5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
2	PATIENT'S NAME	Enter the patient's full last name, first name, and middle initial. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should **not** be included with the name.
3	PATIENT'S BIRTH DATE, SEX	Enter the patient's 8-digit birth date (MM|DD|YYYY). Enter an X in the correct box to indicate sex of the patient. Only one box can be marked. If gender is unknown, leave blank.
4	INSURED'S NAME	Enter the insured's full last name, first name, and middle initial. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. **Do not use terms such as "Self" or "Same" if the patient is also the insured.** If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should **not** be included with the name.
5	PATIENT'S ADDRESS	Enter the patient's mailing address. This field has 3 lines -- the first line is for the street address; the second line, the city and state; and the third line, the ZIP code. "Patient's Telephone" is not used in processing and is not required by Highmark. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code **without** the hyphen.
6	PATIENT RELATIONSHIP TO INSURED	Enter an X in the correct box to indicate the patient's relationship to insured. Only one box can be marked.
7	INSURED'S ADDRESS	Enter the insured's address. If Item #4 is completed, then this field should also be completed. This field has 3 lines -- the first line is for the street address; the second line, the city and state; and the third line, the ZIP code. "Insured's Telephone" is not used in processing and is not required by Highmark. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code **without** the hyphen.

Continued on next page

5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
8	RESERVED FOR NUCC USE	**Highmark does not need this information to adjudicate the claim.** Leave blank.
9	OTHER INSURED'S NAME	If Item #11d is marked, complete fields 9 and 9a-d; otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item #2. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. **Do not use periods within the name.** If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should **not** be included with the name.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the policy or group number of the other insured.
9b	RESERVED FOR NUCC USE	**Highmark does not need this information to adjudicate the claim.** Leave blank.
9c	RESERVED FOR NUCC USE	**Highmark does not need this information to adjudicate the claim.** Leave blank.
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Enter the other insured's insurance plan or program name.
10a,b,c	IS PATIENT'S CONDITION RELATED TO:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item #24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The 2-letter state code (e.g., PA, DE) must be shown if "YES" is marked in Item #10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance.
10d	CLAIM CODES (Designated by NUCC)	Highmark requires the sub-set of Condition Codes approved by the NUCC in this field, when applicable. When reporting more than one code, enter three blank spaces and then the next code. The Condition Codes approved for use on the 1500 Claim Form are available at http://www.nucc.org under Code Sets.

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,
Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
11	INSURED'S POLICY, GROUP, OR FECA NUMBER	Enter the insured's policy or group number as it appears on the insured's health care identification card. **Do not use a hyphen or space as a separator within the policy or group number.** If Item #4 is completed, then this box should also be completed.
11a	INSURED'S DATE OF BIRTH, SEX	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex of the insured. Only one box can be marked. If gender is unknown, leave blank.
11b	OTHER CLAIM ID (Designated by NUCC)	**Highmark does not need this information to adjudicate the claim.** Leave blank.
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Enter the insurance plan or program name of the insured.
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**Highmark does not need this information to adjudicate the claim.** The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim. You may report "Signature on File," "SOF," or a legal signature in this box. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes, and (2) enter the date signed in 6-digit format (MM|DD|YY). If there is no signature on file, leave blank or enter "No Signature on File."
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	**Highmark does not need this information to adjudicate the claim.** The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits. You may report "Signature on File," "SOF," or a legal signature in this box. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes, and (2) enter the date signed in 6-digit format (MM|DD|YY). If there is no signature on file, leave blank or enter "No Signature on File."

Continued on next page

5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

What Is My Service Area?

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
14	DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	Enter the 6-digit (MM|DD|YY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Be sure to complete this field when services were performed as a result of accident or injury. Enter the applicable qualifier to identify which date is being reported: • 431 - Onset of Current Symptoms or Illness • 484 - Last Menstrual Period **Be sure to enter the date and qualifier in the correct fields.** The qualifier is entered to the right of the vertical, dotted line.
		For physical, occupational, and speech therapy services: This box **must** be completed if the Highmark Delaware member has a per condition benefit.
15	OTHER DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit format (MM|DD|YY). (*Previous pregnancies are not a similar illness.*) Leave blank if unknown. Enter the applicable qualifier to identify which date is being reported. • 454 - Initial Treatment • 304 - Latest Visit or Consultation • 453 - Acute Manifestation of a Chronic Condition • 439 - Accident • 455 - Last X-ray • 471 - Prescription • 090 - Report Start (Assumed Care Date) • 091 - Report End (Relinquished Care Date) • 444 - First Visit or Consultation **Be sure to enter the date and qualifier in the correct fields.** The qualifier is entered between the left-hand set of vertical, dotted lines.
		For physical, occupational, and speech therapy services: Please provide date if applicable.
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	If the patient is employed and is unable to work in current occupation, a 6-digit (MM|DD|YY) date must be shown for the "from-to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim. Do not use periods or commas. A hyphen can be used for hyphenated names. If multiple providers are involved, **enter <u>one</u> provider only** using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Enter the applicable qualifier to identify which provider is being reported. • DN - Referring Provider • DK - Ordering Provider • DQ - Supervising Provider **Enter the qualifier to the left of the vertical, dotted line.**
17a	OTHER ID#	**When the Referring Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.** The **PXC** Provider Taxonomy qualifier is reported in the qualifier field to the immediate right of the box containing "17a," followed by the referring Provider's taxonomy code.
17b	NPI#	Enter the NPI number of the referring provider, ordering provider, or other source in Item #17b.
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Enter the inpatient 6-digit (MM|DD|YY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization (inpatient services only).
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Highmark does not need this information to adjudicate the claim.** Leave blank.
20	OUTSIDE LAB? $CHARGES	**Highmark does not need this information to adjudicate the claim.** Leave blank.

