

* * * Communication Result Report (Jan. 5. 2026 9:56AM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: Jan. 5. 2026 9:54AM

File No. Mode	Destination	Pg(s)	Result	Page Not Sent
1190 Memory TX	918444962357	P. 4	OK	

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E. 2) Busy
 m. 4) No facsimile connection
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12/31/25 13:15:42 Claims Management Sy ->

3M2443396 Claims Management Sy Page 881



labcorp

FAX TRANSMITTAL - Confidential Information

Please Fax information to:
 +1 (844) 496-2367 or +1 (844) 496-2356

TO: Practice Name: AURUM UNIVERSITY AT MONTGOMER Fax: # (334) 244-3396 Account No: 01026540 No of Pages (including this page): 1		FROM: Labcorp - RCM Order Processing and Exception Management Name of Representative: sislosa Phone #: +1 (877) 352-4361	
To bill appropriately and timely for our services, we are requesting that your office provides the information indicated below.			
Specimen Number: 533705100970 Patient Name: FLEMING, JORDAN Date of Birth: 08/04/1981 Date of Service: 12/03/2025 Physician Name: GUTHRIE H		Please Provide Requested Information:	
Test Codes: TEST TEST NUM NAME 093895 Roblox Nout Absa YbraL			
Information Needed: ☐ Ordering Physician's Name ☐ Ordering Physician's UPIIN (if available) ☐ Ordering Physician's NPI ☐ ICD-10 Diagnostic Codes (Highest Level Of Specificity) ☒ Insurance Carrier ☒ Subscriber Number ☒ Group Number ☒ Insurance Address ☐ Patient's Address ☐ Patient's DOB ☐ Patient's Gender ☐ Patient Status (In Patient, Out Patient or Non Patient) ☐ Date Of Injury ☐ Patient ID or MRN (if Available)			
Labcorp Comments: PLEASE PROVIDE PATIENT'S INSURANCE INFORMATION THAT IS PRIMARY AND ACTIVE WITHIN DATE OF SERVICE. IF UNINSURED, PLEASE TELL US HOW YOU'D LIKE US TO BILL THIS CLAIM. THANK YOU NOTE: FAX # IS 8444962367/8444962356; CALL BACK # IS 8773524361		Signature & Title of Physician or Designee Required: X <u>MF</u> <u>DRN</u> Date: 11/5/2026	
THE INFORMATION CONTAINED IN THIS FACSIMILE IS LEGALLY PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL AND ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR REPRODUCTION OF THIS TELECOPY IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS TELECOPY IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AND RETURN THE ORIGINAL FACSIMILE TO US AT THE ADDRESS LISTED ABOVE VIA THE UNITED STATES POSTAL SERVICE. WE WILL REIMBURSE YOU			



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TO:

Practice Name: AUBURN UNIVERSITY AT MONTGOMER

Fax : # (334) 244-3396

Account No : 01026540

No of Pages (including this page): 1

FROM:

Labcorp - RCM Order Processing and Exception Management

Name of Representative: sistosa

Phone #: +1 (877) 352-4381

To bill appropriately and timely for our services, we are requesting that your office provides the information indicated below.

Specimen Number: 533705100970

Patient Name: FLEMING, JORDAN

Date of Birth: 09/04/1991

Date of Service: 12/03/2025

Physician Name: GUTHRIE H

Please Provide Requested Information:**Test Codes:**

TEST TEST

NUM NAME

083885 Rabies Neut. Abs Titrat. (

Information Needed:

- () Ordering Physician's Name
- () Ordering Physician's UPIN (if available)
- () Ordering Physician's NPI
- () ICD-10 Diagnosis Codes (Highest Level Of Specificity)
- (X) Insurance Carrier
- (X) Subscriber Number
- (X) Group Number
- (X) Insurance Address
- () Patient's Address
- () Patient's DOB
- () Patient's Gender
- () Patient Status (In Patient, Out Patient or Non Patient)
- () Date Of Injury
- () Patient ID or MRN (If Available)

Labcorp Comments:

PLEASE PROVIDE PATIENT'S INSURANCE INFORMATION THAT IS PRIMARY AND ACTIVE WITHIN DATE OF SERVICE. IF UNINSURED, PLEASE TELL US HOW YOU'D LIKE US TO BILL THIS CLAIM. THANK YOU.

NOTE: FAX # IS 8444962357/8444962356; CALL BACK # IS 8773524381

Signature & Title of Physician or Designee Required:

X

Date :

11/5/2026

Auburn Montgomery Student Health Services

7461 East Dr
Montgomery, AL 36117
334-244-3281

Patient Demographics

Name: FLEMING, JORDAN
Address: 1839 ELM STREET ROAD
TROY, AL 36081
Pri Phy:

Chart No.: 2130
DOB: 09/04/1991
SSN:
Gender: FEMALE

Contact Information

Home Phone: 334-672-3209
Mobile Phone:
Mobile Phone 2:
Personal Email: jordan.fleming@sim.org
Work Email:

Work Phone:
Other Phone:

Primary Insurance Information

Insurance Company: 90 Degree Benefits
Address: P O BOX 211348
SAINT PAUL, MN 55121

Group No.: T031158
Policy No.: 800177410
Phone: Invalid Phone



The Right Turn For Your Benefits

Member

Group #: T031158
Plan: B
Member: John Fleming
Member ID: 800177410

Pharmacy Plan

Rx Bin: 015433
PCN: SSN
Rx Group: T031158



PBM Website: www.liviniti.com
PBM Phone: 800 710 9341

Copays: Generic: \$10
Brand: Preferred \$25 / Non-Preferred \$50

Health Plan

PHCS Partnership for
Healthy Communities multiplan.com/phcspacanc.com
877 952 7427

Coverage: Family

For Customer Assistance information, please call
844-632-7878 or visit www.90DegreeBenefits.com.

Copays / Deductible / Out-of-Pocket

OV \$25, UC \$25, ER PHYS \$500
Family Monthly Deductible \$500
Out-of-Pocket Maximum \$6,000

Pre-Certification



Pre-Certification is required prior to any hospital admission. Please have admitting physician or member call 877-465-3435. Emergency admission must be certified on the next business day. Failure to obtain pre-admission certification may result in a reduction of benefits.

Members

For your personal Medical Helpline Advocate call 844-341-7878



For 24/7 web access login to www.90DegreeBenefits.com

Claim Submission

Medical, Dental and Vision Claims Submission

EDI: Payer ID 36878

Mail: 90 Degree Benefits - Houston
PO Box 211348
Eagan, MN 55121

Providers

To confirm eligibility, verify benefits or check the status of a claim, please call 90 Degree Benefits at 844-632-7878 or visit our website at www.90DegreeBenefits.com. This Plan utilizes the PHCS Network ONLY for professional providers. Professional means physicians, ancillary providers, and other non-hospital contracted PHCS Network providers. For all hospital facility providers, the Plan pays 70% above the Medicare allowable schedule. This card does not guarantee benefits or payment. Plan allowable amount, limitations, and exclusions apply for all providers.

Ancillary Plan(s)

Dental Plan

Coverage: Family

Vision Plan

Coverage: Family