Docket #1509 Date Filed: 05/01/2026

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

In re:	:	Chapter 11
MODIVCARE INC., *et al.*,	:	Case No. 25-90309 (ARP)
Reorganized Debtors.[1]	:	(Jointly Administered)

NOTICE OF REORGANIZED DEBTORS' ELEVENTH OMNIBUS CLAIM OBJECTION

This is an objection to your claim. This objection asks the Court to disallow the claim you filed in this 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.

Claimants receiving this notice (this "*Notice*") should locate the affected claims and the name of the creditor who filed it on the exhibits attached to the Omnibus Objection (as defined below). If you do not file a response by April 30, 2026, at 4:00 p.m. (prevailing Central Time), your claim may be disallowed without a hearing.

If you timely file a response that cannot be resolved, a hearing will be scheduled.

INTRODUCTION

Why am I receiving this document? You are receiving this Notice because ModivCare Inc. and its debtor affiliates (referred to as the "***Reorganized Debtors***") have filed the Objection attached hereto as **Appendix 1** (the "***Omnibus Objection***") to your claim(s).[2]

Why is my claim being objected to? As summarized in the exhibit(s) to the Omnibus Objection, the Reorganized Debtors believe that the Proof of Claim that you filed or that was filed on your behalf is deficient because: the claim embodied in the Proof of Claim was satisfied through the Cure Amounts for applicable Designated Contract.

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[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.

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

2590309260504000000000001

Where can I find out which claim is being objected to? The appendices attached hereto contain information needed for you to search for and identify the name of the creditor who filed the disputed claim, as well as the number of the claim as it appears on the claims register maintained by the Reorganized Debtors' Claims and Noticing Agent.

What do I need to do? If you disagree with the grounds of the objection, you must file a response (each, a "***Response***") with the United States Bankruptcy Court for the Southern District of Texas (the "***Court***") and send a copy to the Reorganized Debtors' attorneys pursuant to the procedures set forth below by no later than **April 30, 2026, at 4:00 p.m. (prevailing Central Time).**

Where can I find out more information? To obtain more information about the Omnibus Objection, you can contact counsel to the Reorganized Debtors listed below. These attorneys represent the Reorganized Debtors and cannot give you legal advice. If you are seeking advice about your legal rights, you should consult your own attorney.

How do I file a response? To respond to this objection, you will need to state in writing why you believe the Omnibus Objection should be overruled in accordance with the Objection Procedures (as defined below). Any such response will need to be filed with the Court. More information on how to file documents with the Court can be found on the Court's website at https://www.txs.uscourts.gov or call the clerk's office at 713-250-5500. **Please do not contact the Court to discuss the merits of your Claim or the objection. The Court cannot give you legal advice.**

When do I need to file my response? Your Response must be filed no later than **April 30, 2026, at 4:00 p.m. (prevailing Central Time).** If you do not respond by that date, **your Claim may be disallowed and expunged without further notice to you.**

IMPORTANT INFORMATION REGARDING THE OBJECTION

Grounds for the Omnibus Objection. By the Omnibus Objection, the Reorganized Debtors are seeking to **disallow and expunge** your Claim(s) based on the grounds set forth in the Omnibus Objection.

Omnibus Objection Procedures. On February 19, 2026, the Court entered an order [Docket No. 1313] approving procedures, a copy of which are attached hereto as **Appendix 2**, for filing and resolving omnibus objections to claims asserted against the Reorganized Debtors in the Chapter 11 Cases (the "***Objection Procedures***").

Please review the response procedures for resolving the Omnibus Objection to ensure your response to the Omnibus Objection, if any, is timely and correctly filed.

RESPONSE PROCEDURES FOR RESOLVING THE OMNIBUS OBJECTION

Parties Required to File a Response. If you disagree with the Omnibus Objection filed against your Claim, you must file a Response with the Court in accordance with the Objection Procedures and appear at a hearing on the matter.

Response Contents. The Objection Procedures requires that each Response must contain the following information (at a minimum):

a caption stating the name of the Court, the name of the Reorganized Debtor(s), the case number, and the title of the Omnibus Objection to which the Response is directed;

a concise statement setting forth the reasons why the Court should not grant the Omnibus Objection with respect to your Claim or Proof of Claim, including the specific factual and legal bases upon which you rely in opposing the Omnibus Objection; and

the following contact information for the responding party:

the name, mailing address, telephone number, and email address of the responding claimant, or the name, address, telephone number, and email address of the claimant's attorney or designated representative to whom the Reorganized Debtors' counsel should serve a reply to the Response, if any; or

the name, mailing address, telephone number, and email address of the party with authority to reconcile, settle, or resolve the Omnibus Objection on your behalf.

Notice and Service. Your Response must be filed with the Court by **April 30, 2026**, at 4:00 p.m. (prevailing Central Time) unless otherwise ordered by the Court.

Failure to Respond. **Failure to timely file a Response as set forth herein or to appear at the hearing, if one is set, may result in the Court sustaining the Omnibus Objection without further notice or hearing.** Upon entry of an order sustaining an Omnibus Objection, affected creditors will be served with such order.

Hearing. If a Response is timely filed that cannot be resolved, the Court will hold an initial hearing. The initial hearing will be non-evidentiary and used as a scheduling conference. **Failure to appear at the initial hearing may result in the summary disposition of the objection.**

Discovery. If any party determines that discovery is necessary in advance of a hearing on an Omnibus Objection, the party may serve notice on the affected Reorganized Debtor or claimant and its counsel of record. Failure to comply with this paragraph will not preclude a party from later seeking discovery.

ADDITIONAL INFORMATION

Questions or Information. Copies of all pleadings filed in the Chapter 11 Cases (including the Omnibus Objection) are available at no cost on the website maintained by the Reorganized Debtors' Claims and Noticing agent at https://www.veritaglobal.net/ModivCare. You may also obtain copies of any pleadings filed in these Chapter 11 Cases for a fee via PACER at: https://ecf.txsb.uscourts.gov. **Please do not contact the Court to discuss the merits of any Claim or Objection.**

RESERVATION OF RIGHTS

Nothing in the Omnibus Objection or this Notice shall be deemed: (a) an implication or admission as to the amount of, basis for, or validity of any claim against the Reorganized Debtors; (b) a waiver or limitation of the Reorganized Debtors' or any other party in interest's right to dispute the amount of, basis for, or validity of any claim; (c) a waiver of the Reorganized Debtors' or any other party in interest's rights under the Bankruptcy Code or any other applicable non-bankruptcy law; (d) a waiver of the obligation of any party in interest to file a proof of claim; (e) an implication or admission that any particular claim is of a type specified or defined in the Omnibus Objection, or any order granting the relief requested by the Omnibus Objection; (f) a promise or requirement to pay any particular claim; (g) a waiver of any claims or causes of action which may exist against any entity under the Bankruptcy Code or any other applicable law; or (h) an admission as to the validity, priority, enforceability, or perfection of any lien on, security interest in, or other encumbrance on property of the Reorganized Debtors' estates or the Reorganized Debtors' property.

April 20, 2026

Response to Eleventh Omnibus Objection Case No. 25-90309 (ARP)

United States Bankruptcy Court for the Southern District of Texas
Timothy A. Davidson II - Hunton Andrews Kurth LLP
Case No, 25-90309 (ARP)
Eleventh Omnibus Claim Objection

Re: Claim No. 1169-c

Jackson Parish Ambulance Service District is asking the Court to not grant the Omnibus Objection due to the reasons stated below:

- Claim No. 1169-c is a factual claim originated on date of service 4/4/2025 from Jackson Parish Hospital.
- The transport was initiated due to a call where ER Physician requested transport due to mental health emergency and the patient needed transport to Brentwood Hospital (PEC attached).
- The transport Certification of Ambulance Transportation, the Physician's Certification Statement, and other supporting documents were attached with the initial submission to Modivcare in line with billing procedures.
- Submission of claim was timely (see copy of email sent below).

From: Seth Linn <seth.linn@insightbillingcorp.com>
Sent: Thursday, August 28, 2025 11:58 AM
To: 'Support.Claims@ModivCare.com' <Support.Claims@ModivCare.com>
Subject: RE: Jackson Parish AMB Service - TAX ID: 721433510 - NPI: 1124021092

Please see attached, thank you.

Thanks
Seth Linn|Follow Up Clerk
Insight Billing Corporation
318-747-9977 ext. 191 | Office
888-357-9977 ext. 191
318-747-9994 | Fax

- No response from Modivcare received on outcome of claim processing.

Thank you.

Jackson Parish Ambulance Service District Billing Office
Scott Shurley, 318-841-0222 | scott.shurley@insightbilling.com
Insight Billing Corporation
2640 Youree Dr, Suite 200
Shreveport, LA 71104-3662

Incident Street Address: 165 Beech Springs Rd Incident City: Jonesboro Patient Resides in Service Area: Resident Within EMS Service Area

OBH-1 (PEC)
Rev. 05/2017

Complete Prior to Admission

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH – OFFICE OF BEHAVIORAL HEALTH
PHYSICIAN'S EMERGENCY CERTIFICATE

For observation, diagnosis, and treatment at a treatment facility for a period not to exceed 15 days, or 28 days, for substance abuse (Title 28:52.4). See Louisiana Revised Statutes, Title 28, Sections 53 and 63. These directives must be fulfilled in order for this certificate to be valid.