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	The **"ICD Indicator"** identifies the version of the ICD code set being reported. Enter **0** (zero) for ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field. **Highmark will accept only ICD-10-CM diagnosis codes for dates of service October 1, 2015, and after.** ********** In A – L, enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 diagnosis codes. Use the highest level of specificity. Enter the codes **left-justified** on each line. Do **not** include the decimal point within the diagnosis code. Relate lines A - L to the lines of service in 24E by the letter of the line. **** Do not provide narrative description in this field. **** ********** Please see instructions regarding FEP claims and anesthesia reporting in Chapter 5, Unit 2.
22	RESUBMISSION	*When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the **Resubmission Code** field.* • *7 - Replacement of prior claim* • *8 - Void/cancel of prior claim* *The original claim number is required for all adjustment claims. Enter it in the **Original Ref. No.** field.* ***Note:** Effective January 1, 2018, Highmark will not accept requests for claim corrections via telephone or NaviNet® Claim Investigation. You must submit a paper replacement claim if your original claim was submitted on paper.* Why blue italics?
23	PRIOR AUTHORIZATION NUMBER	For ambulance services, use this block to report the ZIP code of the Point of Origin. (The 9-digit ZIP+4 Code is not required for the Point of Origin but will be accepted if reported.) Ambulance providers who submit paper claims for non-emergent ambulance transports must attach a PMNC (*Physician's Medical Necessity Certification*) form to the claim.

Continued on next page

5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

<table>
<tr><th>ITEM #</th><th>FIELD TITLE /DESCRIPTION</th><th>INSTRUCTIONS</th></tr>
<tr><td>24</td><td></td><td>
Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

The following are types of supplemental information, and their qualifier, that can be entered in the shaded lines of Boxes 24A through 24H:
<table>
<tr><th>QUALIFIER</th><th>TYPE OF INFORMATION</th></tr>
<tr><td>7 Anesthesia information</td><td>Report the surgical HCPC procedure code when a 'Not Otherwise Specified' or 'Not Otherwise Classified' anesthesia service is reported. A complete description of the surgical service performed can be used in lieu of a surgical HCPC code or if the only applicable surgical procedure code is an NOC.</td></tr>
<tr><td>ZZ Narrative description of unspecified code</td><td>Narrative description of unspecified code.</td></tr>
<tr><td>N4 National Drug Codes (NDC)</td><td>National Drug Codes (NDC) for drugs: Report the qualifier, N4, prior to the 11-digit* NDC, e.g., N499999999999.</td></tr>
</table>
To enter supplemental information in the shaded area, begin at Box 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

* Many NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10-digit to 11-digit format requires a strategically placed zero, dependent on the 10-digit format. For more information, refer to the section titled, Reporting National Drug Codes.
</td></tr>
</table>

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
24A	DATE(S) OF SERVICE	Enter date(s) of service, from and to, in 6-digit format (MM|DD|YY). If one date of service only, enter that date under "From." Leave "To" blank. If grouping services, you may range date if the place of service, procedure code, charges, and individual provider for each line is identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in Item #24G. **An exception to this is prolonged detention care. Do not range date these services even when performed on consecutive days.**
24B	PLACE OF SERVICE	Enter the appropriate 2-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: https://www.cms.gov/place-of-service-codes
24C	EMG	**Highmark does not need this information to adjudicate the claim.** Leave blank.
24D	PROCEDURES, SERVICES, OR SUPPLIES	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of one procedure code and up to four 2-character modifiers. The specific procedure code(s) must be shown without a narrative description. Please see Chapter 5, Unit 2 for additional reporting tips.
24E	DIAGNOSIS POINTER	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. **Enter letters left justified in the field.** Do not use commas between the letters; hyphens can be used for ranges of multiple letters. This field allows for the entry of 4 characters in the unshaded area. **Diagnosis codes must be entered in Item Number 21 only.** Do not enter them in 24E.
24F	$ CHARGES	Enter the charge for each listed service. Enter the number right-justified in the left-hand area of the field. Do not use commas or dollar signs when reporting the dollar amount. Do not report negative dollar amounts. Enter 00 in the right-hand area of the field if the amount is a whole number.

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

ITEM #	FIELD TITLE/DESCRIPTION	INSTRUCTIONS
24G	DAYS OR UNITS	Enter the number of days, units, or minutes. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. When required by payers to provide the NDC units in addition to the HCPCS units, enter the applicable NDC units' qualifier and related units in the shaded line following the NDC qualifier and code. The following qualifiers are to be used when reporting an NDC quantity. Report the qualifier prior to the quantity, e.g., UN2. **F2** International Unit | **ML** Milliliter **GR** Gram | **UN** Unit
24H	EPSDT/FAMILY PLAN	**Highmark does not need this information to adjudicate the claim.** Leave blank.
24I	ID QUALIFIER	The 'NPI' ID qualifier is pre-populated in the non-shaded area of Item #24I. (The Rendering Provider's NPI is reported in the non-shaded area of Item #24J.) **When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.** When required to report the Rendering Provider's Taxonomy Code, enter the **PXC** Provider Taxonomy qualifier in the shaded area of Item #24I. **Note:** In most instances, the 3-character PXC qualifier can be printed within Item #24I. If the PXC qualifier runs into Item #24J, our Optical Character Recognition (OCR) scanner will still capture the qualifier and provider taxonomy correctly since 24I and 24J are read as one field.

