

* * * Communication Result Report (Jan. 5. 2026 9:59AM) * * *

1) AUM Warhawk Health Svcs.
2)

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

File No. Mode	Destination	Pg(s)	Result	Page Not Sent
1191 Memory TX	918444962357	P. 4	OK	

Reason for error
 E. 1) Hang up or line fail
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 E. 5) Exceeded max. E-mail size

E. 2) Busy
 E. 4) No facsimile connection
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12/25/25 03:47:34 Claims Management Sys ->

3342443396 Claims Management Sys Page 001



labcorp

FAX TRANSMITTAL - Confidential Information

Please Fax information to:
 +1 (844) 498-2357 or +1 (844) 498-2358

TO: Practice Name: AUBURN UNIVERSITY AT MONTGOMERY Fax: # (334) 244-3396 Account No: 01020540 No of Pages (including this page): 1	FROM: Labcorp - RCM Order Processing and Exception Management Name of Representative: shree 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: 533705101910 Patient Name: FLEMING, JOHN Date of Birth: 08/14/1990 Date of Service: 12/23/2025 Physician Name: GUTHRIE, H Test Codes: 059885 Rabies Neutral Abstr. (I)	Please Provide Requested Information:
Information Needed: ☐ Ordering Physician's Name ☐ Ordering Physician's UPI (if available) ☐ Ordering Physician's NPI ☐ ICD-10 Diagnosis 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 NPI (if Available)	Signature & Title of Physician or Designee Required: X <u>LAB. CORP.</u> Date: <u>11/6/2025</u>
Labcorp Comments:	
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 BY MISTAKE, 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	



FAX TRANSMITTAL - Confidential Information

Please Fax information to:

+1 (844) 496-2357 or +1 (844) 496-2356

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: shree Phone #: +1 (877) 352-4381
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To bill appropriately and timely for our services, we are requesting that your office provides the information indicated below.

Specimen Number: 533705101910

Patient Name: FLEMING, JOHN

Date of Birth: 09/14/1990

Date of Service: 12/03/2025

Physician Name: GUTHRIE H

Test Codes:

083885 Rabies Neut.Abs Titrat.(

Please Provide Requested Information:**Information Needed:**

- ☐ Ordering Physician's Name
- ☐ Ordering Physician's UPIN (if available)
- ☐ Ordering Physician's NPI
- ☐ ICD-10 Diagnosis 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:**Signature & Title of Physician or Designee Required:**

X

Date :

11/9/2024

Auburn Montgomery Student Health Services

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

Patient Demographics

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

Chart No.: 3637
DOB: 09/14/1990
SSN:
Gender: MALE

Contact Information

Home Phone: 334-333-2128
Mobile Phone:
Mobile Phone 2:
Personal Email: david.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.livinti.com
PBM Phone: 800.710.9341

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

Health Plan

PHCS Pharmacia Health Care Services multiplan.com/phospracanc.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

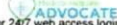
Pre-Certification



Pre-Certification is required prior to any hospital admission. Please have admitting physician or member call 877-463-3435. 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