NAME OF EXAMINING PHYSICIAN:	EXAMINATION DATE:	EXAMINATION TIME:
Lawrence Hill	4-4-2025	1:08 PM

ADDRESS OF EXAMINING PHYSICIAN: Jackson Parish ER

CALDWELL, JOHNNY M
DOB: 12/13/2011 13 Y
DOS: 04/04/2025 12:22
ATT: Hill, Lawrence C
FIN: 10861587
MRN: 651609

NAME OF PATIENT: Johnny Caldwell

ADDRESS OF PATIENT: 10692 Clay Ansley Hwy, Ruston, LA 71270

RACE	SEX	DATE OF BIRTH	BIRTHPLACE
Black	☒ M ☐ F		

MARITAL STATUS	MILITARY STATUS	RELIGION
☐ S ☐ M ☐ D ☐ W ☐ SEP	☐ VETERAN ☐ NON-VETERAN	

NAME OF NEAREST RELATIVE, FRIEND, OR GUARDIAN	RELATIONSHIP
Patricia Flanagan	mother
ADDRESS	PHONE NUMBER
	318 557 5364

CHECK:
☒ Mental Illness or Substance Abuse (15 Day) ☐ Substance Abuse (28 Day) ☐ 1st ☐ 2nd Order For Protective Custody Date: _____

FINDINGS OF EXAMINATION

HISTORY OF PRESENT ILLNESS (REASONS FOR ADMISSION, INCLUDING BEHAVIOR, ACTS, THREATS, ETC.)
13yo male - told teacher he wanted to die - picked up chair and threatened to throw it at teacher

PHYSICAL FINDINGS (MEDICAL HISTORY, CURRENT MEDICATIONS, ETC.)
physical exam normal

MENTAL CONDITION (ORIENTATION, MOOD, THOUGHT CONTENT, AFFECT, ANY HALLUCINATIONS OR DELUSIONS)
suicidal

PREVIOUS PSYCHIATRIC TREATMENT	DATE OF TREATMENT	PLACE, IF KNOWN
☐ INPATIENT ☐ OUTPATIENT Unknown		

IS PATIENT CURRENTLY: ☒ SUICIDAL ☐ HOMICIDAL ☒ VIOLENT

I am of the opinion that the above person named is in need of immediate psychiatric treatment in a treatment facility because he/she is seriously mentally ill or suffering from substance abuse so that he/she is (check where appropriate in both 1 & 2):
1. ☐ Dangerous to self ☐ Dangerous to others ☐ Gravely disabled
2. ☐ Unwilling ☐ Unable to seek voluntary admission

SIGNATURE OF EXAMINING PHYSICIAN	LA MEDICAL LICENSE NUMBER	DATE SIGNED	TIME SIGNED
	013613	4-4-2025	1:09 PM

Completion of above certificate shall constitute legal authority to transport patient to the following facility:

1. _____
2. _____

To be transported by: _____ Relationship to patient: _____

ORIGINAL TO HOSPITAL – ONE COPY TO EXAMINING PHYSICIAN

Louisiana's MEDICAID PROGRAM
Certification of Need for Psychiatric Hospitalization

Patient's N
CALDWELL, JOHNNY
DOB: 12/13/2011 13 Y M
DOS: 04/04/2025 12:22
ATT: Hill, Lawrence C
FIN: 10861587
MRN: 60151
SS #: - -

Facility: :#: DOA: / /

Hospital

Type of Care: (Substance or Mental Disorder)

DSM III – R Axis I Diagnosis and ICD-9 Code:

Primary Reason for Admission: Suicidal thoughts

Admission

- ☐ Patient is currently Medicaid eligible – 13-digit Medicaid ID #:
- ☐ Patient is applying for Medicaid for Medicaid – Application Date: / /
- ☐ Emergency admission (Note: Supporting documentation must be attached.)
- ☐ Court-ordered admission (NOTE: These admissions are subject to the listed criteria to qualify for Medicaid reimbursement.)

The patient named above requires care in a mental facility /program. The following requirements are met:

1. Ambulatory care resource available in the community have been tried or are currently inadequate to meet the treatment needs of this patient (the availability or lack of outpatient resources is not a determining factor for Medicaid reimbursement); and
2. Proper treatment of this patient's psychiatric condition requires services on an in-patient basis under the direction of a psychiatrist or a physician under the supervision of a psychiatrist; and
3. The services can be expected to improve this patient's condition within a reasonable period of time or prevent further regression to the extent that services will no longer be needed.

Independent Team
(Not Associated with Admitting Hospital – If Medicaid Certified)

Date 4 14 2025 D Hill (signature)
(name & credentials)
Date / / Ron Kaiser (signature)
(name & credentials)

Admitting Hospital Interdisciplinary Team
(If Not Medicaid Certified)

Date / / (signature)
(name & credentials)
Date / / (signature)
(name & credentials)
Date / / (signature)
(name & credentials)

(Certification by the appropriate team cannot be made earlier than five (5) days prior to admission. A minimum of two signatures are required. See reverse for specific instructions.)

Support.Claims@Modivcare.com
ModivCare
798 Park Ave NW
4th Floor
Norton, VA 24273

HEALTH INSURANCE CLAIM FORM

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

PICA ☐ | PICA ☐

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0754920174350

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)
Caldwell Johnny	12 13 2011 M ☒ F ☐	Caldwell Johnny
5. PATIENT'S ADDRESS (No., Street)	**6. PATIENT RELATIONSHIP TO INSURED**	**7. INSURED'S ADDRESS (No., Street)**
10692 Clay Ansley Hwy	Self ☒ Spouse ☐ Child ☐ Other ☐	10692 Clay Ansley Hwy
CITY: Ruston / STATE: LA	**8. RESERVED FOR NUCC USE**	CITY: Ruston / STATE: LA
ZIP CODE: 71270 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 71270 / TELEPHONE (Include Area Code): (318) -557-5364
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: 12 13 2011 M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
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.
SIGNED: Signature on File DATE: 04 04 2025

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
04 04 25 QUAL. 431		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	**18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (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.	B.	C.	D.
R456	R45851	Z743	
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 04 04 25	04 04 25	41		A0428	HH	AB	1 000 00	1		ZZ	341600000X
										NPI	1124021092
2 04 04 25	04 04 25	41		A0425	HH	AB	1 975 00	79		ZZ	341600000X
										NPI	1124021092
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
72-1433510 ☐ ☐	025-20250404009:1	☒ YES ☐ NO	$ 2 975 00	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (888) 357 9977
Aaron Johnson 8/28/2025 SIGNED DATE	Jackson Parish 165 Beech Springs Rd Jonesboro, LA 71251 3:23:44 PM a. / b.	Brentwood Hospital 1006 Highland Ave Shreveport, LA 71101 4:50:22 PM a. 1124021092 b. ZZ341600000X
		Jackson Parish Amb Service Dist 115 Watts St Jonesboro, LA 71251

LOUISIANA MEDICAID

Medicaid Eligibility Verification System

PRINT

- IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
- **Note:** For Technical Support, Please Contact **1-877-598-8753**
- **Note:** For Eligibility Information Support, Please Contact **(800) 473-2783** or **(225) 924-5040**
- **Note:** The date field formats have changed - enter date in MM/DD/YYYY format
- **NOTE:** CMS REGULATIONS LIMIT PROVIDING RECIPIENT ELIGIBILITY OLDER THAN THE MOST CURRENT 12 MONTHS.

Search Criteria

Search Type	Recipient ID and DOB	**Recipient ID**	0754920174350	**Date of Birth**	12/13/2011	**Plan Date**	04/04/2025

Subscriber Information

Policy Holder Name	CALDWELL , JOHNNY III
Subscriber ID	0754920174350
Date of Birth	12/13/2011
Sex	Male
Address	10692 CLAY ANSLEY HWY RUSTON LA 71270-8258

Provider Information

Provider	JACKSON PARISH AMBULANCESERV
NPI	1124021092
Submitter ID	3182592891

For name or address discrepancies, recipients must call LA Medicaid-Eligibility Hotline 1-877-252-2447.

For dates of service from 01/01/2023 through 10/27/2023, if the Managed Care Coordinator listed for the Plan Coverage is Humana Health Benefit Plan, all pharmacy POS transaction should be processed as FFS using the Medicaid Recipient ID or CCN and BIN: 610514, PCN: LOUIPROD and Group: HUMANA.

For dates of service on/after 12/1/2015, if there is no Managed Care Coordinator listed for the Plan Coverage Description (Medical Care or Specialized Behavioral Health Care or Dental Care), claims should be sent to Gainwell Technologies.

Health Benefit Plan Coverage

Benefit	Service Type Code	Insurance Type	Plan Coverage Description
Active Coverage	Health Benefit Plan Coverage	Medicaid	Eligible for Medicaid on Plan Date. **Plan Begin Date** 04/01/2023
Deductible	Health Benefit Plan Coverage	Medicaid	Health Plan Base Deductible is $0 for In Plan Network and Out of Plan Network.
Benefit Description	Health Benefit Plan Coverage	Medicaid	Recipient is EPSDT Eligible.
Benefit Description	Health Benefit Plan Coverage	Medicaid	PREFERRED LANGUAGE: ENGLISH
Managed Care Coordinator	Medical Care	Medicaid	BAYOU HEALTH PLAN **Benefit Begin** 01/01/2025 PHARMACY PBM IS Prime Therapeutics, LLC **Managed Care Organization** UNITED HEALTHCARE OF LOUISIAN **Telephone** (866) 675-1607
Managed Care Coordinator	Specialized Behavioral Health Care	Medicaid	BAYOU HEALTH PLAN **Benefit Begin** 01/01/2025 PHARMACY PBM IS Prime Therapeutics, LLC **Payer** UNITED HEALTHCARE OF LOUISIAN **Telephone** (866) 675-1607
Managed Care Coordinator	Dental Care	Medicaid	DENTAL BENEFITS PLAN MANAGER **Benefit Begin** 01/01/2025 **Payer** DENTAQUEST USA INSURANCECO I **Telephone** (800) 417-7140 **URL** https://PROVIDERACCESS.DENTAQUEST.COM
Active Coverage		Medicaid	Eligible for Medicaid on Plan Date.
Co-Insurance		Medicaid	MEDICAID - Benefit Co-Insurance is 0% for In Plan Network and Out of Plan Network
Co-Payment		Medicaid	MEDICAID - Benefit Co-Pay is $0 for In Plan Network and Out of Plan Network

Please Note: Individual coverage level applies to all benefits.