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,

Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
24J	RENDERING PROVIDER ID#	The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the provider's information in Item Numbers 24I and 24J only when different from data recorded in Item Numbers 33a and 33b. In other words, when you report a billing provider (e.g., assignment account) in Item #33, you must report the rendering/performing provider information in Item #24I and Item #24J. Enter the Rendering Provider's NPI number in the non-shaded area of Item #24J. **When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.** In the shaded area of Item #24J, enter the Rendering Provider's Taxonomy Code when required.
25	FEDERAL TAX ID NUMBER	Enter the federal tax ID (employer identification number) or Social Security Number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. **This must be the tax ID which correlates to the billing provider reported in Item #33.**
26	PATIENT'S ACCOUNT NO.	Optional. Highmark does not require this number for processing; however, we can reference this number when contacting your office for additional information.
27	ACCEPT ASSIGNMENT?	Enter an X in the correct box. Only one box can be marked. **Note:** This box is required for government claims only.
28	TOTAL CHARGE	Enter total charges for the services (i.e., total of all charges in column 24F). Enter amount right justified in the left-hand area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the right-hand area if the amount is a whole number.

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,
Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
29	AMOUNT PAID	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	RESERVED FOR NUCC USE	**Highmark does not need this information to adjudicate the claim.** Leave blank.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	This field must be completed on all claims to affirm that the reported services were performed by the provider, or performed under the provider's personal supervision. The name of the individual performing the service on the claim must be entered. The name may be computer printed or typed. Simply reporting the name of the group is insufficient.
32	SERVICE FACILITY LOCATION INFORMATION	Enter the name, address, city, state, and ZIP code of the location where the services were rendered. The full nine digits of the ZIP+4 Code must be reported. Enter the 9-digit ZIP code **without** the hyphen. The use of zeros (0000) or spaces for the last four digits of the ZIP+4 code is not valid. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line - City, State and ZIP+4 Code **Note:** A physical street address must be reported for the Service Facility Location -- a P.O. Box or lock box will not be accepted. Highmark requires the Service Facility Location when the service was performed at a secondary location and the provider's primary location was reported in Item #33. Highmark always requires the Service Facility Location when the Place of Service reported in Item #24B is one of the following: 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room – Hospital 31 - Skilled Nursing Facility 32 - Nursing Facility 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility

Continued on next page

5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,
Continued

ITEM #	FIELD TITLE /DESCRIPTION	INSTRUCTIONS
32a	SERVICE FACILITY - NPI#	Enter the NPI number of the service facility location.
32b	SERVICE FACILITY - Other ID#	**When the National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.** Enter the **PXC** Provider Taxonomy qualifier followed by the Provider's Taxonomy Code when required.
33	BILLING PROVIDER INFO & PH #	Item #33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter the billing provider's name, address, ZIP code, and telephone number. The full nine digits of the ZIP+4 Code must be reported. Enter the 9-digit ZIP code **without** the hyphen. The use of zeros (0000) or spaces for the last four digits of the ZIP+4 code is not valid. The telephone number is to be entered in the area to the right of the box title. Enter the name and address information in the following format: 1st Line - Name 2nd Line – Address 3rd Line - City, State and ZIP+4 Code **Note:** A physical street address must be reported for the Billing Provider -- a P.O. Box or lock box will not be accepted.
33a	BILLING PROVIDER - NPI#	Enter the NPI number of the billing provider reported in Item #33.
33b	BILLING PROVIDER - Other ID#	**When the Billing Provider's National Provider Identifier (NPI) is associated with more than one Highmark-assigned provider number, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.** Enter the **PXC** qualifier followed by the Provider's Taxonomy Code when required.

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5.3 1500 CLAIM FORM (02/12) COMPLETION INSTRUCTIONS,
Continued

