC (Case No. 25-90338) | <input type="checkbox"/> OEP AM, Inc. (Case No. 25-90365) |
| <input type="checkbox"/> All Metro Home Care Services of New York, Inc. (Case No. 25-90319) | <input type="checkbox"/> Caregivers America, LLC. (Case No. 25-90339) | <input type="checkbox"/> Panhandle Support Services, Inc. (Case No. 25-90366) |
| <input type="checkbox"/> All Metro Home Care Services, Inc. (Case No. 25-90320) | <input type="checkbox"/> Caregivers On Call, Inc. (Case No. 25-90340) | <input type="checkbox"/> Personal In-Home Services, Inc. (Case No. 25-90368) |
| <input type="checkbox"/> All Metro Management and Payroll Services Corporation (Case No. 25-90321) | <input type="checkbox"/> CGA Holdco, Inc. (Case No. 25-90341) | <input type="checkbox"/> Philadelphia Home Care Agency, Inc. (Case No. 25-90371) |
| <input type="checkbox"/> All Metro Payroll Services Corporation (Case No. 25-90322) | <input type="checkbox"/> CGA Staffing Services, LLC (Case No. 25-90342) | <input type="checkbox"/> ProVado Technologies, LLC (Case No. 25-90362) |
| <input type="checkbox"/> AM Holdco, Inc. (Case No. 25-90323) | <input type="checkbox"/> Circulation, Inc. (Case No. 25-90343) | <input type="checkbox"/> Red Top Transportation, Inc. (Case No. 25-90364) |
| <input type="checkbox"/> AM Intermediate Holdco, Inc. (Case No. 25-90324) | <input type="checkbox"/> Florida MedTrans Network LLC (Case No. 25-90344) | <input type="checkbox"/> Ride Plus, LLC (Case No. 25-90367) |
| <input type="checkbox"/> Arsens Home Care, Inc. (Case No. 25-90325) | <input type="checkbox"/> Florida MedTrans Network MSO LLC (Case No. 25-90345) | <input type="checkbox"/> SafeLiving Technologies, LLC (Case No. 25-90369) |
| <input type="checkbox"/> ARU Hospice Inc. (Case No. 25-90326) | <input type="checkbox"/> Guardian Medical Monitoring, LLC (Case No. 25-90346) | <input type="checkbox"/> Secura Home Health Holdings, Inc. (Case No. 25-90370) |
| <input type="checkbox"/> Associated Home Services, Inc. (Case No. 25-90327) | <input type="checkbox"/> Health Trans, Inc. (Case No. 25-90347) | <input type="checkbox"/> Secura Home Health, LLC (Case No. 25-90372) |
| <input type="checkbox"/> At-Home Quality Care, LLC (Case No. 25-90328) | <input type="checkbox"/> Healthcare Holdings LLC (Case No. 25-90348) | <input type="checkbox"/> Socrates Health Holdings, LLC (Case No. 25-90373) |
| | <input type="checkbox"/> Healthcom, Inc. (Case No. 25-90349) | <input type="checkbox"/> TriMed, LLC (Case No. 25-90374) |
| | <input type="checkbox"/> Helping Hand Home Health Care Agency Inc (Case No. 25-90350) | <input type="checkbox"/> Union Home Care LLC (Case No. 25-90375) |
| | <input type="checkbox"/> Helping Hand Hospice, Inc. (Case No. 25-90351) | <input type="checkbox"/> Valued Relationships, Inc. (Case No. 25-90376) |
| | <input type="checkbox"/> Higi Care Holdings, LLC (Case No. 25-90352) | <input type="checkbox"/> Victory Health Holdings, LLC (Case No. 25-90377) |
| | <input type="checkbox"/> Higi Care, LLC (Case No. 25-90353) | <input type="checkbox"/> VRI Intermediate Holdings, LLC (Case No. 25-90378) |
| | <input type="checkbox"/> Higi SH Holdings Inc. (Case No. 25-90354) | |

**Modified Official Form 410
Proof of Claim**

04/25

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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 357f.

Fill in all the information about the claim as of the date the case was filed.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 01/19