Request Reference Number 112402109220250828112953 **Response Reference Number** 202508280129378
Transaction run on 08/28/2025 at 11:29:53 CT by LAMedicaid - Louisiana Medicaid

Incident Street Address: 165 Beech Springs Rd
Incident City: Jonesboro
Patient Resides in Service Area: Resident Within EMS Service Area

Jackson Parish Ambulance Service District
115 Watts Street
Town of Jonesboro, LA 71251
Work: (318) 259-2877

PCR Prehospital Care Report

Patient Information

Name: Caldwell, Johnny
Address: 10692 Clay Ansley Hwy. City of Ruston, LA 71270
Age: 13 Years
Gender: Male
Weight 75lbs 34 kg
D.O.B.: 12/13/2011
Race: Black or African American

Patient Phone Numbers

Patient's Phone Number	Type
(318) 557-5364	Mobile

Closest Relative/Guardian

Name: Flanagan, Patricia
Address: 10692 Clay Ansley Hwy. City of Ruston, LA 71270
Relationship: Mother

Closest Relative

Phone Number	Type
(318) 557-5364	Mobile

Provider Impression

Primary Impression: Behavioral - Violent

Patient Complaints

Other Patient Conditions That Apply: Depression

Narrative

Narrative: This call was received from JPH ER, requesting us to respond to their facility for a signal 43 to Brentwood hospital. We arrived at the triage room to find a 13 y/o, CAO x 4, b/m sitting on an exam table with his mother. Patient had been brought to the ER by law enforcement after creating a disturbance at school. Patient had verbalized that he wanted to die and also threatened to attack a teacher with a chair. Patient has a history of ADHD and depression. Patient has been placed under a PEC by Dr. Hill. We assisted the patient onto our stretcher, secured him with straps and moved him to our unit. Initial v/s: P-80 RR-16 B/P 127/85 SPO2 99% RA. Patient was monitored throughout transport and no status changes were noted. PTA @ BH, patient report was given via cell phone to Karlandra. V/S upon arrival @ BH: P-80 RR-16 B/P 122/75 SPO2 100% RA. We assisted him off of our stretcher and escorted him to the intake section. Patient care, along with the JPH transfer paperwork, was turned over to Karlandra Barfield without incident.

ALS Assessment Performed : Yes

Past Medical History

Patient Medications

Medication	Dosage	Route
Clonidine		
Cyproheptadine		
Hydroxyzine		

Other Past Medical History:
Medical History Obtained From: Health Care Personnel

Medication Allergies

Incident Street Address: 165 Beech Springs Rd
Incident City: Jonesboro
Patient Resides in Service Area: Resident Within EMS Service Area

Medication Allergies

No Known Drug Allergy

Medical History: ADHD; Depression

Pregnancy: No

Patient Practitioners

Practitioner's Name	Phone
, Unknown	

Assessment Exam

Time

04/04/2025 15:25:16

Assessment Summary

04/04/2025 15:25:16

Detailed Findings

Location	*Description*	*Details*
Skin	Normal Capillary Nail Bed Refill less than 2 seconds Dry Warm	
Mental Status	Normal Baseline for Patient Oriented-Event Oriented-Person Oriented-Place Oriented-Time	
Neurological	Normal Baseline for Patient Gait-Normal Speech Normal Strength-Normal	
Eye Bilateral: Left: Right:	 Reactive PERRL Reactive Reactive	
Shoulder		
Chest/Lungs	Normal Breath Sounds-Equal Breath Sounds-Normal-Left Breath Sounds-Normal-Right	
Abdomen		
Hip		
Upper Leg		
Knee		
Lower Leg		
Ankle		

Foot
Upper Arm
Elbow
Forearm
Wrist
Hand
Back/Spine

Normal Findings

Head ; Face ; Eye (Bilateral) ; Neck ; Shoulder (Shoulder-Left, Shoulder-Right) ; Heart ;
Abdomen (Generalized, Left Lower Quadrant, Left Upper Quadrant, Periumbilical, Right Lower Quadrant, Right Upper Quadrant, Epigastric)

Pelvis ; Hip (Hip-Left, Hip-Right) ; Upper Leg (Leg-Upper-Left, Leg-Upper-Right) ; Knee (Knee-Left, Knee-Right) ;
Lower Leg (Leg-Lower-Left, Leg-Lower-Right) ; Ankle (Ankle-Left, Ankle-Right) ;
Foot (Foot-Dorsal-Left, Foot-Dorsal-Right, Foot-Plantar-Left, Foot-Plantar-Right, Toe-1st (Big)-Left, Toe-1st (Big)-Right, Toe-2nd-Left, Toe-2nd-Right, Toe-3rd-Left, Toe-3rd-Right, Toe-4th-Left, Toe-4th-Right, Toe-5th (Smallest)-Left, Toe-5th (Smallest)-Right) ;
Upper Arm (Arm-Upper-Left, Arm-Upper-Right) ; Elbow (Elbow-Left, Elbow-Right) ; Forearm (Forearm-Left, Forearm-Right) ;
Wrist (Wrist-Left, Wrist-Right) ;
Hand (Finger-2nd (Index)-Left, Finger-2nd (Index)-Right, Finger-3rd (Middle)-Left, Finger-3rd (Middle)-Right, Finger-4th (Ring)-Left, Finger-4th (Ring)-Right, Finger-5th (Smallest)-Left, Finger-5th (Smallest)-Right, Hand-Dorsal-Left, Hand-Dorsal-Right, Hand-Palm-Left, Hand-Palm-Right, Thumb-Left, Thumb-Right) ;
Back/Spine (Back-General, Cervical-Left, Cervical-Midline, Cervical-Right, Lumbar-Left, Lumbar-Midline, Lumbar-Right, Sacral-Left, Sacral-Midline, Sacral-Right, Thoracic-Left, Thoracic-Midline, Thoracic-Right) ;

Not Done

Patient Condition

Alcohol/Drug Use: None Reported

Primary Symptom: Behavior - Suicidal ideations

Other Associated Symptoms:

Possible Injury: No

Activities

Vitals

Time	BP	Limb	Pulse	Rhythm	Resp	Effort	SpO2	Qual	CO2	GCS	Pain	Stroke Scale	PTA	RTS	Pt. Position
04/04/2025 15:30:29	127 / 85		80	Regular	16	Normal	99			15			No	12	
04/04/2025 15:50:16	118 / 74		76	Regular	16	Normal	100			15			No	12	
04/04/2025 16:10:24	119 / 82		84	Regular	16	Normal	100			15			No	12	
04/04/2025 16:30:37	118 / 71		72	Regular	16	Normal	100			15			No	12	
04/04/2025 16:51:04	122 / 75		80	Regular	16	Normal	100			15			No	12	

GCS

Incident Street Address: 165 Beech Springs Rd
Incident City: Jonesboro
Patient Resides in Service Area: Resident Within EMS Service Area

Time	Eye	Motor	Verbal	Score Qualifier
04/04/2025 15:30:29	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
04/04/2025 15:50:16	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
04/04/2025 16:10:24	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
04/04/2025 16:30:37	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
04/04/2025 16:51:04	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation

Call Type/Location/Disposition

Call Type: Psychiatric Problem/Abnormal Behavior/Suicide Attempt
Resp. Mode: Non-Emergent
Urgency: Non-Immediate
Response: Interfacility Transport
Location: Health Facility - Hospital
Incident Facility or Location Name: Jackson Parish Hospital
Incident Address: 165 Beech Springs Rd Jonesboro, LA 71251
Zone Number: 1
Transferring Physician / Referring MD: Lawrence Hill

Disposition: Patient Treated, Transported by this EMS Unit
Transport Mode: Non-Emergent
Destination: Brentwood Hospital 1006 Highland Ave City of Shreveport, LA 71101
Dest. Determ.: Patient's Physician's Choice
Response Delay: None/No Delay
Transport Delay: None/No Delay
Receiving Physician / Accepting MD: Katherine Smith

Patient Transport/Positioning

Patient's Position in Transport: Fowlers (Semi-Upright Sitting)

Patient Belongings Left With: At Destination with Staff (includes Aeromed. staff)

Response Times and Mileage

PSAP: Not Applicable
Unit Disp.: 04/04/2025 15:20:38
Enroute: 04/04/2025 15:22:28
At Scene: 04/04/2025 15:23:44
At Patient: 04/04/2025 15:24:44
Depart: 04/04/2025 15:33:21
Arrive Dest.: 04/04/2025 16:50:22
Patient Arrived at Destination 04/04/2025 16:50:22

Incident Number: 2025040400 9
Call Sign: T-2
Veh. #: T-2
On-Scene Odometer Reading of Responding Vehicle: 0
Dest. Odom: 79
To Dest: 79.0

Incident Street Address: 165 Beech Springs Rd
Incident City: Jonesboro
Patient Resides in Service Area: Resident Within EMS Service Area
Date/Time:

Destination Patient Transfer of Care Date/Time: 04/04/2025 16:55:04

In Service: 04/04/2025 16:57:02

Unit Personnel

Crew Member	Level of Certification	Role
Hines, Kaitlyn	EMT-Basic	Driver/Pilot-Response ; Driver/Pilot-Transport ; Other Patient Caregiver-At Scene
Burns, Timothy	EMT-Paramedic	Primary Patient Caregiver-At Scene ; Primary Patient Caregiver-Transport