Additional edit checks for paper billers

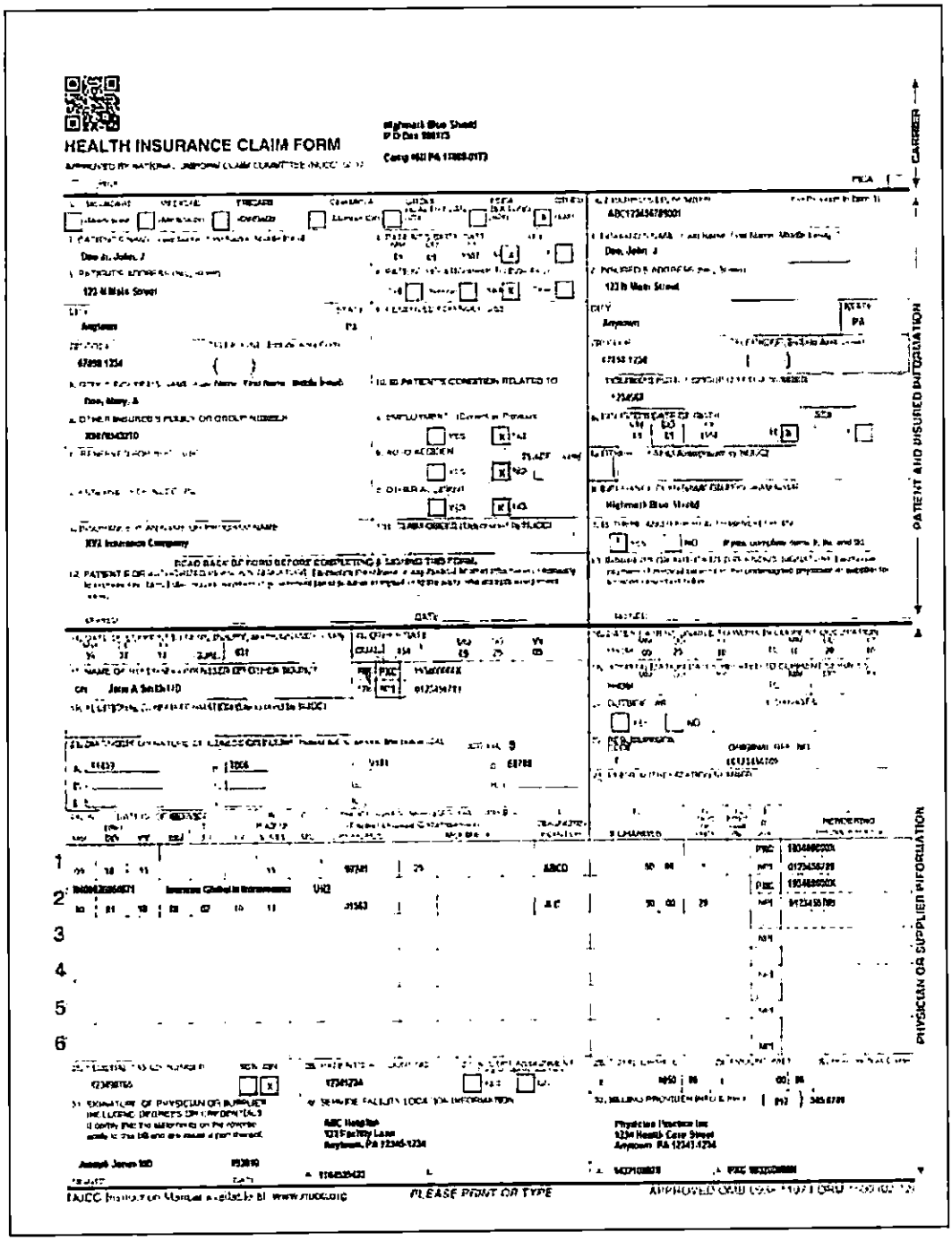
Highmark does not attempt to correct or retrieve missing information for the situations listed below. Instead, these situations will result in a rejection of the claim, and you will be required to resubmit a new claim with the corrected data.

When a claim rejects, it is important for your billing staff and/or vendor to understand exactly what was wrong and what is needed to correct it.

If you submit paper claims, you may encounter the following denial codes and descriptions on your explanation of benefits notices:

REJECTION CODE	DESCRIPTION
B5606	In order to process the claim, additional information is required. Please resubmit the claim with a prescription for this service. Electronically enabled providers should resubmit electronically.
P5039	In order to process this claim, additional information is required. The claim should be resubmitted with a valid modifier and associated number of services rendered. Electronically enabled providers should resubmit electronically.
P5040	The patient's coverage does not provide for this service in the place of treatment reported. Therefore, no payment can be made.
P5010	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.
P5011	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.
P5012	The patient's sex is invalid for the reported procedure. Please resubmit the claim with verification of the patient's sex and/or a corrected procedure code or a complete description of service. Electronically enabled providers should resubmit electronically.

5.3 EXAMPLE 1500 HEALTH INSURANCE CLAIM FORM (02/12)



HEALTH INSURANCE CLAIM FORM

PLEASE PRINT OR TYPE

Exhibit G

HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA

ANCILLARY PROVIDER APPLICATION

A. PROVIDER INFORMATION

Provider Legal Name (From W-9): MedTest Laboratories LLC

Provider DBA Name: _____

Applications must include current copies of the following documentation:

Provider Federal Tax ID Number 47-4213979

Provider Year End: (Fiscal or Calendar) _____

Provider Medicare Number Q5089202281

Participating Status ✓ Non-Participating Status _____

Provider State License, Permit or Registration Number 2318-5271 State: WV

Initial Registration Date 6/12/15 Current Expiration Date _____

Provider Accreditation Name & Number (if applicable) _____

Initial Accreditation Date _____ Current Expiration Date _____

Provider National Provider Identifier Number 1821471319

Please check type of provider/providers this application applies to

- ☐ Ambulance
- ☐ Ambulatory Infusion Suite
- ☐ Durable Medical Equipment
- ☐ Hearing Aids
- ☐ Home Infusion Therapy
- ☐ Independent Diagnostic Testing Facility – Sleep Testing*
- ☐ Independent Diagnostic Testing Facility – Cardiac Event Monitoring
- ☑ Laboratory
- ☐ Orthotics and Prosthetics
- ☐ Pharmacy Vaccinations
- ☐ Portable x-ray*

*See Provider Specific Requirements prior to submitting application.