ModivCare

798 Park Ave NW
4th Floor
Norton, VA 24273

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> (Medicare #)		<input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #)		<input type="checkbox"/> TRICARE <input type="checkbox"/> (TRICARE #)		<input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Champion ID#)		<input type="checkbox"/> GOVERNMENT HEALTH PLAN <input type="checkbox"/> (GHP #)		<input type="checkbox"/> FECA BENEFITING <input type="checkbox"/> (FECA #)		<input type="checkbox"/> OTHER <input type="checkbox"/> (Other #)		10. INSURED'S ID NUMBER 0804001965601			
1. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARPER DARYL A				2. PATIENT'S BIRTH DATE 1971				3. PATIENT'S SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F				4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARPER DARYL A					
5. PATIENT'S ADDRESS (No., Street) [REDACTED]				6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No., Street) [REDACTED]									
8. CITY [REDACTED]				9. STATE [REDACTED]				10. RESERVED FOR NUCC USE				11. INSURED'S ADDRESS (No., Street) [REDACTED]					
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) HARPER DARYL A				13. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				14. INSURED'S DATE OF BIRTH 1971				15. INSURED'S SEX <input type="checkbox"/> M <input type="checkbox"/> F					
16. OTHER INSURED'S POLICY OR GROUP NUMBER 0804001965601				17. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				18. OTHER CLAIM ID (Assigned by NUCC)				19. OTHER CLAIM ID (Assigned by NUCC)					
20. RESERVED FOR NUCC USE				21. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				22. INSURANCE PLAN NAME OF PROGRAM NAME Wyatt Manor				23. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
24. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I do not request payment of government benefits either to myself or to the party who completed this form.																	
25. SIGNATURE OF PATIENT OR AUTHORIZED PERSON'S SIGNATURE Signature on File SIGNED: _____ DATE: 09 30 2023								26. SIGNATURE OF INSURED OR AUTHORIZED PERSON'S SIGNATURE Signature on File SIGNED: _____ DATE: _____									
27. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) 09 30 23				28. OTHER DATE (MM/DD/YY) QUAL: 431				29. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: _____ TO: _____									
30. BASIC OF DEFERRING PROVIDER OR OTHER SOURCE				31. HOSPITALIZATION DATES OF APTD TO CURRENT SERVICES FROM: _____ TO: _____				32. OUTSIDE LAB CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
33. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																	
34. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. R531 B. Z7401 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____																	
35. PRIOR AUTHORIZATION NUMBER																	
36. SERVICE LINE TABLE																	
1	A. DATE OF SERVICE		B. PLACE OF SERVICE		C. ICD-9-CM	D. PROCEDURES, SERVICES, OR SUPPLIES (Complete Use Local Circumstances)	E. DIAGNOSIS POINTER	F. CHARGES	G. DAYS OF LIMITS	H. REASON FOR DENIAL	I. ID. QUAL	J. REFERRING PROVIDER ID. #					
	From	To	YY	MM									DD	YY	MM	DD	
1	09	30	23	09	30	23	41	A0428	HN		AB	1 000.00	1		ZZ	341600000X	1124021092
2	09	30	23	09	30	23	41	A0425	HN		AB	442.50	18		ZZ	341600000X	1124021092
3																	
4																	
5																	
6																	
37. FEDERAL TAX ID NUMBER 72-1433510				38. PATIENT'S ACCOUNT NO. 025-20231001003:1				39. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		40. TOTAL CHARGE 1 442.50		41. AMOUNT PAID 0.00		42. BILLING PROVIDER ID. # 1124021092		43. BILLING PROVIDER ID. # ZZ341600000X	
44. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS Aaron Johnson				45. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS 12/6/2024				46. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS Winnfield Parish		47. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS Wyatt Manor		48. BILLING PROVIDER ID. # 888 357 9977		49. BILLING PROVIDER ID. # Jackson Parish Amb Service Dist		50. BILLING PROVIDER ID. # 115 Watts St Jonesboro, LA 71251	
51. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS 12/6/2024				52. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS 8:06:47 AM				53. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS 8:27:31 AM		54. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS 1124021092		55. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS ZZ341600000X					

Part 1: Identify the Claim

1. Who is the current creditor? Jackson Parish Ambulance Service District
 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? Name <u>Jackson Parish Ambulance Service</u> Number <u>115</u> Street <u>Watts Street</u> City <u>Jonesboro</u> , State <u>LA</u> ZIP Code <u>71251-2053</u> Country <u>U.S.A.</u> Contact phone <u>318-259-2891</u> Contact email <u>office.manager@jpasd.com</u> Uniform claim identifier (if you use one): _____	Where should payments to the creditor be sent? (if different) Name <u>Jackson Parish Ambulance Service</u> Number <u>115</u> Street <u>Watts Street</u> City <u>Jonesboro</u> , State <u>LA</u> ZIP Code <u>71251-2053</u> Country <u>U.S.A.</u> Contact phone <u>318-259-2891</u> Contact email <u>office.manager@jpasd.com</u>
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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? \$ 1,442.50
 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.
Ambulance services performed to insured.

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 amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: \$ _____

Annual interest rate (when case was filed) _____%

Fixed

Variable

10. Is this claim based on a lease?

No

Yes. Amount necessary to cure any default as of the date of the petition. \$ _____

11. Is this claim subject to a right of setoff?

No

Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

No

Yes. Check all that apply:

Amount entitled to priority

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

Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B). \$ _____

Up to \$3,800* 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 \$17,150*) 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 4/01/28 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.

\$ _____

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)(3) 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:

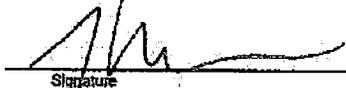
- I am the creditor.
- I am the creditor's attorney or authorized agent.
- I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this Proof of Claim serves as an acknowledgement 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 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 22 2025
MM / DD / YYYY


Signature

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

Name Scott Shurley
First name Middle name Last name

Title Billing Manager

Company Insight Billing Corporation
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 2640 Youree Dr Suite 200
Number Street

Shreveport LA 71104 U.S.A.
City State ZIP Code Country

Contact phone 888-357-9977 EXT 142 Email scott.shurley@insightbillingco
COA