Billing Information

Payment: Medicaid

Billing Notes: JPH Contract

Insurance Information

Company Name	Company City	Company State	Insurance Policy #	Relationship
United Healthcare			0754920174350	

Signatures

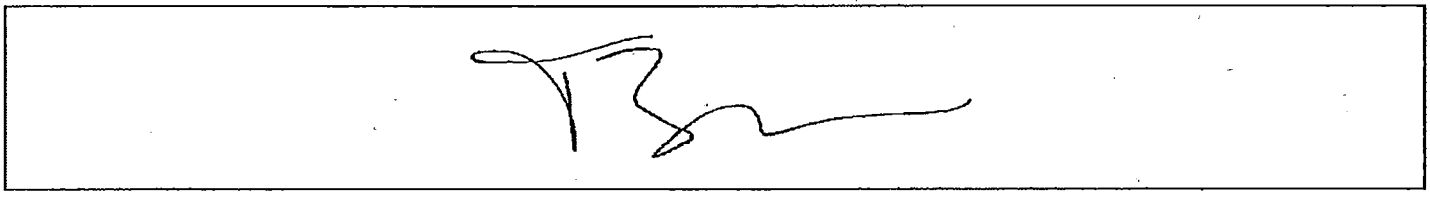
Type of Person Signing: EMS Crew Member Completing Report

Signature Reason: Crewmember Signature

Paragraph Text: I was the primary care provider for this incident.

Status: Signed

Signature Graphic:



Printed Name: Timothy Burns

Signature Date: 04/04/2025 15:21:37

Type of Person Signing: Patient Representative

Type Of Patient Representative: Mother

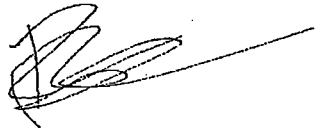
Signature Reason: HIPAA acknowledgement/Release; Release for Billing; Patient/Medical Necessity Unable to Sign

Paragraph Text:
Billing Authorization/Privacy Practices Acknowledgement: I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Jackson Parish Ambulance Service District(JPASD) for any services provided to me by JPASD now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by JPASD, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to JPASD and payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all right to such payments to JPASD. I authorize JPASD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information other relevant documentation about me to release such information to JPASD and its billing agents, the Centers for Medicare and Medicaid Services, and/or and other payers or insures, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by JPASD, now, in the past, or in the future. A copy of this form is as valid as an original. Also acknowledge that I have received JPASD's Notice of Privacy Practice.

Status: Signed

Signature Graphic:

Incident Street Address: 165 Beech Springs Rd Incident City: Jonesboro Patient Resides in Service Area: Resident Within EMS Service Area



Printed Name: Patricia Flanagan

Signature Date: 04/04/2025 15:26:50

Type of Person Signing: Patient

Signature Reason: HIPAA acknowledgement/Release; Release for Billing

Paragraph Text:
Billing Authorization/Privacy Practices Acknowledgement: I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Jackson Parish Ambulance Service District(JPASD) for any services provided to me by JPASD now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by JPASD, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to JPASD and payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all right to such payments to JPASD. I authorize JPASD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information other relevant documentation about me to release such information to JPASD and its billing agents, the Centers for Medicare and Medicaid Services, and/or and other payers or insures, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by JPASD, now, in the past, or in the future. A copy of this form is as valid as an original. Also acknowledge that I have received JPASD's Notice of Privacy Practice.

Status: Not Signed - Minor/Child

Signature Graphic:

Printed Name: Johnny Caldwell

Signature Date: 04/04/2025 15:27:34

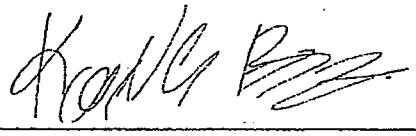
Type of Person Signing: Healthcare Provider

Signature Reason: Transfer of Patient Care; Patient Belongings (Receipt); Medical Necessity

Paragraph Text:
I acknowledge that the patient documented on this Patient Care Report (PCR) has been transferred to my care.

Status: Signed

Signature Graphic:



Printed Name: Karlandra Barfield

Signature Date: 04/04/2025 16:55:00

Type of Person Signing: EMS Crew Member (Other)

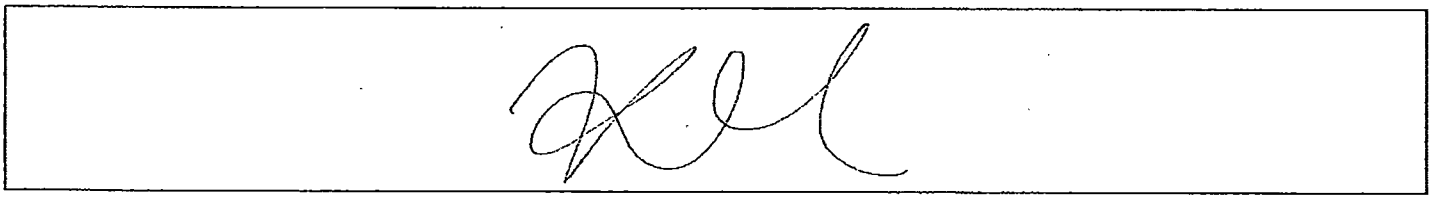
Signature Reason: Crewmember Signature

Incident Street Address: 165 Beech Springs Rd Incident City: Jonesboro Patient Resides in Service Area: Resident Within EMS Service Area

Paragraph Text: I was the secondary provider on this incident.

Status: Signed

Signature Graphic:



Printed Name: Kaitlyn Hines

Signature Date: 04/04/2025 16:56:58

Attachments

File Name: j. caldwell 4-4-25 105
Modified By: Michelle Bartlett
Modified On: 04/10/2025 16:49:36

DEPARTMENT OF HEALTH

CERTIFICATION OF AMBULANCE TRANSPORTATION

SECTION I – GENERAL INFORMATION

Patient's Last Name: Caldwell Patient's First Name: Johnny MI: Gender: ☒ Male ☐ Female

Date of Birth (MM/DD/YYYY): 12/13/11 Medicare#: Medicaid#: 075492017485D

Transport Date (if form will be used for a single transport) : 04/04/2025 Round Trip: ☐ Yes ☒ No

Date Range (if applicable) Start date: / / End date: / /

☐ 180 days from start date *(Maximum 180 days from start date - LA Medicaid ONLY)*

Transport from: ☐ Home, or Jackson Parish Hospital 165 Beech Springs Road Jonesboro, La 71251

Transport To: Brentwood 1000 Highland Ave. Shreveport, LA 71101

SECTION II – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

Certifying Physician/Practitioner Information:

Facility: Jackson Parish Hospital Address: 165 Beech Springs Road

City: Jonesboro State: La Zip Code: 71251

Telephone number *(and extension if applicable)*: 318-259-4321 Extension:

I certify that the information contained in this document represents an accurate assessment of the patient's medical condition on the date(s) of service.

x _____ 4/4/25
Signature of Physician or Authorized Healthcare Professional — Date Signed

Steven Linder, RN — 1093793408
Printed Name of Physician or Authorized Healthcare Professional — NPI or License Number

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner
☒ Registered Nurse (RN) ☐ Clinical Nurse Specialist (CNS)

Please complete page 2

Incident Street Address: 165 Beech Springs Rd Incident City: Jonesboro Patient Resides in Service Area: Resident Within EMS Service Area

DEPARTMENT OF HEALTH

CERTIFICATION OF AMBULANCE TRANSPORTATION

Medicaid

Patient's Name: CALDWELL, JOHNNY Johnny Caldwell
DOB: 12/13/2011 13 Y M
DOS: 04/04/2025 12:22
ATT: Hill, Lawrence C
FIN: 10861587
MRN: 60915

Medicare #:

DOB: 12, 13 2011

Medicaid #: 07549201743S0

ECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transportation are contraindicated or it would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or the patient's condition is such that other methods of transportation are contraindicated. Medical necessity is determined by the patient's condition, not the diagnosis that makes the use of any other method of transportation contraindicated. Please answer the questions below to describe the reason (physical and/or mental) that makes non-emergency ambulance transportation necessary. Documentation supporting the information provided on this form must be maintained in the patient's medical record.

The following questions shall be answered by the healthcare professional whose signature is in Section II of this form to substantiate medical necessity for transport, and for this form to be valid.

1) Is this patient "bed confined" as defined below? ☐ Yes ☒ No

To be "bed confined" the patient must satisfy all three of the following criteria:
(a) *unable* to get up from bed without assistance; AND (b) *unable* to ambulate; AND (c) *unable* to sit in a chair or wheelchair.

2) Other means of transportation are contraindicated *because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience.* ☒ Yes ☐ No

Reason(s) (physical and/or mental) that non-emergency ground transport by ambulance is required. Supporting documentation for any checked item must be maintained in the patient's medical record. Check all that apply:

☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and deconditioning	
☐ Spinal Cord Injury – Paralysis	☐ *Postural Instability*
☐ CVA with sequelae (late effect of CVA) that impair mobility and result in bed confinement	
☐ *Hemiparesis*	☐ Progressive demyelinating disease
☐ *Hemiplegia*	☐ Moderate to severe pain on movement
☐ *Unable to transfer independently*	☐ Chronic wounds requiring immobilization
☐ Risk of falling out of wheelchair while in motion *(not related to obesity)*	☐ Special handling enroute – Isolation
☐ *Non-weight Bearing Condition*	☐ *Completely immobile*
☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks	
☐ *Requires extensive/total care for ADL's*	☐ DVT requires elevation of lower extremity
☐ Non-healed fractures requiring ambulance	☐ Morbid obesity requires additional personnel/equipment to handle
☐ Contractures that impair mobility and result in bed confinement	☐ Third party attendant required to regulate or adjust oxygen enroute
☐ Incapacitating Osteoarthritis	☐ IV medications/fluids required during transport
☐ Orthopedic device required in transit	☐ Cardiac monitoring required enroute
☐ Amputations	☐ *Hemodynamic monitoring required*
☐ Severe muscular weakness/paresis and deconditioned state precludes any significant physical activity	
☐ Confused, combative, lethargic, comatose	☒ Danger to self or others
☐ Restraints *(physical or chemical)* anticipated or used during transport, *or to prevent falling*	
☒ Other, describe: if Suspicion Edentulous Complete	

Revision Date: 10.01.2024 Page | 2

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.)**

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

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.