Main Provider Physical Address: *must include zip+4*
3800 Teays Valley Road Suite 2
Hurricane, WV. 25526-9022

County Putnam

Main Provider: Phone Number 304.945-9424

Customer Contact Number 304.945.9424 Fax Number 304.945.9093

v.10 040315

Web Site _____

Email _____

Practice Address if different from Main: ***must include zip+4***

_____

_____

County _____

Phone Number (____) _____-_____ Customer Contact Number (____) _____-_____

Fax Number (____) _____-_____ Web Site _____

Email _____

Billing/Check Address (if applicable): ***must include zip+4***

P.O. Box 4100

Bridgeville, WV. 25504-1909

Phone Number (304) 955 6200 Fax Number (304) 399 2526

1. Can the Provider provide 24 hour, 7 days / week coverage? Y If no, please specify hours available.
   M_____ T_____ W_____ Th_____ F_____ Sat_____ Sun_____
2. Will the Provider provide a Customer Service/Technical Support 1-800 telephone number or dedicated phone line?
   Yes____ No✓ If Yes, please attach a listing of the addresses of the Call Centers.
3. Does the Provider have electronic connectivity capability to facilitate communications and electronic billing?
   Yes✓ No____ If no, please give timeframe for the Provider to have the capability. _____ ***(required within 1 year of contracting)***
4. List any languages other than English fluently spoken by staff: _____
5. Are interpreters available? _____ Are they available after hours? _____
6. Do the company's facilities meet applicable American Disability Act (ADA) standards for accessibility? Please provide supporting documents for the main location and each location listed on Attachment A.
   Yes
7. Is the Provider subject to Act 13 of 2002 (MCARE – Medical Care Availability and Reduction of Error)? N
8. Please list the products and services the Provider will provide to members.
   All Laboratory Services.

9. Please check the counties where Provider expects to provide services.

WV County	Provide Services	WV County	Provide Services	WV County	Provide Services
Barbour		Kanawha		Preston	
Berkeley		Lewis		Putnam	✓
Boone		Lincoln		Raleigh	
Braxton		Logan		Randolph	
Brooke		Marion		Ritchie	
Cabell		Marshall		Roane	
Calhoun		Mason		Summers	
Clay		McDowell		Taylor	
Doddridge		Mercer		Tucker	
Fayette		Mineral		Tyler	
Gilmer		Mingo		Upshur	
Grant		Monongalia		Wayne	
Greenbrier		Monroe		Webster	
Hampshire		Morgan		Wetzel	
Hancock		Nicholas		Wirt	
Hardy		Ohio		Wood	
Harrison		Pendleton		Wyoming	
Jackson		Pleasants			
Jefferson		Pocahontas			

10. Do you have a Quality Assurance program? YES_____ NO ✓ (If yes, please attach Performance Improvement results for the past 2 years including a copy of quality indicators, methods of improvement and documentation of results.)

11. Do you conduct and trend patient satisfaction by survey? YES_____ NO ✓ (If yes, please attach a summary of the following: a) percentage of patients surveyed b) number of surveys returned c) results of the returned surveys d) include only local surveys)

B. PROVIDER CONTACTS

Application Contact Person Name Angela Taylor

Application Contact Person Title Credentialing Specialist

Phone Number (304) 399-4405 Fax Number (304) 399-2526

E-Mail Address Angela.Taylor@mpmswv.com

Parent Corporation Name (if applicable): _____

Address of Parent Corporation: *must include zip+4* _____

_____

Parent Corp. Contact Name _____

Contact Number (_____) _____-_____

Name of Credentialing Contact: Angela Taylor

Address: *must include zip+4*

P.O. Box 4100
Barboursville, WV. 25504-1909

Phone Number (304) 399-4406 Fax Number (304) 399-2526

E-Mail Address angela.taylor@mpmswv.com

Name of Chief Executive Officer: Muhammad Amjad

Address: *must include zip+4*

3860 Teays Valley Road
Hurricane, WV. 25526-9022

Phone Number 304.945.9424 Fax 304.945-9093

E-Mail Address _____

Name of Chief Financial Officer: _____

Address: *must include zip+4*

_____
_____

Phone Number (____) ____-____ Fax (____) ____-____

E-Mail Address _____

Name of Contract Administrator: Same as Credentialing

Address: *must include zip+4*

_____
_____

Phone Number (____) ____-____ Fax (____) ____-____

E-Mail Address _____

Name of Medical Director: Same as CEO

Address: *must include zip+4*

_____
_____

Phone Number (____)_____-_____ Fax (____)_____-_____

E-Mail Address_____

C. INSURANCE AND ACCREDITATION

Name of Professional Liability Insurance Carrier The Hilb Group of WV.

Address of Insurance Carrier P.O. Box 10618
Scott Depot, WV 25560

Phone Number (304) 757-0606 Fax 304) 757-2787

E-Mail Address Catherine.Gerichten@hilbgroup.com

To what limits is the Provider insured? Each Occurrence ✓ Aggregate _____

A copy of the current Certificate of Insurance is required.

