Vatex Comment: The description quoted below is from the Third Amended Complaint in the federal court case noted at the top of the page. This invoice was submitted as evidence in the court proceedings.

"For example, appended hereto as Exhibit J is an invoice to an insurer for confirmatory testing of just one POCT cup in the amount of $1,920 (this is after the insurer was billed by the Health Care Provider for the initial screening test)."

Exhibit J

132956

PAGE: 2

19 HFHP COMMERCIAL
PO BOX 565001
ROCKLEDGE FL 32956

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA | FICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — [redacted]

3. PATIENT'S BIRTH DATE — SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) — [redacted]

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: FL

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY — [redacted] | STATE: FL

ZIP CODE — [redacted] | TELEPHONE (Include Area Code)

ZIP CODE — [redacted] | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER — [redacted]

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH — SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH — SEX: M | F

b. AUTO ACCIDENT? YES | NO X — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: 18 HFHP COMMERCIAL

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: MSP

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO X — If yes, return to and complete item 9 a-d.

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

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: AUTHORIZATION ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — [redacted]

17a.

17b. NPI — [redacted]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 338.29

2.

3.

4.

22. MEDICAID 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. #
09 23 08	09 23 08	81		82145	AmDH	1	140 00	1		NPI	
09 23 08	09 23 08	81		82491 SPECIMEN #1	NON SPECIFIC URINE QUANT	1	140 00	1		NPI	
09 23 08	09 23 08	81		82491 SPECIMEN #2	SINGLE STRIP	1	140 00	1		NPI	
09 23 08	09 23 08	81		82491 SPECIMEN #3		2	140 00	1		NPI	
09 23 08	09 23 08	81		82491 SPECIMEN #4		1	140 00	1		NPI	
09 23 08	09 23 08	81		82491 SPECIMEN #5		1	140 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER: 156555 — SSN | EIN

26. PATIENT'S ACCOUNT NO.: 28142663

27. ACCEPT ASSIGNMENT? (For govt. claims, see back): X

28. TOTAL CHARGE: CONTINUED

29. AMOUNT PAID

30. BALANCE DUE

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.)

MILLENIUM LABORATORIES16981 VIA TAZON, STE F [illegible]

32. SERVICE FACILITY LOCATION INFORMATION

MILLENIUM LABORATORIES

33. BILLING PROVIDER INFO & PH #: 603 578-3902

MILLENIUM LAB OF CA INC
PO BOX 841773
DALLAS TX 75284
9779133162

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM 1500 (08-05) FL

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

132956

PAGE. 1

18 HFHP COMMERCIAL
PO BOX 565001
ROCKLEDGE FL 32956

500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID#)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]		3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M X F					4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]
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 FL	8. PATIENT STATUS Single Married Other					CITY [redacted] STATE FL
ZIP CODE [redacted]	TELEPHONE (Include Area Code) [redacted]	Employed Full-Time Student Part-Time Student					ZIP CODE [redacted] TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER [redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES X NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F		b. AUTO ACCIDENT? YES X NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES X NO					c. INSURANCE PLAN NAME OR PROGRAM NAME 18 HFHP COMMERCIAL
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE MSP					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d

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

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 AUTHORIZATION ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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 [redacted]	17a. 17b. NPI [redacted]	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 338.29 3. 2. 4.		22. MEDICAID 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. #
09 23 08	09 23 08	81		80102 SPECIMEN #1	CONF-ANAL	1	100 00	1		NPI	
09 23 08	09 23 08	81		80102 SPECIMEN #2		1	100 00	1		NPI	
09 23 08	09 23 08	81		80102 SPECIMEN #3		1	100 00	1		NPI	
09 23 08	09 23 08	81		80154	BENZO	1	140 00	1		NPI	
09 23 08	09 23 08	81		82055	ETOH	1	80 00	1		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. BALANCE DUE
26-1565578		28142663	X YES NO	CONTINUED		

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 #
MILLENIUM LABORATORIES	MILLENIUM LABORATORIES	MILLENIUM LAB OF CA INC 805 578-3902
	15981 VIA JAZON, STE F	PO BOX 841773
	SAN DIEGO CA 92127	DALLAS TX 75284
		1467933162

PLEASE PRINT OR TYPE

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

APPROVED OMB-0938-0999 FORM 1500 (08-05)

132956

PAGE 3

18 HFHP COMMERCIAL
PO BOX 565001
ROCKLEDGE FL 32956

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [X]

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

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: FL

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: [redacted] STATE: FL

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: [redacted]

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: 18 HFHP COMMERCIAL

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: MSP

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

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

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 AUTHORIZATION ON FILE

PATIENT AND INSURED INFORMATION

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE 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: [redacted] 17a. 17b. NPI [redacted]

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 338.29
2.
3.
4.

22. MEDICAID 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 CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
09 23 08	09 23 08	81		82520	COCAINE	1	140 00	1		NPI	
09 23 08	09 23 08	81		83840	mTp	1	140 00	1		NPI	
09 23 08	09 23 08	81		83925 SPECIMEN #1	OP	1	140 00	1		NPI	
09 23 08	09 23 08	81		83925 SPECIMEN #2	OC	1	140 00	1		NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 2[illegible]

26. PATIENT'S ACCOUNT NO.: 28142657

27. ACCEPT ASSIGNMENT? [X] YES [ ] NO

28. TOTAL CHARGE: 1920 00

29. AMOUNT PAID: 0 00

30. BALANCE DUE: 1920 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.)

MILLENIUM LABORATORIES

32. SERVICE FACILITY LOCATION INFORMATION: MILLENIUM LABORATORIES 16981 VIA TAZON STE F SAN DIEGO CA 92127

33. BILLING PROVIDER INFO & PH #: 805 378-3922
MILLENIUM LAB OF CA INC
PO BOX 841773
DALLAS, TX 75284

a. 1497933162

NUCC Instruction Manual available at: www.nucc.org

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