RECEIVED
SEP 30 2025
VERITA GLOBAL

1169-c

2590359250930000000000032

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: Jackson Parish Ambulance Service
   Number Street: 115 Watts Street
   City State ZIP Code: Jonesboro, LA 71251-2053
   Country: U.S.A.
   Contact phone: 318-259-2891
   Contact email: officemanager@jpasd.com

   Where should payments to the creditor be sent? (if different)
   Name: Jackson Parish Ambulance Serv
   Number Street: 115 Watts Street
   City State ZIP Code: Jonesboro, LA 71251-2053
   Country: U.S.A.
   Contact phone: 318-259-2891
   Contact email: officemanager@jpasd.com

   RECEIVED
   SEP 30 2025
   VERITA GLOBAL

   Uniform claim identifier (if you use one): _____

4. **Does this claim amend one already filed?**
   ☒ No
   ☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**
   ☒ No
   ☐ Yes. Who made the earlier filing? _____

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
   ☐ No
   ☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ___ ___ ___ ___

7. **How much is the claim?**
   $ 2,975.00 . **Does this amount include interest or other charges?**
   ☐ No
   ☑ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**
   Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
   Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
   Limit disclosing information that is entitled to privacy, such as health care information.
   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)?

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

☒ No

☐ Yes. *Check all that apply:*

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:

RECEIVED
SEP 30 2025
VERITA GLOBAL

Name: Scott (First name) Shurley (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
COI

Support.Claims@Modivcare.com
ModivCare

798 Park Ave NW
4th Floor
Norton, VA 24273

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0754920174350
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Caldwell Johnny	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 2011 SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial): Caldwell Johnny
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street): [redacted]
CITY: [redacted] STATE: [redacted]	8. RESERVED FOR NUCC USE		CITY: [redacted] STATE: [redacted]
ZIP CODE: [redacted] TELEPHONE (Include Area Code): ( )			ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]) [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Caldwell Johnny	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 0754920174350	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]		a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 2011 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
d. INSURANCE PLAN NAME OR PROGRAM NAME: UHC of LA	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE: 04 04 2025

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 04 25 QUAL.: 431	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	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ 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. R456 B. R45851 C. Z743 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 04 04 25	04 04 25	41		A0428	HH	AB	1 000 00	1		ZZ	341600000X
										NPI	1124021092
2 04 04 25	04 04 25	41		A0425	HH	AB	1 975 00	79		ZZ	341600000X
										NPI	1124021092
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 72-1433510	26. PATIENT'S ACCOUNT NO.: 025-20250404009:1	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 2 975 00	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 8/28/2025
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Jackson Parish
165 Beech Springs Rd
Jonesboro, LA 71251
3:23:44 PM
a. b.

Brentwood Hospital
1006 Highland Ave
Shreveport, LA 71101
4:50:22 PM

33. BILLING PROVIDER INFO & PH # (888) 357 9977
Jackson Parish Amb Service Dist
115 Watts St Jonesboro, LA 71251
a. 1124021092 b. ZZ341600000X

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061657 APPROVED OMB-0938-1197 FORM 1500 (02-12)
MB-0D3W-M7PA

SECOND FOLD

FIRST FOLD

ENVELOPE BSS-92568-024

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the [redacted] payment in full. See Black Lung and FECA instructions regarding required proced[redacted]

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, [redacted] 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regu[redacted]gra[redacted]ructions for payment incl[redacted]not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark la[redacted]); 5) services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

April 20, 2026

Response to Eleventh Omnibus Objection Case No. 25-90309 (ARP)

United States Bankruptcy Court for the Southern District of Texas
Timothy A. Davidson II - Hunton Andrews Kurth LLP
Case No, 25-90309 (ARP)
Eleventh Omnibus Claim Objection

Re: Claim No. 1182-c

Jackson Parish Ambulance Service District is asking the Court to not grant the Omnibus Objection due to the reasons stated below:

- Claim No. 1182-c is a factual claim originated on date of service 6/15/2025 from Jackson Parish Hospital.
- The transport was initiated due to a call where ER Physician requested transport due to mental health emergency and patient needs transport to LA Behavioral Health Hospital (PEC attached).
- The transport Certification of Ambulance Transportation, the Physician's Certification Statement, and other supporting documents were attached with the initial submission to Modivcare in line with billing procedures.
- Submission of claim was timely (see copy of email sent below).

From: Seth Linn <seth.linn@insightbillingcorp.com>
Sent: Thursday, August 28, 2025 11:58 AM
To: 'Support.Claims@ModivCare.com' <Support.Claims@ModivCare.com>
Subject: RE: Jackson Parish AMB Service - TAX ID: 721433510 - NPI: 1124021092

Please see attached, thank you.

Thanks
Seth Linn|Follow Up Clerk
Insight Billing Corporation
318-747-9977 ext. 191 | Office
888-357-9977 ext. 191
318-747-9994 | Fax

- No response from Modivcare received on outcome of claim processing.

Thank you.

Jackson Parish Ambulance Service District Billing Office
Scott Shurley, 318-841-0222 | scott.shurley@insightbilling.com
Insight Billing Corporation
2640 Youree Dr, Suite 200
Shreveport, LA 71104-3662

DHH-1 (PEC) Rev. 05/2017

Complete Prior to Admission

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH – OFFICE OF BEHAVIORAL HEALTH
PHYSICIAN'S EMERGENCY CERTIFICATE

For observation, diagnosis, and treatment at a treatment facility for a period not to exceed 15 days, or 28 days, for substance abuse (Title 28:52.4). See Louisiana Revised Statutes, Title 28, Sections 53 and 63. These directives must be fulfilled in order for this certificate to be valid.

NAME OF EXAMINING PHYSICIAN:	EXAMINATION DATE:	EXAMINATION TIME:
James McNamara PMDO	6/15/25	1946 hrs

ADDRESS OF EXAMINING PHYSICIAN: 165 Beech Springs Rd Jonesboro, LA 71251

NAME OF PATIENT: Kiara Maxwell

ADDRESS OF PATIENT: P.O Box 102 Quitman, LA 71268

RACE	SEX	DATE OF BIRTH	BIRTHPLACE
	☐ M ☑ F	5/23/2008	

MARITAL STATUS	MILITARY STATUS	RELIGION
☑ S ☐ M ☐ D ☐ W ☐ SEP	☐ VETERAN ☐ NON-VETERAN	

NAME OF NEAREST RELATIVE, FRIEND, OR GUARDIAN	RELATIONSHIP
Chakeithia Maxwell	mother
ADDRESS	**PHONE NUMBER**
P.O. Box 102 Quitman, LA	318-278-9810

MAXWELL, KIARA L
DOB: 05/22/2008 17Y
DOS: 06/15/2025 19:29
ATF:
FIN: 10871530

CHECK: ☐ Mental Illness or Substance Abuse (15 Day) ☐ Substance Abuse (28 Day) ☐ 1st ☐ 2nd Order For Protective Custody Date: _____

FINDINGS OF EXAMINATION

HISTORY OF PRESENT ILLNESS (REASONS FOR ADMISSION, INCLUDING BEHAVIOR, ACTS, THREATS, ETC.)
Overdose on Tylenol – denies SI
OD attempt 6/14/25

PHYSICAL FINDINGS (MEDICAL HISTORY, CURRENT MEDICATIONS, ETC.)
VSS

MENTAL CONDITION (ORIENTATION, MOOD, THOUGHT CONTENT, AFFECT, ANY HALLUCINATIONS OR DELUSIONS)
Patient appears to be in no acute distress – this appears to be facade.

PREVIOUS PSYCHIATRIC TREATMENT	DATE OF TREATMENT	PLACE, IF KNOWN
☐ INPATIENT ☐ OUTPATIENT		

IS PATIENT CURRENTLY: ☐ SUICIDAL ☐ HOMICIDAL ☐ VIOLENT

I am of the opinion that the above person named is in need of immediate psychiatric treatment in a treatment facility because he/she is seriously mentally ill or suffering from substance abuse so that he/she is (check where appropriate in both 1 & 2):
1. ☑ Dangerous to self ☐ Dangerous to others ☐ Gravely disabled
2. ☐ Unwilling ☑ Unable to seek voluntary admission

SIGNATURE OF EXAMINING PHYSICIAN	LA MEDICAL LICENSE NUMBER	DATE SIGNED	TIME SIGNED
James McNamara PMDO	328373	6/15/25	1949 hrs

Completion of above certificate shall constitute legal authority to transport patient to the following facility:
1. _____
2. _____

To be transported by: _____ Relationship to patient: _____

ORIGINAL TO HOSPITAL – ONE COPY TO EXAMINING PHYSICIAN

Support.Claims@Modivcare.com
ModivCare

798 Park Ave NW
4th Floor
Norton, VA 24273

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9316535276733

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)
MAXWELL KIARA L	05 22 2008	M F X	MAXWELL KIARA L

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
115 JOANN DR	Self X Spouse Child Other	115 JOANN DR

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
JONESBORO	LA		JONESBORO	LA

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
71251	( )		71251	(318) -533-0248

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 X	a. INSURED'S DATE OF BIRTH MM DD YY 05 22 2008 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
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE: 06 15 2025

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
06 15 25 QUAL. 431		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO X $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. R45851	B. Z743	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 06 15 25	06 15 25	41		A0428	HH	AB	1 000 00	1		ZZ	341600000X
										NPI	1124021092
2 06 15 25	06 15 25	41		A0425	HH	AB	2 192 50	88		ZZ	341600000X
										NPI	1124021092
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
72-1433510	025-20250616001:1	X YES NO	$ 3 192 50	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Aaron Johnson 8/28/2025
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Jackson Parish
165 Beech Springs Rd
Jonesboro, LA 71251
10:22:49 PM
a. b.