Please check the appropriate responses for each accreditation/certification:

Accrediting Body	Yes	No	Conditional (Y/N)	Expiration Date
ABC – American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc.				
ACHC – Accreditation Commission for Health Care, Inc.				
BOC - Board of Orthotist/Prothetist Certification				
CARF - Commission on Accreditation of Rehabilitation Facilities				
CHAP - Community Health Accreditation Program				
HQAA - HealthCare Quality Association on Accreditation				
The Joint Commission				
The Compliance Team, Inc.				
Medicare Certified IDTF Provider				
American Academy of Sleep Medicine				
NBAOS - The National Board Of Accreditation for Orthotic Suppliers				
NABP – The National Board of Pharmacy				
DEA (Drug Enforcement Agency) Number				
ACLS Certified				
ATLS Certified				
APLS Certified				
PALS Certified				

College of American Pathologist				
Clinical Laboratory Improvement Act				
Other (specify):				
Other (specify):				

(Please attach a copy of Provider's most recent letter of accreditation/certification for each item for which the response was "Yes". Include any recommendations, limitations or conditions.)

D. PROVIDER INTEGRITY – Please answer all questions completely.

1. Within the past three years, has the Provider had any contingency and/or Type I, II or III recommendations, limitations, or conditional accreditation imposed by JCAHO or other accrediting body?

   Yes_____ No_✓_

   (If yes, please enclose a brief statement describing the circumstances, a copy of any corrective action plan which resulted descriptions of corrective actions taken and copies of pertinent correspondence from the accrediting body.)

2. *Within the past three years, has the Provider party to a malpractice or liability suit?

   Yes_____ No_✓_

   (If yes, please enclose a brief statement describing the circumstance, any corrective action taken and copies of pertinent correspondence.)

3. Within the past three years, has the Provider, been suspended from the Medicare or Medicaid program, Title V or Title XX programs, or had its state operating license revoked or suspended?

   Yes_____ No_✓_

   (If yes, please enclose a brief statement describing the circumstance, any corrective action taken and copies of pertinent correspondence from the government program which took the action.)

4. Has any insurer refused to issue coverage to the organization or canceled coverage within the last five (5) years?

   Yes_____ No_✓_

   (If yes, please enclose a brief statement describing the circumstance.)

5. Have any of the employees of the Provider ever been convicted of a felony offense?

   Yes_____ No_✓_

   (If yes, please enclose a brief statement describing the circumstance.)

*It is recognized that business requirements may necessitate that certain litigation strategies and settlements be maintained as confidential. When the Provider has such a concern, it should provide as much information as possible, as Highmark Blue Cross Blue Shield West Virginia is primarily interested in identifying issues of a quality assurance or improvement nature and the manner in which the provider addresses such issues. The Provider may where necessary omit physician and patient names.

The Provider should provide information on malpractice or liability suits involving Provider staff members to the extent available.

E. FINANCIAL PERFORMANCE

Please enclose the Provider's most recent audited report or balance sheet or budgeted financial statements *(if a new business and statements are not available).*

F. ADDITIONAL INFORMATION

Please provide any additional information that will assist in determining the need for the Provider and rationale for Highmark Blue Cross Blue Shield West Virginia to contract with the Provider to be a participating provider.

G. CONDITIONS OF APPLICATION

By applying for participation status with Highmark Blue Cross Blue Shield West Virginia, the Provider hereby:

* acknowledges that any material misstatements in or omissions from this application constitute cause for denial of the application or termination of an Agreement that will be entered into between the Provider and Highmark Blue Cross Blue Shield West Virginia;

*. understands that submission of this application is not an assurance of acceptance for participation with Highmark Blue Cross Blue Shield West Virginia and if not accepted it is not necessarily a reflection of the quality of the Provider; and

* represents and warrants that the signatory is authorized by the Provider, on its own behalf and on behalf of its participating providers, to submit this application and to provide additional information to Highmark Blue Cross Blue Shield West Virginia in connection with this application.

All information submitted in this application is true and complete to the best of my knowledge and belief. A photo static copy of this original statement constitutes written authorization and requires Provider to release any and all documentation relevant to this application. Such photo static copy shall have the same force and effect as the signed original.

6/6/16
Date

Angela Taylor
Authorized Signatory

Angela Taylor
Print Name

Credentialing Specialist
Title

MATERIALS CHECKLIST

- ✓ Copy of license/registration/certification (if applicable)
- ✓ Copy of Medicare certification
- N/A Copy of most recent letter of accreditation (if applicable)
- N/A Copy of CPA audit report and management letter and/or budgeted financial statements (if available)
- ✓ Copy of National Provider Identifier documentation including taxonomies from CMS and/or the appropriate CMS-contracted entity (if issued, must be provided for provider and all subparts)
- ✓ Copy of W-9 Form
- ✓ Copy of the current insurance verification (Professional Liability Insurance or Certificate of Insurance)

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
MedTest Laboratories LLC

2 Business name/disregarded entity name, if different from above
MedTest Laboratories, LLC

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☑ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ P
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
2006 Springdale Road

Requester's name and address (optional)
DPW, Provider Enrollment Unit
P.O. Box 8045
Harrisburg, PA 17105-8045

6 City, state, and ZIP code
Hurricane, WV 25526

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number: ___ - ___ - ____

or

Employer identification number: 47-4213979

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here Signature of U.S. person ▶ Muhammad Amjad, PhD Director Date ▶ 6/6/2016

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF REGISTRATION

LABORATORY NAME AND ADDRESS
MED TEST LABORATORIES LLC
3860 TEAYS VALLEY ROAD
HURRICANE, WV 25526

CLIA ID NUMBER
51D2098204

EFFECTIVE DATE
07/02/2015

LABORATORY DIRECTOR
MUHAMMAD AMJAD PHD

EXPIRATION DATE
07/01/2017

Pursuant to Section 353 of the Public Health Service Act (42 U.S.C. 263a), as amended by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown herein and qualified (or deemed qualified) may accept human specimens for the purposes of performing laboratory testing and/or procedures.