Louisiana Behavioral
9320 Linwood Ave
Shreveport, LA 71106
11:53:45 PM

33. BILLING PROVIDER INFO & PH # (888) 357 9977
Jackson Parish Amb Service Dist
115 Watts St Jonesboro, LA 71251
a. 1124021092 b. ZZ341600000X

LOUISIANA MEDICAID

Medicaid Eligibility Verification System

PRINT

- IMPORTANT: DO NOT use the "BACK" browser button - please use the navigation menu.
- **Note:** For Technical Support, Please Contact **1-877-598-8753**
- **Note:** For Eligibility Information Support, Please Contact **(800) 473-2783** or **(225) 924-5040**
- **Note:** The date field formats have changed - enter date in MM/DD/YYYY format
- **NOTE:** CMS REGULATIONS LIMIT PROVIDING RECIPIENT ELIGIBILITY OLDER THAN THE MOST CURRENT 12 MONTHS.

Search Criteria

Search Type	Recipient ID and DOB	**Recipient ID**	9316535276733	**Date of Birth**	05/22/2008	**Plan Date**	06/15/2025

Subscriber Information

Policy Holder Name	MAXWELL , KIARA L
Subscriber ID	9316535276733
Date of Birth	05/22/2008
Sex	Female
Address	PO BOX 102 QUITMAN LA 71268-0000

Provider Information

Provider	JACKSON PARISH AMBULANCESERV
NPI	1124021092
Submitter ID	3182592891

For name or address discrepancies, recipients must call LA Medicaid-Eligibility Hotline 1-877-252-2447.

For dates of service from 01/01/2023 through 10/27/2023, if the Managed Care Coordinator listed for the Plan Coverage is Humana Health Benefit Plan, all pharmacy POS transaction should be processed as FFS using the Medicaid Recipient ID or CCN and BIN: 610514, PCN: LOUIPROD and Group: HUMANA.

For dates of service on/after 12/1/2015, if there is no Managed Care Coordinator listed for the Plan Coverage Description (Medical Care or Specialized Behavioral Health Care or Dental Care), claims should be sent to Gainwell Technologies.

Health Benefit Plan Coverage

Benefit	Service Type Code	Insurance Type	Plan Coverage Description
Active Coverage	Health Benefit Plan Coverage	Medicaid	Eligible for Medicaid on Plan Date. **Plan Begin Date** 11/01/2018
Deductible	Health Benefit Plan Coverage	Medicaid	Health Plan Base Deductible is $0 for In Plan Network and Out of Plan Network.
Benefit Description	Health Benefit Plan Coverage	Medicaid	Recipient is EPSDT Eligible.
Benefit Description	Health Benefit Plan Coverage	Medicaid	PREFERRED LANGUAGE: ENGLISH
Managed Care Coordinator	Medical Care	Medicaid	BAYOU HEALTH PLAN **Benefit Begin** 01/01/2023 PHARMACY PBM IS Prime Therapeutics, LLC **Managed Care Organization** UNITED HEALTHCARE OF LOUISIAN **Telephone** (866) 675-1607
Managed Care Coordinator	Specialized Behavioral Health Care	Medicaid	BAYOU HEALTH PLAN **Benefit Begin** 01/01/2023 PHARMACY PBM IS Prime Therapeutics, LLC **Payer** UNITED HEALTHCARE OF LOUISIAN **Telephone** (866) 675-1607
Managed Care Coordinator	Dental Care	Medicaid	DENTAL BENEFITS PLAN MANAGER **Benefit Begin** 01/01/2021 **Payer** MCNA INSURANCE COMPANY **Telephone** (855) 701-6262 **URL** https://PORTAL.MCNA.NET
Active Coverage		Medicaid	Eligible for Medicaid on Plan Date.
Co-Insurance		Medicaid	MEDICAID - Benefit Co-Insurance is 0% for In Plan Network and Out of Plan Network
Co-Payment		Medicaid	MEDICAID - Benefit Co-Pay is $0 for In Plan Network and Out of Plan Network

Please Note: Individual coverage level applies to all benefits.

Request Reference Number 11240210922025082811303 9 **Response Reference Number** 202508280129530
Transaction run on 08/28/2025 at 11:30:39 CT by LAMedicaid - Louisiana Medicaid

Incident Number: 20250616001 **Patient Name:** Maxwell , Kiara L **Unit Notified by Dispatch Date/Time:** 06/15/2025 22:19:13

Incident Street Address: 165 Beech Springs Rd **Incident City:** Jonesboro **Patient Resides in Service Area:** Resident Within EMS Service Area

Jackson Parish Ambulance Service District
115 Watts Street
Town of Jonesboro, LA 71251
Work: (318) 259-2877

PCR Prehospital Care Report

Patient Information

Name: Maxwell , Kiara L
Address: 115 Joann Dr.
Town of Jonesboro, LA 71251

Age: 17 Years
Gender: Female
Weight 124lbs
56.2 kg

D.O.B.: 05/22/2008
Race: Black or African American

Patient Phone Numbers

Patient's Phone Number	Type
(318) 533-0248	Mobile

Closest Relative/Guardian

Name: Maxwell , Geoffrey
Address: 115 Joann Dr.
Town of Jonesboro, LA 71251

Relationship: Father

Closest Relative

Phone Number	Type
(318) 533-2347	Mobile

Provider Impression

Primary Impression: Behavioral - Depression

Patient Complaints

Other Patient Conditions That Apply:

Narrative

Narrative: This call was received from JPH ER, requesting us to respond to their facility for a signal 43 to Louisiana Behavioral Health-Shreveport. We arrived at exam room 4 to find a 17 y/o, CAO X 4, b/F sitting up on the stretcher. Patient states that she had taken an excessive amount of Tylenol about 24 hrs ago in an effort to harm herself. Her parents were made aware of it this evening and they brought her to the ER. Patient has no acute physical complaints and has been medically cleared by the ER physician. Patient has been placed under a PEC by Dr. J. McNamara. We assisted her onto our stretcher, secured her with straps and moved her to our unit. Initial v/s: P-76 RR-16 B/P 110/72 SPO2 99% RA. Patient was monitored throughout transport and no status changes were noted. PTA @ LBH, patient report was given via cell phone to Chris. V/S upon arrival @ OBH: P-72 RR-16 B/P 114/71 SPO2 99% RA. We assisted the patient to the intake area. Patient care, along with the JPH transfer paperwork, was turned over to Chris Brian without incident.

ALS Assessment Performed: Yes

Past Medical History

Patient Medications

Medication	Dosage	Route
None Reported		

Other Past Medical History:

Medical History Obtained From: Health Care Personnel

Medication Allergies

Medication Allergies
No Known Drug Allergy

Incident Street Address: 165 Beech Springs Rd **Incident City:** Jonesboro **Patient Resides in Service Area:** Resident Within EMS Service Area

Medical History: None Reported **Pregnancy:** No

Patient Practitioners

Practitioner's Name	Phone
Dyer ,	

Assessment Exam

Time

06/15/2025 22:26:29

Assessment Summary

06/15/2025 22:26:29

Detailed Findings

Location	*Description*	*Details*
Skin	Normal Capillary Nail Bed Refill less than 2 seconds Dry Warm	
Mental Status	Normal Baseline for Patient Oriented-Event Oriented-Person Oriented-Place Oriented-Time	
Neurological	Normal Baseline for Patient Gait-Normal Speech Normal Strength-Normal	
Eye Bilateral: Left: Right:	 Reactive PERRL Reactive Reactive	
Shoulder		
Chest/Lungs	Normal Breath Sounds-Equal Breath Sounds-Normal-Left Breath Sounds-Normal-Right	
Abdomen		
Hip		
Upper Leg		
Knee		
Lower Leg		
Ankle		
Foot		

Upper Arm
Elbow
Forearm
Wrist
Hand
Back/Spine

Normal Findings

Head; Face; Eye (Bilateral); Neck; Shoulder (Shoulder-Left, Shoulder-Right); Heart;
Abdomen (Generalized, Left Lower Quadrant, Left Upper Quadrant, Periumbilical, Right Lower Quadrant, Right Upper Quadrant, Epigastric)

Pelvis; Hip (Hip-Left, Hip-Right); Upper Leg (Leg-Upper-Left, Leg-Upper-Right); Knee (Knee-Left, Knee-Right);
Lower Leg (Leg-Lower-Left, Leg-Lower-Right); Ankle (Ankle-Left, Ankle-Right);
Foot (Foot-Dorsal-Left, Foot-Dorsal-Right, Foot-Plantar-Left, Foot-Plantar-Right, Toe-1st (Big)-Left, Toe-1st (Big)-Right, Toe-2nd-Left, Toe-2nd-Right, Toe-3rd-Left, Toe-3rd-Right, Toe-4th-Left, Toe-4th-Right, Toe-5th (Smallest)-Left, Toe-5th (Smallest)-Right);
Upper Arm (Arm-Upper-Left, Arm-Upper-Right); Elbow (Elbow-Left, Elbow-Right); Forearm (Forearm-Left, Forearm-Right);
Wrist (Wrist-Left, Wrist-Right);
Hand (Finger-2nd (Index)-Left, Finger-2nd (Index)-Right, Finger-3rd (Middle)-Left, Finger-3rd (Middle)-Right, Finger-4th (Ring)-Left, Finger-4th (Ring)-Right, Finger-5th (Smallest)-Left, Finger-5th (Smallest)-Right, Hand-Dorsal-Left, Hand-Dorsal-Right, Hand-Palm-Left, Hand-Palm-Right, Thumb-Left, Thumb-Right);
Back/Spine (Back-General, Cervical-Left, Cervical-Midline, Cervical-Right, Lumbar-Left, Lumbar-Midline, Lumbar-Right, Sacral-Left, Sacral-Midline, Sacral-Right, Thoracic-Left, Thoracic-Midline, Thoracic-Right);

Not Done

Patient Condition

Alcohol/Drug Use: None Reported

Primary Symptom: Behavior - Suicidal ideations

Other Associated Symptoms:

Possible Injury: No

Activities

Vitals

Time	BP	Limb	Pulse	Rhythm	Resp	Effort	SpO2	Qual	CO2	GCS	Pain	Stroke Scale	PTA	RTS	Pt. Position
06/15/2025 22:32:00	110/72		76	Regular	16	Normal	99			15			No	12	
06/15/2025 22:47:16	111/68		76	Regular	16	Normal	98			15			No	12	
06/15/2025 23:02:26	109/71		72	Regular	16	Normal	97			15			No	12	
06/15/2025 23:17:12	114/70		72	Regular	16	Normal	98			15			No	12	
06/15/2025 23:32:29	106/67		80	Regular	16	Normal	99			15			No	12	
06/15/2025 23:47:38	109/62		76	Regular	16	Normal	98			15			No	12	
06/15/2025 23:54:10	114/71		72	Regular	16	Normal	99			15			No	12	

GCS

Incident Street Address: 165 Beech Springs Rd Incident City: Jonesboro Patient Resides in Service Area: Resident Within EMS Service Area

Time	Eye	Motor	Verbal	Score Qualifier
06/15/2025 22:32:00	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
06/15/2025 22:47:16	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
06/15/2025 23:02:26	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
06/15/2025 23:17:12	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
06/15/2025 23:32:29	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
06/15/2025 23:47:38	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation
06/15/2025 23:54:10	Opens Eyes spontaneously (All Age Groups)	Obeys commands (>2Years); Appropriate response to stimulation	Oriented (>2 Years); Smiles, oriented to sounds, follows objects, interacts	Initial GCS has legitimate values without interventions such as intubation and sedation

Call Type/Location/Disposition

Call Type: Psychiatric Problem/Abnormal Behavior/Suicide Attempt
Disposition: Patient Treated, Transported by this EMS Unit
Resp. Mode: Non-Emergent
Transport Mode: Non-Emergent
Urgency: Non-Immediate
Destination: Louisiana Behavioral Health- Shreveport 9320 Linwood Ave. Shreveport, LA 71106
Response: Interfacility Transport
Dest. Determ.: Patient's Physician's Choice
Location: Health Facility - Hospital
Incident Facility or Location Name: Jackson Parish Hospital
Response Delay: None/No Delay
Incident Address: 165 Beech Springs Rd Jonesboro, LA 71251
Transport Delay: None/No Delay
Zone Number: 1
Receiving Physician / Accepting MD: Sean McNeal
Transferring Physician / Referring MD: James McNamara

Patient Transport/Positioning

Patient's Position in Transport: Fowlers (Semi-Upright Sitting)
Patient Belongings Left With: At Destination with Staff (includes Aeromed. staff)

Response Times and Mileage

PSAP: Not Applicable
Incident Number: 20250616001
Call Sign: T-2
To Dest: 87.7
Unit Disp.: 06/15/2025 22:19:13
Veh. #: T-2
Enroute: 06/15/2025 22:21:24
At Scene: 06/15/2025 22:22:49
On-Scene Odometer Reading of Responding Vehicle: 0
At Patient: 06/15/2025 22:25:38
Dest. Odom: 87.7

Incident Street Address: 165 Beech Springs Rd **Incident City:** Jonesboro **Patient Resides in Service Area:** Resident Within EMS Service Area

Depart: 06/15/2025 22:33:18

Arrive Dest.: 06/15/2025 23:53:45

Patient Arrived at Destination Date/Time: 06/15/2025 23:53:45

Destination Patient Transfer of Care Date/Time: 06/16/2025 00:00:29

In Service: 06/16/2025 00:04:18

Unit Personnel

Crew Member	Level of Certification	Role
Burns, Timothy	EMT-Paramedic	Primary Patient Caregiver-At Scene ; Primary Patient Caregiver-Transport
Hines, Kaitlyn	EMT-Basic	Driver/Pilot-Response ; Driver/Pilot-Transport ; Other Patient Caregiver-At Scene

Billing Information

Payment: Medicaid **Billing Notes:** JPH Contract

Insurance Information

Company Name	Company City	Company State	Insurance Policy #	Relationship
United Healthcare Community Care			107261267	

Signatures

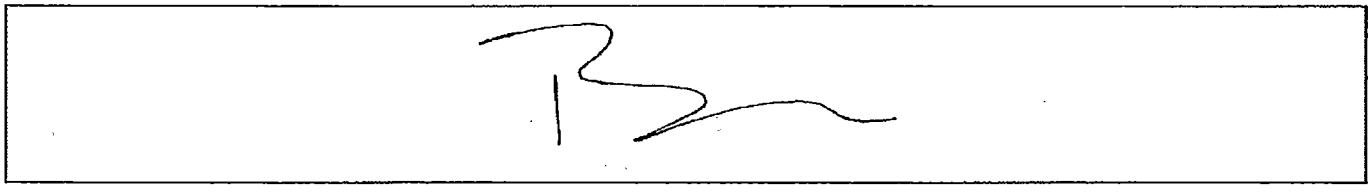
Type of Person Signing: EMS Crew Member Completing Report

Signature Reason: Crewmember Signature

Paragraph Text: I was the primary care provider for this incident.

Status: Signed

Signature Graphic:



Printed Name: Timothy Burns

Signature Date: 06/15/2025 22:20:06

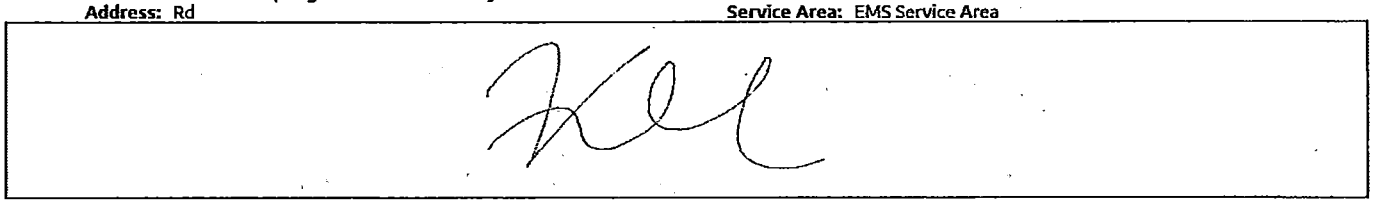
Type of Person Signing: EMS Crew Member (Other)

Signature Reason: Crewmember Signature

Paragraph Text: I was the secondary provider on this incident.

Status: Signed

Signature Graphic:



Printed Name: Kaitlyn Hines

Signature Date: 06/15/2025 22:21:04

Type of Person Signing: Patient Representative

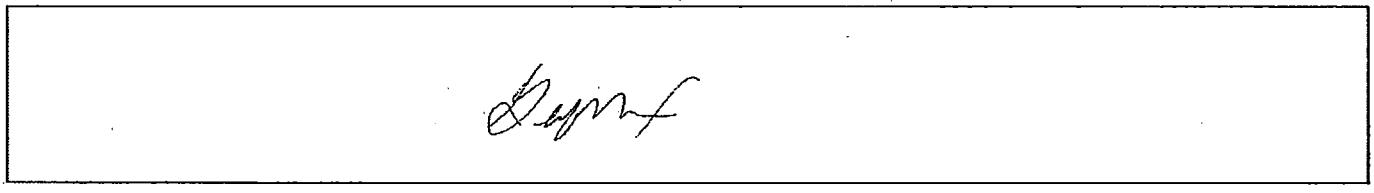
Type Of Patient Representative: Father

Signature Reason: HIPAA acknowledgement/Release; Release for Billing; Patient/Medical Necessity Unable to Sign

Paragraph Text:
Billing Authorization/Privacy Practices Acknowledgement: I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Jackson Parish Ambulance Service District(JPASD) for any services provided to me by JPASD now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by JPASD, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to JPASD and payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all right to such payments to JPASD. I authorize JPASD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information other relevant documentation about me to release such information to JPASD and its billing agents, the Centers for Medicare and Medicaid Services, and/or and other payers or insures, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by JPASD, now, in the past, or in the future. A copy of this form is as valid as an original. Also acknowledge that I have received JPASD's Notice of Privacy Practice.