This certificate shall be valid until the expiration date noted, subject to timely and satisfactory participation in proficiency testing, or earlier revocation for violation of the Act or the regulations promulgated thereunder.

Randy W. Dyer, Acting Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

CMS-1014-07/2015

- If this is a Certificate of Registration, it indicates only the enrollment of the laboratory in the CLIA program and does not indicate a full and final determination of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.

WEST VIRGINIA
STATE TAX DEPARTMENT
BUSINESS REGISTRATION CERTIFICATE

ISSUED TO:
MEDTEST LABORATORIES, LLC
3860 TEAYS VALLEY RD 2
HURRICANE, WV 25526-9772

BUSINESS REGISTRATION ACCOUNT NUMBER: 2318-5271

This certificate is issued on: 06/12/2015

This certificate is issued by
the West Virginia State Tax Commissioner
in accordance with Chapter 11, Article 12, of the West Virginia Code

The person or organization identified on this certificate is registered to conduct business in the State of West Virginia at the location above.

This certificate is not transferrable and must be displayed at the location for which issued

This certificate shall be permanent until cessation of the business for which the certificate of registration was granted or until it is suspended, revoked or cancelled by the Tax Commissioner.

Change in name or change of location shall be considered a cessation of the business and a new certificate shall be required.

TRAVELING/STREET VENDORS: Must carry a copy of this certificate in every vehicle operated by them. CONTRACTORS, DRILLING OPERATORS, TIMBER/LOGGING OPERATIONS: Must have a copy of this certificate displayed at every job site within West Virginia.

atL006 v.4
L0265681216

PO BOX 100239 | COLUMBIA, SC 29202 | PALMETTOGBA.COM/MEDICARE | ISO 9001

A/B MAC JURISDICTION M
North Carolina, South Carolina, Virginia, West Virginia, Home Health and Hospice

PALMETTO GBA.
A CELERIAN GROUP COMPANY

September 24, 2015

ATTN: Muhammad Amjad
Medtest Laboratories LLC
3860 Teays Valley Rd Ste 2
Hurricane, WV 25526

DCN: 15202003000743

Dear provider,

We are pleased to inform you that the Medicare Enrollment application you had submitted has been approved. Listed below are your National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).

Organization Name:	Medtest Laboratories LLC
Practice location:	3860 Teays Valley Rd Ste 2 Hurricane, WV 25526
National Provider Identifier (NPI):	1821471319
Provider Transaction Access Number:	Q508920281
Specialty:	Independent Lab CLIA
You are a:	Participating Provider
Effective date:	06/21/2015

Please verify the accuracy of your enrollment information.

You are required by regulations found at 42 CFR 424.516 to submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information, and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Providers and suppliers may enroll or make changes to their existing enrollment in the Medicare program using the Internet-based Provider Enrollment, Chain and Organization System (PECOS). To apply via the Internet-based PECOS or to download the CMS-855 enrollment applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

Provider Information for 1821471319

MEDTEST LABORATORIES LLC
Organization Subpart: NO

NPI: 1821471319

Last Updated: 2015-08-07

Details

Name	Value
NPI	1821471319
Enumeration Date	2015-07-02
NPI Type	2- Organization
Status	Active
Mailing Address	2006 SPRINGDALE RD HURRICANE, WV 25526-9344 United States Phone: 304-757-9982 | Fax: 304-945-9093 View Map (/registry/map-view?q=2006 SPRINGDALE RD, HURRICANE, WV, 255269344, United States)
Primary Practice	3860 TEAYS VALLEY RD SUITE 2

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/12/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
The Hilb Group of West Virginia, LLC dba
P. O. Box 1068
Scott Depot WV 25560

CONTACT NAME: Catherine Gorichton
PHONE (A/C, No, Ext): (304)757-5666 FAX (A/C, No): (304)757-2787
E-MAIL ADDRESS: Catherine.Gorichton@hilbgroup.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Hartford Casualty Insurance Co	29424
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Medtest Laboratories, LLC
3860 Teays Valley Road
Hurricane WV 25526

COVERAGES CERTIFICATE NUMBER: CL1561228366 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC			40SBA442OLG	6/12/2015	6/12/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N N/A If yes, describe under DESCRIPTION OF OPERATIONS below						WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
A	Contents			40SBA442OLG	6/12/2015	6/12/2016	$100,000	$1,000 ded

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Evidence of Insurance

CERTIFICATE HOLDER
Evidence of Insurance

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
© Gorichton/CMG Catherine Gorichton

IN THE CIRCUIT COURT OF WOOD COUNTY, WEST VIRGINIA

HIGHMARK WEST VIRGINIA INC.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 18-C-271
	)	
MEDTEST LABORATORIES LLC, BRICE AND/OR BILLY TAYLOR, MUHAMMAD AMJAD, PH.D., MICHAEL CHEN, PH.D., JAMES TAYLOR, and VITAS LABORATORY, LLC	)	
	)	
Defendant.	)	
	)	
MEDTEST LABORATORIES LLC	)	
	)	
Counterclaim-Plaintiff,	)	
	)	
v.	)	
	)	
Highmark West Virginia Inc., Blue Cross and Blue Shield of Alabama, Anthem, Inc., Health Care Service Corporation, A Mutual Legal Reserve Company, Cambia Health Solutions, Inc., CareFirst, Inc., Premera Blue Cross, Blue Cross and Blue Shield of Arizona, Inc., USAble Mutual Insurance Company, d/b/a Arkansas Blue Cross and Blue Shield, Blue Cross of California d/b/a Anthem Blue Cross, California Physicians' Service, Inc. d/b/a Blue Shield of California, Rocky Mountain Hospital and Medical Service, Inc., d/b/a Anthem Blue Cross and Blue Shield, Anthem Blue Cross and Blue Shield, Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield of Connecticut, Highmark Inc,	)	

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware,
Group Hospitalization and Medical Services, Inc. d/b/a CareFirst BlueCross BlueShield,
Blue Cross and Blue Shield of Florida, Inc.,
Blue Cross and Blue Shield of Georgia, Inc.,
Blue Cross of Idaho Health Service, Inc.,
Regence BlueShield of Idaho, Inc.,
Blue Cross and Blue Shield of Illinois,
Anthem Insurance Companies, Inc. d/b/a Anthem Blue Cross and Blue Shield of Indiana,
Wellmark, Inc. d/b/a/ Wellmark Blue Cross and Blue Shield of Iowa,
Blue Cross and Blue Shield of Kansas, Inc.,
Anthem Health Plans of Kentucky, Inc. d/b/a Anthem Blue Cross and Blue Shield of Kentucky,
Louisiana Health Service and Indemnity Company, PAC d/b/a/ Blue Cross and Blue Shield of Louisiana,
Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield of Maine,
CareFirst of Maryland, Inc. d/b/a CareFirst BlueCross BlueShield,
Blue Cross and Blue Shield of Massachusetts, Inc.,
Blue Cross and Blue Shield of Michigan,
BCBSM, Inc. d/b/a/ Blue Cross and Blue Shield of Minnesota,
Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company,
HMO Missouri, Inc. d/b/a Anthem Blue Cross and Blue Shield of Missouri,
Blue Cross and Blue Shield of Kansas City,
Caring for Montanans, Inc. f/k/a Blue Cross Blue Shield of Montana, Inc.,
Blue Cross and Blue Shield of Nebraska, Inc,
Anthem Blue Cross and Blue Shield of Nevada,
Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield of New Hampshire,

Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey,
Blue Cross and Blue Shield of New Mexico Insurance Company,
HealthNow New York Inc.,
Blue Shield of Northeastern New York, Inc.,
Blue Cross and Blue Shield of Western New York, Inc.,
Empire HealthChoice Assurance, Inc. d/b/a Empire BlueCross BlueShield,
Excellus Health Plan, Inc. d/b/a Excellus BlueCross BlueShield,
Blue Cross and Blue Shield of North Carolina,
Noridian Mutual Insurance Company d/b/a Blue Cross Blue Shield of North Dakota,
Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield of Ohio,
Blue Cross and Blue Shield of Oklahoma,
Regence BlueCross BlueShield of Oregon,
Capital Blue Cross,
Independence Hospital Indemnity Plan, Inc.,
Triple-S Salud, Inc.,
Blue Cross & Blue Shield of Rhode Island,
BlueCross BlueShield of South Carolina Inc.,
Wellmark of South Dakota, Inc. d/b/a Wellmark Blue Cross and Blue Shield of South Dakota,
BlueCross BlueShield of Tennessee, Inc.,
Blue Cross and Blue Shield of Texas,
Regence BlueCross BlueShield of Utah,
Blue Cross and Blue Shield of Vermont,
Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield of Virginia, Inc.,
Regence BlueShield,
Blue Cross Blue Shield of Wisconsin d/b/a Anthem Blue Cross and Blue Shield of Wisconsin,
Blue Cross & Blue Shield of Wyoming,

Counterclaim and Third-Party Defendants.

CERTIFICATE OF SERVICE

The undersigned, counsel for the Defendants', MedTest Laboratories, LLC, Brice Taylor, Billy Taylor, Muhammad Amjad, Ph.D., Michael Chen, Ph.D., James Taylor and Vitas Laboratory, LLC, does hereby certify that I have served a true and accurate copy of the foregoing *Answer on Behalf of MedTest Laboratories, LLC, Billy Taylor, Brice Taylor, James Taylor, Vitas Laboratories and Michael Chen, Ph.D. and Counterclaims and Third-Party Complaint* on the 8th day of April, 2019 via electronic mail upon the following counsel of record:

Stuart A. McMillan
Peter G. Markham
Gabriel Wohl
BOWLES RICE LLP
600 Quarrier Street
Charleston, WV 25301
P.O. Box 1386
Charleston, WV 25325-1386
Counsel for Plaintiff

Raymond S. Franks II (WVSB #6523)