Status: Signed

Signature Graphic:



Printed Name: Geoffrey Maxwell

Signature Date: 06/15/2025 22:25:15

Type of Person Signing: Patient

Signature Reason: HIPAA acknowledgement/Release; Release for Billing

Paragraph Text:
Billing Authorization/Privacy Practices Acknowledgement: I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Jackson Parish Ambulance Service District(JPASD) for any services provided to me by JPASD now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by JPASD, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to JPASD and payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all right to such payments to JPASD. I authorize JPASD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information other relevant documentation about me to release such information to JPASD and its billing agents, the Centers for Medicare and Medicaid Services, and/or and other payers or insures, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by JPASD, now, in the past, or in the future. A copy of this form is as valid as an original. Also acknowledge that I have received JPASD's Notice of Privacy Practice.

Status: Not Signed - Minor/Child

Signature Graphic:

Printed Name: Kiara Maxwell

Signature Date: 06/15/2025 22:26:05

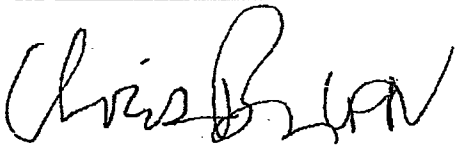
Type of Person Signing: Healthcare Provider

Signature Reason: Transfer of Patient Care; Patient Belongings (Receipt); Medical Necessity

Paragraph Text:
I acknowledge that the patient documented on this Patient Care Report (PCR) has been transferred to my care.

Status: Signed

Signature Graphic:



Printed Name: Chris Brian

Signature Date: 06/16/2025 00:00:25

Attachments

File Name: k. maxwell 6-15-25 105
Modified By: Michelle Bartlett
Modified On: 06/19/2025 17:59:50

DEPARTMENT OF HEALTH

CERTIFICATION OF AMBULANCE TRANSPORTATION

MAXWELL, KIARA L
DOB: 05/22/2008 17 Y F
DOS: 06/13/2025 19:29
ATT:
PIN: 10871530 Maxwell

GENERAL INFORMATION

Patient's Last Name: Maxwell First Name: Kiara MI: Gender: ☐ Male ☒ Female

Date of Birth (MM/DD/YYYY): 05/22/2008 Medicaid#: 9316535276733

Transport Date (if form will be used for a single transport): 06 / 15 /2025 Round Trip: ☐ Yes ☒ No

Date Range (if applicable) Start date: / / End date: / /

☐ 180 days from start date *(Maximum 180 days from start date - LA Medicaid ONLY)*

Transport from: ☐ Home, or Jackson Parish Hospital 165 Beech Springs Road Jonesboro, La 71251

Transport To: Oceans Behavioral 9320 Linwood Shreveport Louisiana Behavioral Health Shreveport 9320 Linwood Dr Shreveport, LA 71106

SECTION II – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

Certifying Physician/Practitioner Information:

Facility: Jackson Parish Hospital Address: 165 Beech Springs Road

City: Jonesboro State: La Zip Code: 71251

Telephone number *(and extension if applicable)*: 318-259-4321 Extension:

I certify that the information contained in this document represents an accurate assessment of the patient's medical condition on the date(s) of service.

x S. Thissel, RN
Signature of Physician or Authorized Healthcare Professional

6-15-25
Date Signed

S. Thissel, RN
Printed Name of Physician or Authorized Healthcare Professional

1093793408
NPI or License Number

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner
☒ Registered Nurse (RN) ☐ Clinical Nurse Specialist (CNS)

Please complete page 2

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DEPARTMENT OF HEALTH
Medicaid

MAXWELL, KIARA L
DOB: 05/22/2008 17 Y F
DOS: 06/15/2025 19:29
ATT:
FIN: 10871530 Kiara Maxwell

OF AMBULANCE TRANSPORTATION

Patient's Name:	DOB: 05 / 22 / 2008
Medicare #:	Medicaid #: 9316535276733

SECTION III – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transportation are contraindicated or it would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or the patient's condition is such that other methods of transportation are contraindicated. Medical necessity is determined by the patient's condition, not the diagnosis that makes the use of any other method of transportation contraindicated. Please answer the questions below to describe the reason (physical and/or mental) that makes non-emergency ambulance transportation necessary. Documentation supporting the information provided on this form must be maintained in the patient's medical record.

The following questions shall be answered by the healthcare professional whose signature is in Section II of this form to substantiate medical necessity for transport, and for this form to be valid.

1) Is this patient "bed confined" as defined below? ☐ Yes ☒ No

To be "bed confined" the patient must satisfy all three of the following criteria:
(a) unable to get up from bed without assistance; AND (b) unable to ambulate; AND (c) unable to sit in a chair or wheelchair.

2) Other means of transportation are contraindicated *because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience.* ☒ Yes ☐ No

Reason(s) (physical and/or mental) that non-emergency ground transport by ambulance is required. Supporting documentation for any checked item must be maintained in the patient's medical record. Check all that apply:

☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and deconditioning	
☐ Spinal Cord Injury - Paralysis	☐ Postural Instability
☐ CVA with sequelae (late effect of CVA) that impair mobility and result in bed confinement	
☐ Hemiparesis	☐ Progressive demyelinating disease
☐ Hemiplegia	☐ Moderate to severe pain on movement
☐ Unable to transfer independently	☐ Chronic wounds requiring immobilization
☐ Risk of falling out of wheelchair while in motion (not related to obesity)	☐ Special handling ensure - isolation
☐ Non-weight Bearing Condition	☐ Completely immobile
☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks	
☐ Requires extensive medical care for ADLs	☐ DVT requires elevation of lower extremity
☐ Non-healed fractures requiring ambulance	☐ Morbid obesity requires additional personnel/equipment to handle
☐ Contractures that impair mobility and result in bed confinement	☐ Third party attendant required to regulate or adjust oxygen outputs
☐ Incapacitating Osteoarthritis	☐ IV medications/fluids required during transport
☐ Orthopedic device required in transit	☐ Cardiac monitoring required enroute
☐ Amputations	☐ Hemodynamic monitoring required
☐ Severe cerebral accident/paresis and deconditioned state precludes any significant physical activity	
☐ Confused, combative, lethargic, comatose	☐ Danger to self or others
☐ Restraints (physical or chemical) anticipated or used during transport, or to prevent falling	
☒ Other, describe: Intentional drug overdose	

Revision Date: 10.01.2024 Page | 2

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.)**

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

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.

1182-C

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)

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   VERITA GLOBAL

   Where should notices to the creditor be sent?
   Jackson Parish Ambulance Service
   Name
   115 Watts Street
   Number Street
   Jonesboro, LA 71251-2053
   City State ZIP Code
   U.S.A.
   Country
   Contact phone 318-259-2891
   Contact email officemanager@jpasd.com

   Where should payments to the creditor be sent? (if different)
   Jackson Parish Ambulance Serv
   Name
   115 Watts Street
   Number Street
   Jonesboro, LA 71251-2053
   City State ZIP Code
   U.S.A.
   Country
   Contact phone 318-259-2891
   Contact email officemanager@jpasd.com

   Uniform claim identifier (if you use one):
   _____

4. **Does this claim amend one already filed?**
   ☒ No
   ☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**
   ☒ No
   ☐ Yes. Who made the earlier filing? _____

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
   ☐ No
   ☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ___ ___ ___ ___

7. **How much is the claim?**
   $ 3,192.50 . **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)?**

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

☒ No

☐ Yes. *Check all that apply:*

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:

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SEP 30 2025
VERITA GLOBAL

Name: Scott (First name) Shurley (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 (City) LA (State) 71104 (ZIP Code) U.S.A. (Country)

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

Support.Claims@Modivcare.com
ModivCare

798 Park Ave NW
4th Floor
Norton, VA 24273

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

1. MEDICARE (Medicare#)	MEDICAID X (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9316535276733
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MAXWELL KIARA L	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 2008	SEX: M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial): MAXWELL KIARA L				
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other		7. INSURED'S ADDRESS (No., Street): [redacted]				
CITY: [redacted] STATE: [redacted]	8. RESERVED FOR NUCC USE		CITY: [redacted] STATE: [redacted]				
ZIP CODE: [redacted] TELEPHONE (Include Area Code): ( )			ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]) [redacted]				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): MAXWELL KIARA L	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 9316535276733	a. EMPLOYMENT? (Current or Previous): YES NO X		a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] 2008 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				
d. INSURANCE PLAN NAME OR PROGRAM NAME: UHC of LA	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.
SIGNED: Signature on File DATE: 06 15 2025

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 06 15 25 QUAL.: 431	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	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY 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. R45851 B. Z743 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 06 15 25	06 15 25	41		A0428	HH	AB	1 000 00	1		ZZ	341600000X
										NPI	1124021092
2 06 15 25	06 15 25	41		A0425	HH	AB	2 192 50	88		ZZ	341600000X
										NPI	1124021092
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
72-1433510	025-20250616001:1	X YES NO	$ 3 192 50	$ 0 00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Aaron Johnson 8/28/2025 SIGNED DATE	Jackson Parish 165 Beech Springs Rd Jonesboro, LA 71251 10:22:49 PM a.	Louisiana Behavioral 9320 Linwood Ave Shreveport, LA 71106 11:53:45 PM b.	(888) 357 9977 Jackson Parish Amb Service Dist 115 Watts St Jonesboro, LA 71251 a. 1124021092 b. ZZ341600000X

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061657 APPROVED OMB-0938-1197 FORM 1500 (02-12)

MB-0D3W-M7PA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD

ENVELOPE BSS-92588-024

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the [redacted] payment in full. See Black Lung and FECA instructions regarding required proced[redacted]

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

I submit[redacted] this claim for payment from federal funds, [redacted] 1) the information on this form is true, accurate and [redacted]plete; 2) I have familiarized myself with all applic[redacted] regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regu[redacted] gra[redacted]ructions for payment incl[redacted] not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark. I[redacted] services [redacted] this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision (except as otherwise expressly permitted by Medicare or TRICARE); 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any [redacted] who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq. 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.